UNIVERSITY OF SOUTHAMPTON

FACULTY OF EDUCATIONAL STUDIES

Doctor of Philosophy

INTER-SECTORAL COLLABORATION AND THE WORLD HEALTH ORGANISATION'S HEALTH FOR ALL INITIATIVE: A STUDY OF FIVE PROJECTS IN EASTLEIGH, HAMPSHIRE

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ABSTRACT

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INTER-SECTORAL COLLABORATION AND THE WORLD HEALTH ORGANISATION'S HEALTH FOR ALL INITIATIVE; A STUDY OF FIVE PROJECTS IN EASTLEIGH, HAMPSHIRE

This research focuses on inter-sectoral collaboration in health promotion within the World Health Organisation's Health for All Project. In recent years the impetus to work collaboratively across agencies to promote health has been increasing and this study provides the opportunity to test a viable model for effective joint working in this area.The research explores the development and the key principles of the World Health Organisation's Health for All initiative. The principle of inter-sectoral collaboration is the key theme for the research and a Health for All initiative in a local authority area in Hampshire - Eastleigh, provides the case study. The initiative was established on a funded basis in June 1990 and represents collaboration across the two health authorities providing services for the area, the local authority, social services, education and the voluntary services. The research provides the opportunity to test levels of collaboration achieved across areas of work to emerge from the Healthy Eastleigh initiative and from this to identify generalisable features for effective collaboration.

A review of the literature touching on the meanings and interpretations around the principle of joint working assists in the development of a model combining the essential features of effective collaboration. This is tested by means of a triangulated approach to research

using three methods - interview, analysis of documentary evidence and participant observation. The research tools are applied to five projects developed from the Healthy Eastleigh initiative. These focus on a variety of health issues and settings, from a project focusing on the promotion of healthy eating in the community to an initiative aimed at increasing the exchange of information across agencies to assist in project planning.

Interviews are undertaken with participants drawn from the agencies involved in Healthy Eastleigh and documentary evidence relating to each of the projects is analysed to assist in the identification of key characteristics linked to effective inter-sectoral collaboration. Participant observation is employed as a means of utilising the perceptions and observations of the researcher who was also a key participant in the initiative.

The viable model proposed for effective collaboration at the outset of the research, has been significantly expanded and modified by the end of this study. The recommendations to emerge from this study indicate a range of factors which impact on the degree to which effective joint working in the area of health promotion is achieved.

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INTRODUCTION

The World Health Organisation's Health for All initiative was launched in 1977 with the key aim of improving the social, physical, environmental and emotional health of all communities. The European Region's Health for All initiative published targets in 1984 to provide a focus for the planning, implementation and review and monitoring of health promoting activity. The key principles underpinning the Health for All movement comprise community participation, equity and inter-sectoral collaboration. The development of a viable model for inter-sectoral collaboration across agencies around health promotion and Health for All activity is the main focus of this research. The Health for All initiative established in Eastleigh, Hampshire, a local authority area provides the case study for the research, and detailed enquiry is undertaken into five separate projects developed from that initiative.

In Chapter One the background to Health for All is explored. The key principles of equity and community participation are examined in detail. Definitions for these principles are considered. The latter part of this chapter focuses on the importance of multi-agency approaches to health promotion and seeks to define inter-sectoral collaboration. A review of the theoretical literature around inter-sectoral collaboration and the current impetus for multi-agency working leads to the proposal of a possible model for effective joint working. This comprises five key features and provides the framework around which the research tools for the research are developed.

The background to the establishment of the Healthy Eastleigh initiative provides the focus for Chapter Two. The structure of the initiative is explored and a demographic profile of the Borough is outlined. The key

partners in the initiative are considered and a profile of the key service responsibilities of the statutory and non-statutory agencies participating is provided. This approach provides both the historical context for the initiative and an overview of the degree of multi-agency involvement.

Chapter Three builds on the review of the literature pertaining to the theory of inter-sectoral collaboration provided in Chapter One. The key themes around collaboration and Health for All in the European region are considered and models of good practice from both Health for All and health promotion are critically reviewed. Five initiatives are analysed in detail and a range of local authority based health promotion initiatives are proposed in the latter part of this chapter.

The process for identifying priority areas of work for the Healthy Eastleigh initiative is considered in detail in Chapter Four. The approach adopted to involve staff from across agencies in identifying local health needs is chronicled and the subsequent key areas of work are proposed. These focus on four priority issues: information and research, staff education and development, community participation and health promotion. The five projects providing the focus for the research into inter-sectoral collaboration emerged from this priority setting process.

The research design is considered in detail in Chapter Five. The triangulation of research methods is outlined and the methods of interview, analysis of documentary evidence and participant observation are critically reviewed. The benefits of each method are analysed and the way in which they are to be employed for the research into Healthy Eastleigh is explored. The interview schedule and the way in which it develops around the five

key features for effective collaboration proposed in Chapter One is considered. A framework for the analysis of documentary evidence is proposed which attempts to increase the wealth of qualitative data collected and to maximise the research outcomes from this approach.

Chapters Six to Ten focus in turn on each of the five Healthy Eastleigh projects providing the focus for this research, the Community Participation Project, the Healthy Shopping Scheme, the Smoking Prevention Programme, the Health Promotion Group and the Shared Information Project. For each the background in terms of focus and key aims and objectives is explored and the outcomes of the interview based research and the analysis of documentary evidence is provided. At the end of each chapter the key themes to emerge from the research findings are summarised.

The research process and findings from the employment of participant observation are considered in detail in Chapter Eleven. Each project is considered in detail and the observations are structured around a number of key themes. These include reference to the framework for analysis proposed in Chapter One and observations on such issues as multi-agency participation in project planning and implementation and official sanction for the projects across agencies.

Chapters Twelve and Thirteen consist of detailed analyses around the research outcomes and the key themes to emerge around inter-sectoral collaboration and Health for All and health promotion. In Chapter Twelve reference back to the model for effective collaboration proposed in Chapter One is made and an expanded viable model around effective collaboration proposed as a result of the research findings. In Chapter Thirteen a critical review of the research process and outcomes from the researcher's perspective is proposed. This provides

the opportunity to identify both the strengths and weaknesses of the research undertaken and its perceived value in terms of extending the boundaries of knowledge in this field. Future lines of enquiry uncovered by this approach to identify a viable model for inter-sectoral collaboration in health promotion are also proposed.

CHAPTER ONE

HEALTH FOR ALL BY THE YEAR 2000 - A WORLD HEALTH INITIATIVE

1. INTRODUCTION

The Health for All project in Eastleigh, Healthy Eastleigh, represents a local response to the World Health Organisation's (W.H.O.) Health for All by the Year 2000 initiative. Prior to focusing down on Healthy Eastleigh, the key features of the W.H.O. initiative will be explored. The European targets for health and key principles of Equity and Community Participation will be examined in the first half of this chapter. The second half will focus on the principle of Inter-sectoral Collaboration analysing meanings, interpretations and applications and propose a model of key features comprising effective collaboration. This will provide a framework for analysis for the main focus of this research - Inter-sectoral Collaboration and the Healthy Eastleigh Initiative.

2. BACKGROUND

In 1977 the World Health Assembly decided that the main social target of government's and the World Health Organisation should be the attainment by all the people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. The initiative was named Health for All by the Year 2000. In 1978 an international conference on Primary Health Care held in Alma Ata U.S.S.R. endorsed the Health for All concept and emphasised the need for co-ordination with other sectors to achieve this goal (Primary Health Care, W.H.O. 1978).
Health for All - global, regional and in countries is the

most ambitious health policy ever set. At the heart of the Health for All movement is a new look at health with a broad perspective. Health remains the goal of health policies and health care systems, but it has a wider definition. Member states by being signatories to this proposal have pledged to attain for their people more than a reduction in disease and disability. They are working for a positive kind of health, a state of complete physical, mental and social well-being. Reaching such a goal requires a wider view of the factors that affect health, encompassing something more than the physical problems of individual people. This view must examine the ways in which factors in society and in the environment affect peoples' health. A policy for health for all thus requires positive health to be built in new ways and new settings, by new combinations of people, in addition, to the methods and means used successfully in the past (W.H.O.1988).

3. TARGETS FOR HEALTH

The European Region of the World Health Organisation adopted 38 regional targets as concrete goals in 1984. The targets describe how present conditions must be changed to reach Health for All. The regional targets were identified to form a flexible framework that individual member states and localities within those member states could use to build their own targets, policies and programmes for Health for All.

The targets can be divided into three groups, each closely related and supportive of the other. The targets have been carefully designed and fit together in tablets of stone that form a pyramid. The diagram below illustrates how the regional targets fit together. The European targets are outlined in full in Appendix 1.

FIGURE 1

HEALTH FOR ALL TARGETS

Fundamental requirements for health (targets 1 -12)

Necessary changes

Healthy Lifestyles (targets 13-17)	Healthy environment (targets 18-25)	Appropriate care (targets 26-31)

Support for health development (targets 32-38)

World Health Organisation 1988

Targets 1-12 are the fundamental requirements for health. These include equity, a long and better life for all and reductions in deaths from certain causes. Their achievement will mean that health for all is a reality.

Targets 13-31 detail the 3 kinds of change needed to reach the first group of targets:

- making healthy lifestyles easier for people to choose
- eliminating risks to health in the environment and improving peoples' homes and workplaces
- redirecting the focus of health away from the hospital and towards primary health care in the community.

Targets 32-38 form the third group and were set to be achieved before 1990. Each specifies one kind of support needed to reach the other targets. Research, the management of health development, training for manpower in health and other sectors represent key elements of this group.

4. KEY PRINCIPLES OF HEALTH FOR ALL

Three key principles underpin the W.H.O. targets for health:

- Equity
- Community Participation
- Inter-sectoral Collaboration

4.1 Equity in Health

It is proposed that equity to health is an underlying principle of the targets for health and underpin activities/programmes to achieve Health for All. The first of the 38 targets addresses equity:

"By the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the level of health of disadvantaged nations and groups".

In every part of the W.H.O. European region and in every type of political and social system, differences in health have been noted between different social groups in the population and between different geographical areas in the same country. Firstly, there is consistent evidence that disadvantaged groups have poorer survival chances, dying at a younger age than more affluent groups. For example a child born to professional parents in the U.K. can expect to live over five years more than a child born into an unskilled manual household (Black,D. 1980).

In terms of illness/morbidity there are great differences of experience. Disadvantaged groups not only suffer a heavier burden of illness than others but also experience the onset of chronic illness and disability at younger

ages. In a study carried out in the U.K. of people who died prematurely in different neighbourhoods, men and women in poorer areas were likely to have been chronically ill or disabled for longer before death and to have suffered a greater number of distinct health problems than their counterparts in more affluent localities (Phillimore,P.1989). Other dimensions of health and well-being show a similar pattern of reduced quality of life. In 1986 a major study carried out in the U.K. found similar differences in relation to physiological indicators such as blood pressure and lung function, even when smoking habits were taken into account as well as for indicators of physiological malaise (Cox,B.et al 1987).

As discussed above the health career of different groups within the same country varies considerably and research concludes that those in less affluent social groups experience higher levels of morbidity and premature mortality. These differences can be measured from standard health statistics. However, in defining the meaning of equity in health a wider moral and ethical dimension must be considered (Whitehead,M. 1990). Whitehead proposes that the term inequity refers to "differences which are unnecessary and avoidable but, in addition are also considered unfair and unjust. So in order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society". Furthermore Whitehead proposes 7 key determinants of health differentials:

1. Natural, biological variation.
2. Health damaging behaviour if freely chosen, such as participation in certain sports and pass times.
3. The transient health advantage of one group over another when that group is first to adopt a health

promoting behaviour (as long as other groups have the means to catch up fairly soon).

4. Health damaging behaviour where the degree of choice of lifestyles is severely restricted.
5. Exposure to unhealthy stressful living and working conditions.
6. Inadequate access to essential health and other public services.
7. Natural selection of health related social mobility involving the tendency for sick people to move down the social scale.

The consensus view appears to be that 1-3 would not be classed as inequities. Four, five and six would be and in the seventh, ill health may have been unavoidable but low income of the sick seems preventable and unjust.

4.1.1 Towards a Definition of Equity in Health

The term "inequity" as used in World Health Organisation documents refers to differences in health which are not only unnecessary and avoidable but, in addition are considered unfair and unjust. Where people have little or no choice of living conditions, the resulting health differences are more likely to be considered unjust than those resulting from health risks chosen voluntarily. Thus, one working definition would be:

"Equity in health implies that ideally everyone should have a fair opportunity to attain full health potential and more pragmatically, that no one should be disadvantaged from achieving this potential if this can be avoided."

(W.H.O. 1986)

Based on this definition, the aim of policy for equity and health is not to eliminate all health differences so

that everyone has the same level and quality of health but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible. Equity of access to services and in particular health care services is also implicit in this key Health for All principle. It is proposed that equity in health related care can be defined as:

" • equal access to available care for equal need
• equal utilization for equal need
• equal quality of care for all"

(Leenan, H. 1985)

Considering each of the themes in turn, equal access to available care for equal need implies equal entitlement to the available services for everyone, a fair distribution throughout the country based on health care needs, and ease of access in each geographical area and the removal of other barriers of access. Secondly, where use of services is restricted by social or economic disadvantage there is a case for aiming at equal utilization rates for equal need. Finally, with regard to equal quality of care it is very important in many societies that every person has an equal opportunity of being selected for attention through a fair procedure based on need rather than social influence. Equal quality of care for everyone also implies that providers will strive to put the same commitment into the services they deliver for all sections of the community so that everyone can expect the same high standard of professional care.

4.1.2 Equity - Principle in Action

It is proposed that the theoretical definition outlined above is translated into policies and programmes for action through both national and international Health for All initiatives. At a practical level Whitehead (1990) proposes general points to underpin both policy/programme development and implementation. These are outlined below:

1. Equity policies should be concerned with improving living and working conditions. Because most of the present inequities in health are determined by living and working conditions attempts to reduce them need to focus on these root causes, with the aim of preventing problems developing.
2. Equity policies should be directed at enabling people to adopt healthier lifestyles.
3. Equity policies require a genuine commitment to decentralising power and decision making, encouraging people to participate in every stage of the policy making process.
4. Health impact assessment together with inter-sectoral collaboration. (Illustrates that determinants of inequities lie in many different sectors).
5. Mutual concern and control at the international level.
6. Equity in health care is based on the principle of making high quality health care accessible to all.
7. Equity policies should be based on appropriate research, monitoring and evaluation.

4.2 Community Participation

The concept of community participation has become increasingly important in recent years particularly for those interested in planning and delivering services which are responsive to consumer need. Community participation can perhaps be best defined as a process by which ordinary people have some say in prioritising, planning, delivering and reviewing services. Levels of participation have been proposed by Brager and Specht as comprising the continuum outlined below.

PARTICIPATION CONTINUUM

Degree	Participants Action	Illustrative Mode
Low	None	Community is told nothing
	Receives information	Organisation makes a plan and announces it. community is convened for informational purposes; compliance is expected
	Is consulted	Organisation tries to promote a plan. Seeks to develop support to facilitate acceptance or give sufficient sanction to plan so that administrative compliance can be expected
	Advises	Organisation presents a plan and invites questions. Prepared to modify plan only if absolutely necessary
	Plans Jointly	Organisation presents tentative plan subject to change and open to change from those affected. Expect to change plan at least slightly and perhaps more subsequently
	Has delegated authority	Organisation identifies and presents a problem to the community; defines the limits and asks community to make a series of decisions which can be embodied in a plan which it will accept
High	Has control	Organisation asks community to identify the problem and make all key decisions on goals and means. Willing to help community at each step to accomplish own goals

Why is Community Participation Important?

Community Participation is a central theme in much Health for All work and is well documented in various W.H.O. documents. The quote below from the Adelaide Conference 1988 illustrates the importance of this principle:

"Consumer and community participation in decision making about health care and the conditions that predispose to health and illness is important - in fact essential - if we are to deal with the health policy challenges of the 21st century".

(Adelaide Conference Report - W.H.O. 1989)

Community participation is, therefore, a key principle underlying the development of Health for All work and closely related to the other key principles of equity and inter-sectoral collaboration.

4.2.1 Community Participation - Principle in Action

To achieve effective community participation the development of a coherent and co-ordinated strategy is vital. Community development can be proposed as a process by which community participation can be promoted. As a way of working a number of distinct features can be identified:

- major focus is on collective rather than individual change
- community development (C.D.) works to actively counter prejudice and discrimination through positive action for equal opportunities
- work with disadvantaged and oppressed groups is usually seen as a priority
- process is held to be important in itself

- problems and concerns are seen to be inter-linked, so a C.D. approach encompasses all aspects of peoples lives that affect their health and health potential i.e. an holistic approach
- C.D. recognises the central importance of formal and informal social support and networks in bringing about change
- C.D. seeks to enable people to identify common needs and concerns and to facilitate collective action in ways agreed on and prioritised by people themselves
- C.D. is concerned with opening up access to resources, services and information to assist people to make realistic, informed decisions and choices in relation to their individual and collective health and welfare
- precise outcomes can be unpredictable so ongoing participative evaluation is needed which focuses on processes and outcomes

To translate community participation into effective action it has been proposed that activity be undertaken on three levels:

- Grass roots
- Middle level
- Policy Level

4.3 Inter-sectoral Collaboration

The key focus for this research is the extent to which inter-sectoral collaboration is being achieved in all aspects of the Healthy Eastleigh initiative in Hampshire. In this section the current impetus for both statutory and non-statutory agencies to collaborate will be explored. This will illustrate some of the positive and negative influences at work within the community which enhance or hinder multi-agency working. Towards the end

of this section a model representing the key features of effective collaboration will be proposed. This will provide a framework for analysis for the main body of this research -the levels of collaboration being achieved in Healthy Eastleigh.

4.3.1 Current Impetus to Collaborate

Multi-agency working and the development of joint programmes of action represent key principles underpinning current statutory agency activity. Inter-sectoral collaboration not only represents an integral feature of Health for All, but is proposed as an "imperative" for effective statutory agency activity. The impetus to encourage collaborative working has been explicit in both recent legislation and government directives. A number of the key directives are outlined below.

4.3.2 Working for Patients - The Health Service Caring for the 1990's

In outlining the changing role of district health authorities the Department of Health has explicitly identified the need for collaboration across agencies. In the creation of purchasing authorities which identify the needs of the community and whose goal is better health in health outcome terms, collaboration is identified as a key principle. In the Department of Health's document "Working for Patients - Developing Districts" a clear impetus to establish and sustain healthy alliances to assist in achieving health gain in the community can be identified. It proposes that:

" close working relationships between local authorities, social services and district health authorities are required in relation to care in the community as the

proposals in "Caring for People" are taken forward.

Key areas for liaison relate to:

(a) **the division of responsibilities**: to agree the division between health and social care and responsibility for funding;
(b) **choice of care options**: local authority social services departments will be responsible for arranging the assessment of the needs of individuals which will include services provided by other agencies, including district health authorities;
(c) **continuity of care**: for example to ensure the need for social care is assessed before discharge from hospital; and
(d) **community care plans**: to ensure that plans produced by district health authorities and social services departments are compatible."

(D.O.H. 1990 H.M.S.O. Community Care in the next decade and beyond).

4.3.3 Community Care - Caring for People

Developments under the banner of care in the community also illustrate an impetus for a multi-agency approach to service planning and delivery. The Government's White Paper "Caring for People" and the N.H.S. and Community Care Act 1990 set out the governments' policy framework for the next decade and beyond. Integral to the identification of local need and the development of shared community plans and services is the need for inter-agency collaboration.

Links between housing and community care have been identified and the need for a joint approach around this issue has been proposed. Section 46 of the Act imposes a

duty on social services departments to consult local authority housing departments and housing associations when drawing up their community care plans. It emphasises that appropriate housing can play an important part in allowing those with community care needs to remain within the community. The emphasis throughout is the need for effective collaboration to provide a "seamless service" for users.

Alliances between health care and social care in service planning, assessment, care management, commissioning and service delivery are proposed as key features of effective community care:

"Effective local collaboration is the key to making a reality of community care. All the authorities and agencies which contribute to the care of vulnerable people in their own community need to be involved in preparing plans and services to meet these local needs. They need to be aware of and respect each others roles, responsibilities and objectives and build relationships based on this mutual understanding and respect".

(D.O.H. 1990 - Community Care in the next decade and beyond).

4.3.4 The Government's Green and White Papers on Health - The Health of the Nation

The Department of Health's recent Green and White Papers on health proposing a national health strategy for England, provide a clear impetus for an inter-agency approach to health promoting activity. The papers, published in June 1991 and July 1992, recognise the wide range of health related activity undertaken across agencies. They cite local government as well as the health service as a key contributor to health promotion.

The potential role of different government departments in contributing to and implementing a national strategy for health is also identified. For example the role of the Department of Trade and Industry is identified in raising public awareness about potential hazards in and around the home. The Employment Department's responsibility through its Employment Rehabilitation Service for assisting people with long term sickness and disability is identified.

The Green Paper suggests that:

"The spread of responsibilities offers an opportunity because it means a shared interest in health amongst departments, and a challenge because of the need to ensure policies and programmes are developed with action taken on a concerted basis across departmental boundaries".

(D.O.H. 1991)

The White Paper goes on to identify that to achieve key areas of action there is a need to work collaboratively. It highlights in particular the significant opportunities offered by:

"joint working and focusing action on various settings - the home, the school, the workplace, cities and the general environment."

(D.O.H.1992)

Both the Green and White Papers provide impetus to an inter-agency approach to health promotion activity at both a national and local level and provide support for a Health for All approach.

4.3.5 Inter-sectoral Collaboration - Towards a Definition

In terms of Health for All the World Health Assembly called on member states to develop inter-sectoral strategies for Health for All which have collaboration as a key principle. The World Health Organisation identified key areas of action which clearly illustrate the multi-agency influences and potential for health promoting action:

"The World Health Organisation calls on member states:

- to identify and develop health objectives as an integral part of sectoral policies for agriculture, the environment, education, water, housing and other health related sectors and to include health impact analysis in all feasibility studies of health related programmes and projects.
- to encourage and support action oriented multi-disciplinary research focusing on socio-economic and environmental determinants of health in order to identify cost effective inter-sectoral actions for improving the health status of disadvantaged groups
- to develop appropriate mechanisms within the overall development process to promote inter-sectoral action for health at national and local levels in order to facilitate an efficient use of existing resources for achieving multi-sectoral Health for All targets".

(W.H.O. 1986)

Inter-sectoral collaboration has been accepted as one of the guiding principles of Health for All. It recognises that contributions from many sectors, in particular housing, education, public services, communication,

transport, trade and agriculture and the voluntary sector are required if effective strategies for health are to be developed. In practical terms it may be suggested that to all aspects of strategy development and implementation a shared commitment needs to be established, in particular in the areas of:

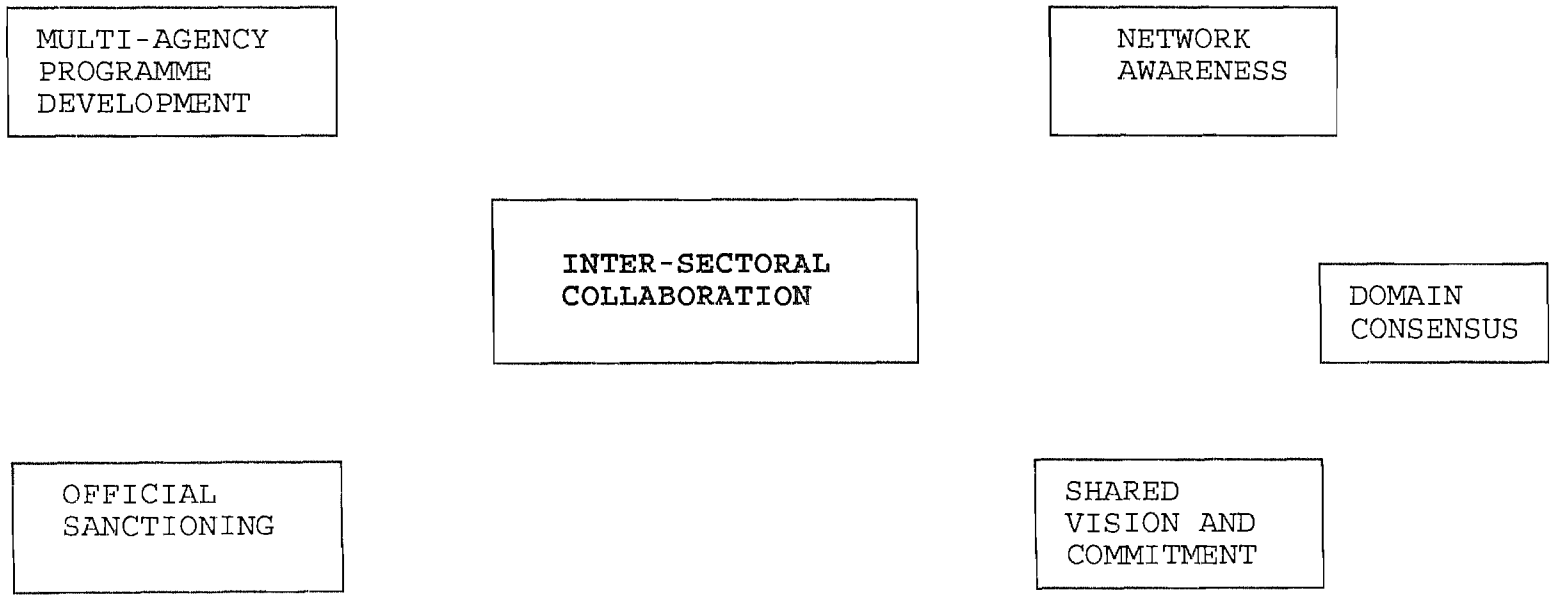
- identifying priorities
- planning programmes of action
- implementing programmes of action
- monitoring and evaluating programmes of action

4.3.6 Inter-sectoral Collaboration - A Framework for Analysis

Collaboration and co-ordination between agencies can support the achievement of diverse aims and objectives. It can support both joint and individual areas of work. Collaboration can result in the more efficient use of resources. It can reduce areas of overlap and clarify the responsibilities of individual agencies. Some of the current impetus to foster joint working have been identified above. A review of the literature around collaborative working has revealed a number of key characteristics required if joint working is to be effective. Outlined in the diagram below is a framework of key features of effective joint working. These will comprise the elements around which the tools for the research in Eastleigh will be developed.

FIGURE 2

MODEL FOR INTER-SECTORAL COLLABORATION



1. Inter-agency approach to programme development

A shared, co-ordinated approach to the planning, implementation and evaluation of projects/areas of work represents a key feature of effective collaboration. Benson suggests that effective collaboration and co-ordination is explicit where 2 or more organisations are geared together for maximum effect and emphasises the need for collaboration at all levels of programme development (Benson 1973).

In examining the key areas to develop under Healthy Eastleigh the extent to which collaboration across programme development is being achieved will be tested. For certain areas of work the participation of all statutory agencies should be a feature, for others the key players may comprise several or one or two of the agencies.

2. Network Awareness

An understanding across agencies of the roles of each other and their position in the alliance is of key importance. This is defined as "network awareness." Implicit in this is the need to establish formalisation of the collaboration (Hudson, 1987). Variations can exist in the intensity of the network. Two measures of intensity have been proposed:

- the amount of resources involved in the relationship
- the frequency of interaction

Both of these measures recognise that close co-operation can be extremely costly in terms of staff time. Measures of the intensity of the network and levels of network awareness have been proposed as ranging from senior officer acquaintance, senior officer interaction,

information exchange, overlapping membership and written agreement (Roger 1974). Whatever the intensity of the relationship the degree of **reciprocity** and **mutual exchange** is key to the establishment of effective networks and collaborative arrangements. Exchange across agencies in terms of resources, information and long term benefits in meeting the objectives of individual agencies impinge on the effectiveness of the alliance.

3. Domain Consensus

The extent to which agencies appreciate the potential role and responsibilities of the partnership organisations in the alliance is an important feature of effective collaboration. Thompson (1967) defined domain consensus as:

"a set of expectations both for members of an organisation and for others with whom they interact, about what the other organisation will and will not do..... it provides an image of the organisations role in a larger system, which in turn serves as a guide for the ordering of action in certain directions and not in others."

Integral to this key feature is the need for agencies to have a positive evaluation of their partners. The notion of valuing the roles of other agencies and their potential contribution to programme/project aims and objectives is implicit in this. The possession of a domain permits an organisation to operate in a certain sphere, claim support for its activities and define how it should be done. Establishing domain consensus can be problematic since it requires agreement on goals and assumes commonality/comparability in terms of struct-ure across organisations. Much will depend on the interest groups which the agencies service and other forces within

individual agencies. It would seem that some degree of similarity between organisations assists in the development of alliances. However, as domain similarity increases so does the potential for territorial dispute. The maximum inducement for collaboration is where there is some degree of similarity, not identity in the nature of resources and aims and objectives so that collaboration can take place for mutual benefit.

4. Shared Vision and Commitment

A shared vision across agencies and commitment to Health for All principles and local objectives is proposed as another key feature of effective inter-sectoral collaboration. The notion of interdependence between agencies to achieve their own and shared goals can be a key factor in stimulating and sustaining collaboration (Hudson, 1987). In terms of Health for All a commitment across agencies to the attainment of the key principles of community participation and equity in health represent pre-requisites to the development of shared objectives.

5. Official Sanctioning of Collaboration

The extent to which collaboration is explicit and sanctioned by agencies is another important feature of effective joint working (Hudson, 1987). The degree of formalisation can be considered in terms of official sanctioning by the parties involved in terms of policies/activities which govern inter-agency agreement and by the existence and functioning of a co-ordinating body for inter-sectoral collaboration. In terms of Health for All activity, it is proposed that the effective functioning of the joint management structure for the initiative represents a key feature of effective collaboration.

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CHAPTER TWO

HEALTHY EASTLEIGH 2000 BACKGROUND AND STRUCTURE

1. INTRODUCTION

The purpose of this chapter is to provide both the background to the establishment of the Healthy Eastleigh initiative and an outline of the key partnership agencies participating and their individual structures. A profile of Eastleigh Borough is provided. The developments leading up to the establishment of the initiative will be outlined and in particular the outcomes of a conference mounted by Winchester Health Authority as a key stage in the establishment of Health for All on the local agenda. The partnership agencies in terms of their structure within the Eastleigh area will be explored as a means of creating a comprehensive overview of the key stakeholders and participants in the initiative.

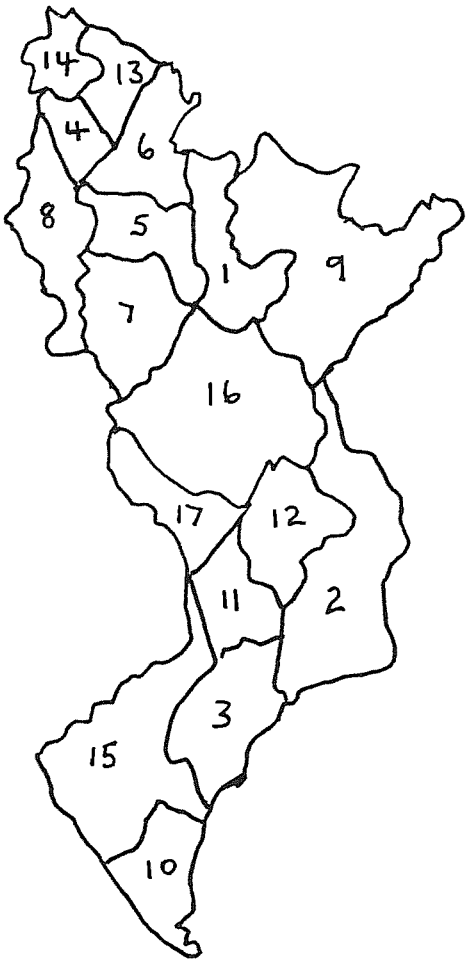
2. BACKGROUND

In September 1988 Winchester Health Authority organised a "Health for All" conference as a means of stimulating awareness and interest in the World Health Organisation initiative. An inter-sectoral approach underpinned both the planning of and participation in the conference. This marked the first stage in establishing Health for All initiatives in the Winchester Health Authority area in collaboration with its statutory and voluntary agency partners. As a key preliminary step in the creation of Healthy Eastleigh the format and participation of this event are discussed below.

3. HEALTH FOR ALL BY THE YEAR 2000 CONFERENCE - WINCHESTER GUILDHALL - 29 SEPTEMBER 1988

Outlined in the map below is the geographical area covered by Winchester Health Authority at the time of the conference. Approximately 60% of Eastleigh Borough Council's population are served by Winchester Health Authority, the other part of the borough receiving its health services from Southampton and South West Hants Health authority.

MAP OF THE BOROUGH



1	Bishopstoke
2	Botley
3	Bursledon
4	Chandlers Ford
5	Eastleigh Central
6	Eastleigh North
7	Eastleigh South
8	Eastleigh West
9	Fair Oak
10	Hamble
11	Hedge End St Johns
12	Hedge End Wildern
13	Hiltingbury East
14	Hiltingbury West
15	Hound
16	West End North
17	West End South

The objectives of the conference were threefold:

- to raise awareness about the World Health Organisation's Health for All initiative among local statutory and non-statutory agencies in the area
- to build links across agencies and thus create a climate for collaborative working
- to consider some of the key health issues facing the population within the Winchester Health Authority area

As a forerunner to the establishment of Healthy Eastleigh, the participation across statutory and voluntary agencies within the district was of key importance. Outlined in the table below is a summary of the range of agencies involved across the district and the roles/functions represented within each agency.

WINCHESTER HEALTH FOR ALL CONFERENCE

AGENCY PARTICIPATION

HEALTH SERVICES

PUBLIC HEALTH CONSULTANT
COMMUNITY PAEDIATRICIAN
HEALTH AUTHORITY MEMBER
COMMUNITY NURSING MANAGER
DISTRICT PLANNING MANAGER
CONSULTANT GERIATRICIAN
HEALTH VISITOR
DISTRICT DIETITIAN
NURSE ADVISER
UNIT GENERAL MANAGER (ACUTE UNIT)

LOCAL AUTHORITY SERVICES

LEISURE CENTRE MANAGER
CHAIRMAN OF HOUSING COMMITTEE
DIRECTOR OF AMENITIES SERVICES
HOUSING MANAGER
ENVIRONMENTAL HEALTH OFFICER

VOLUNTARY SECTOR

COMMUNITY HEALTH
COUNCIL REPRESENTATIVE
SECRETARY - EASTLEIGH COUNCIL OF COMMUNITY SERVICE
DIRECTOR - AGE CONCERN
CHIEF RURAL OFFICER - HAMPSHIRE COUNCIL OF COMMUNITY SERVICE

FAMILY HEALTH SERVICES

2 GPs
PLANNING MANAGER

EDUCATION

F.E. LECTURER
SCHOOL CATERER
EDUCATION OFFICER
ADULT EDUCATION OFFICERS X 2

SOCIAL SERVICES

OCCUPATIONAL THERAPIST
SOCIAL WORKER
AREA MANAGER
MENTAL HEALTH - SOCIAL WORKER
COMMUNITY CARE REPRESENTATIVES

3.1 Conference Overview

An introductory talk about the key principles of Health for All and Sheffield's experience was presented by the Assistant Director of Health and Consumer Services from Sheffield City Council. This gave participants both a background knowledge of the key principles of Health for All and most significantly an overview of the levels of collaboration and commitment achieved in the Healthy Sheffield initiative. This provided participants with a vision of what could be achieved at a local level in the Winchester Health Authority area. Examples of Sheffield projects and initiatives were provided which illustrated the potential of a multi-sectoral approach to health promotion activity. Examples cited included the inter-sectoral approach being adopted to the development and implementation of smoking policies. Reference was also made to the management structure developed for Healthy Sheffield. The membership of the inter-sectoral planning group was outlined as follows:

Assistant Director Health and Consumer Services (L.A.)
Education and Recreation Officer (L.A.)
Family and Community Services (H.A.)
Central Policy Officer (L.A.)
Community Nurse Manager (H.A.)
Health Strategy Officer (H.A.)
Consultant in Community Medicine (H.A.)
District Manager (F.H.S.A.)
General Secretary (C.C.S.)
General Secretary (C.H.C.)
Principal Officer (C.R.E.)

L.A. - Local Authority
H.A. - Health Authority
F.H.S.A. - Family Health Services Authority
C.C.S. - Council for Community Services

C.H.C. - Community Health Council
C.R.E. - Council for Racial Equality

After the initial presentations the conference focused down on a number of individual workshops:

Equity in Health
Cancer and Heart Disease
Mental Health
Accident Prevention
Partnership

Participation in the workshops was multi-agency in terms of both host agency and professional role. The format of each workshop allowed for consideration of each issue and a sharing of ideas and approaches on how best to address the key issues.

Collaboration in planning and implementing programmes of action was a consistent theme underpinning each of the workshops. The workshop on "partnership" had inter-sectoral collaboration as its principle theme. This workshop provided a stimulus for the establishment of the Healthy Eastleigh initiative.

Partnership

The participants in this workshop represented a good mix of agencies:

General Secretary (E.C.C.S.)
Member (W.H.A.)
Elected Member (W.C.C.)
Chairman (C.H.C.)
Unit General Manager (W.H.A.)
General Manager (W.H.A.)
Director - Age Concern

Assistant Education Officer (H.C.C.)
Director of Nursing (W.H.A.)
Chief Rural Officer (H.C.C.S.)
E.C.C.S - Eastleigh Council of Community Service
W.H.A. - Winchester Health Authority
W.C.C. - Winchester City Council
C.H.C. - Community Health Council
H.C.C. - Hampshire County Council
H.C.C.S. - Hampshire Council of Community Service

The workshop focused on collaboration between the community and statutory and non-statutory agencies and across service providers. Four key recommendations were proposed as outcomes from the workshop:

" • It was felt that information on what was going on locally in terms of agency activities was needed
• There was a need to gain commitment from senior officers and members to move collaborative working forward
• It was proposed that they raise awareness about the potential health promoting role of agencies
• It was agreed that Winchester Health Authority take a lead role in developing inter-sectoral committees to establish Health for All initiatives with their local authority partners."

(Winchester Health Authority 1988)

3.2 Significance of the Health for All Conference

The key outcomes of the Health For All Conference are outlined below:

1. It provided the opportunity for agencies to get together to talk about health promotion issues
2. It broadened agency perceptions about who could contribute to health promotion activity.

3. It placed Health For All on the local agenda across the statutory and non-statutory agencies
4. It provided an opportunity for a mix of staff from various professional backgrounds and seniority to pool ideas about health promotion.
5. A commitment was obtained from the statutory and non-statutory agencies to move forward on Health for All.

4. THE ESTABLISHMENT OF THE EASTLEIGH HEALTH FOR ALL INITIATIVE AND THE MANAGEMENT STRUCTURE

During the year following the conference (Sept.1988-Nov. 1989) discussions were initiated between senior officers in Eastleigh Borough Council and Winchester Health Authority:

Sector Manager - Winchester Health Authority
Assistant Director Environmental Health - Eastleigh Borough Council
Health Promotion Manager - Winchester Health Authority
Consultant in Public Health - Winchester Health Authority

The discussions focused on three key issues:

- consideration of current inter-agency and single agency work towards Health for All principles
- consideration of a possible structure to enable the establishment of a joint Health for All initiative
- development of a proposal for consideration by the local authority and health authority

The discussions resulted in the submission of a report to a joint local authority/health authority meeting on 20 July 1989. An overview of Health for All 2000 and the key principles underpinning the initiative were outlined.

Consideration was given to the many health related activities already undertaken by the individual agencies under the following headings:

Health Promotion
Housing
Health information
Health and Safety at work
Food Safety
Road Safety
Recreational activities
Pollution control
Green issues
Service delivery

The main thrust of the proposal was the need to co-ordinate activities more effectively and to work collaboratively to develop a comprehensive strategy to address all health issues. Key benefits of inter-sectoral collaboration were proposed by the senior officers:

- elimination of duplication by agencies, leading to more efficient use of resources
- pooling of health related information, enabling all agencies to make better decisions
- ability to ensure all areas of need are addressed (i.e. do not leave gaps by assuming a need is being met by another organisation).
- better mechanisms to set priorities
- high quality information and monitoring systems so that actions can be properly evaluated
- more involvement of the community, enabling them to positively influence their own health.

A central theme to the proposal was the establishment of an organisational structure which would enable inter-sectoral collaboration across the statutory and voluntary

sector and the establishment of a jointly funded Health for All co-ordinator post to support this inter-agency approach to health.

These proposals were approved by the local authority and the health authority and a successful bid to secure joint funding from the two statutory agencies of the co-ordinator post was submitted.

4.1 Health for All Management Structure

The management structure for the Health for All initiative in Eastleigh - Healthy Eastleigh 2000 was established during November 1989 and July 1990. The Health for All co-ordinator took up post in June 1990. An outline of the organisational structure established is outlined in the schedule below.

HEALTHY EASTLEIGH 2000 MANAGEMENT STRUCTURE

HEALTHY EASTLEIGH JOINT COMMITTEE

3 Councillors Eastleigh Borough Council
(representing the 3 political parties)
Health Authority Member (Winchester)
Health Authority Member (Southampton)
Business Representative (Pirelli General PLC)
Social Services Representative (Hampshire County Council

HEALTHY EASTLEIGH STEERING GROUP

Health for All Co-ordinator
Assistant Director - Environmental Health (Eastleigh Borough Council)
Sector Manager (Winchester Health Authority)
Area Manager (Eastleigh Social Service)
General Secretary (Eastleigh Council of Community Service)
Director of Health Promotion (Winchester Health Authority)
District Health Promotion Manager (Southampton Health Authority)
Operational Manager (Family Health Services Authority)
Teacher Adviser - Health Education (Central Education Division)

HEALTHY EASTLEIGH CO-ORDINATOR'S MANAGEMENT GROUP

Health for All Co-ordinator
Assistant Director - Environmental Health (Eastleigh Borough Council)
District Health Promotion Manager (Winchester Health Authority)
Sector Manager (Winchester Health Authority)

The terms of reference of the Eastleigh Health For All Joint Committee are outlined below.

HEALTH FOR ALL EASTLEIGH JOINT COMMITTEE

TERMS OF REFERENCE

1. To consider health issues in relation to the people of Eastleigh, and in particular to receive reports from the Eastleigh Health For All 2000 Steering Group.

2. To develop policies to achieve the aims of "Health for All 2000" in Eastleigh.

3. To develop a co-ordinated approach to health issues so as to use available resources to maximum effect.

4. To report to the constituent organisations of the Joint Committee on health issues considered by the Committee.

The terms of reference of the Health for All Steering Group are outlined below:

EASTLEIGH HEALTH FOR ALL 2000 STEERING GROUP

DRAFT TERMS OF REFERENCE

To review the current range of services offered by statutory and voluntary sectors.

To facilitate the activities of other organisations and of the community in achieving the objectives of Health For All.

To co-ordinate the activities of member organisations and others.

To guide the activities of the Health For All Co-ordinator.

To develop and recommend Health For All targets.

To develop programmes to achieve Health for All targets.

To monitor and evaluate the progress of programmes.

To receive reports from member organisations of the group, from the Health For All Co-ordinator and from the sub-groups.

To submit reports to, and make recommendations to, the Eastleigh Health For All Joint Committee.

Membership of each committee reflects participation of both Winchester and Southampton and South West Hants Health Authorities and the other statutory and voluntary agencies providing services in the Borough.

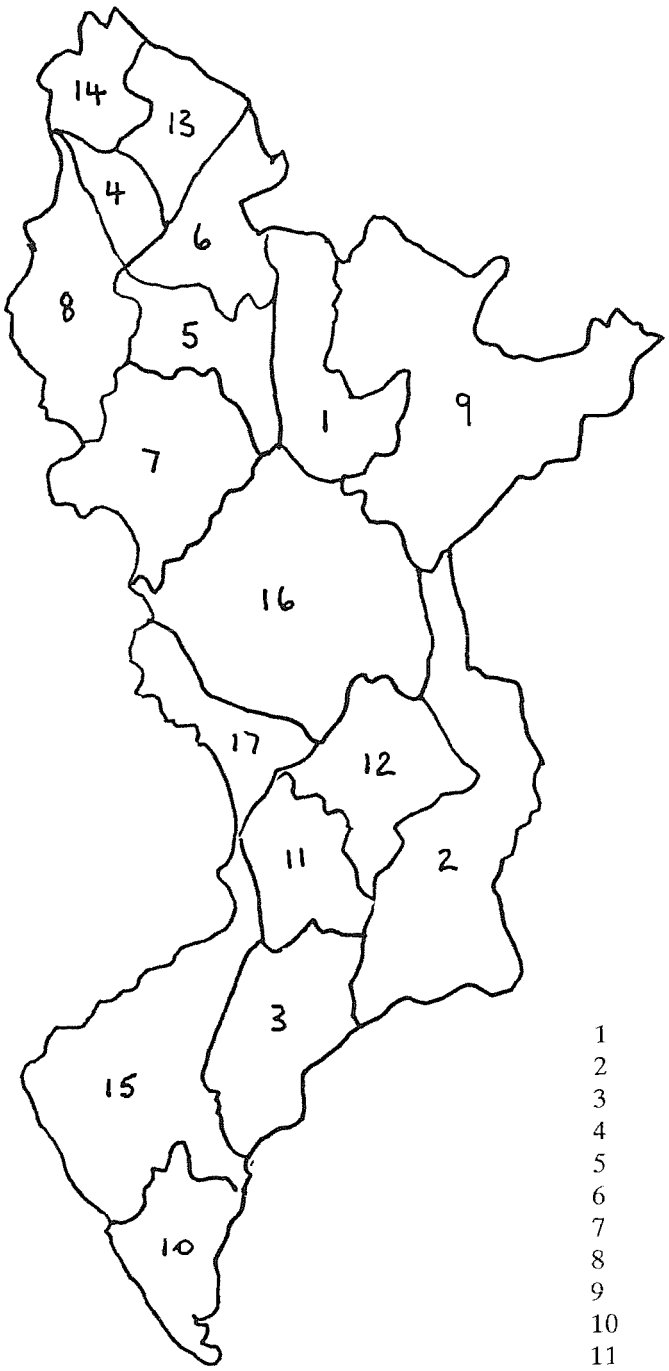
The framework for analysis proposed in Chapter One identified "Official Sanctioning" of inter-sectoral collaboration as a key feature of effective multi-agency work. The Healthy Eastleigh structure outlined above exhibits participation from senior members/officers across the statutory and non-statutory agencies. Research outlined in subsequent chapters will consider the issue of official sanctioning in more detail in relation to specific areas of work under the Healthy Eastleigh initiative.

Before focusing on the individual agencies participating in the Healthy Eastleigh initiative, a brief profile of the Borough is outlined below.

5. PROFILE OF THE BOROUGH OF EASTLEIGH

The Borough of Eastleigh lies between Southampton Water, the River Hamble and the borders of Winchester and Test Valley in Hampshire. It is within a developing area of southern Hampshire and a popular location for industrial and residential development. The borough comprises 17 electoral ward areas identified in the map below.

MAP OF THE BOROUGH



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14	Hiltingbury West
15	Hound
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17	West End South

Population

Outlined in the table below is a breakdown of the population within the borough.

TABLE 1

EASTLEIGH BOROUGH TOTAL POPULATION BY WARD 1981 - 1996

	1981	1987	1989	1991	1993	1995	1996
Bishopstoke	8,550	9,519	9,586	9,677	9,697	9,626	9,586
Botley	4,730	4,884	4,994	5,093	5,235	5,307	5,311
Bursledon	4,590	5,642	5,653	5,706	5,806	5,822	5,826
Chandlers Ford	5,950	6,491	6,321	6,298	6,340	6,272	6,255
Eastleigh Central	5,970	5,899	5,828	5,897	5,877	5,854	5,841
Eastleigh North	8,410	9,038	9,024	9,049	9,044	8,990	8,959
Eastleigh South	4,970	4,848	4,734	4,663	4,581	4,493	4,449
Eastleigh West	6,580	6,993	7,267	7,270	7,265	7,192	7,159
Fair Oak	6,220	7,148	7,554	8,450	9,002	9,235	9,311
Hamble	2,930	3,015	3,188	3,307	3,580	3,660	3,710
Hedge End St. Johns	5,120	5,393	5,602	6,146	6,410	6,394	6,386
Hedge End Wildern	5,180	5,075	6,428	8,026	9,531	10,455	10,775
Hiltingbury East	5,770	5,661	5,482	5,370	5,297	5,279	5,273
Hiltingbury West	5,180	5,909	5,778	5,679	5,600	5,569	5,561
Hound	5,810	6,875	6,801	6,905	6,857	6,790	6,759
West End North	3,130	3,095	3,097	3,254	3,569	3,848	3,950
West End South	3,080	5,714	6,154	6,393	6,914	7,076	7,165

Source: 1981 Census of Population and Hampshire County SAPF - 1989 Update

Housing and Residential Development

As at April 1991 there were an estimated 43 356 dwellings in Eastleigh Borough. At the same time the Borough Council owned 4,939 dwellings. One quarter of all dwellings are located in the Eastleigh wards. Outlined in the tables below is information about household size and type in the Borough.

TABLE 2

AVERAGE HOUSEHOLD SIZE			
	1971	1981	1989
EASTLEIGH	2.98	2.79	2.58
HAMPSHIRE	2.93	2.76	2.56
GREAT BRITAIN	2.91	2.70	N/A

TABLE 3

HOUSEHOLD TYPE %	HAMPSHIRE 1981 CENSUS	HAMPSHIRE 1989 EER	EASTLEIGH 1981 CENSUS	EASTLEIGH 1989 EER
Single Parent Household	1.82	2.12	1.39	1.85
1 Person Household (under retirement age)	5.85	7.77	5.02	7.42
1 Person Household (retirement age & over)	11.53	12.68	9.47	11.11
2 or more adult Households (with 1 or more retirement age or over, with or without children)	18.44	19.20	16.99	17.82
2 or more adult Households (with 1 or more children)	30.35	23.26	32.59	25.69
2 or more adult Households (with 1 or more persons under retirement age and with no children)	32.01	34.97	34.54	36.11
TOTAL:	100	100	100	100

Note: The households with 2 or more adults are not mutually exclusive e.g. households where a person of retirement age is living with one of his/her grown up children, he/she will appear in 2 of the categories.

Source: 1989 Enhanced Electoral Registration Survey (EER) - HCC

Business and Commerce

Eastleigh town is commonly associated with railway and engineering industries. However, due to the recession and the council's policy to encourage the diversification of employment, this has led to the development of "high tech" industries and a more broadly based commercial and industrial base in the area. The bulk of the Borough's industrial development has been located within trading estates and commercial developments within business parks.

Communication Links

The Borough is situated at the inter-section of the M27 and A33, has 2 railway stations and an airport within its boundaries.

Healthy Eastleigh Partnership Agencies

In the Sections below is a profile of the statutory and non-statutory agencies participating in Healthy Eastleigh. An attempt will be made to define the organisational structure of each and their key service responsibilities.

Eastleigh Borough Council

Outlined in the schedule below is a summary of the organisational structure and the directorates within the Borough Council. The main service areas within the authority are identified to give a picture of the range of activity undertaken within the local authority.

EASTLEIGH BOROUGH COUNCIL DEPARTMENTS

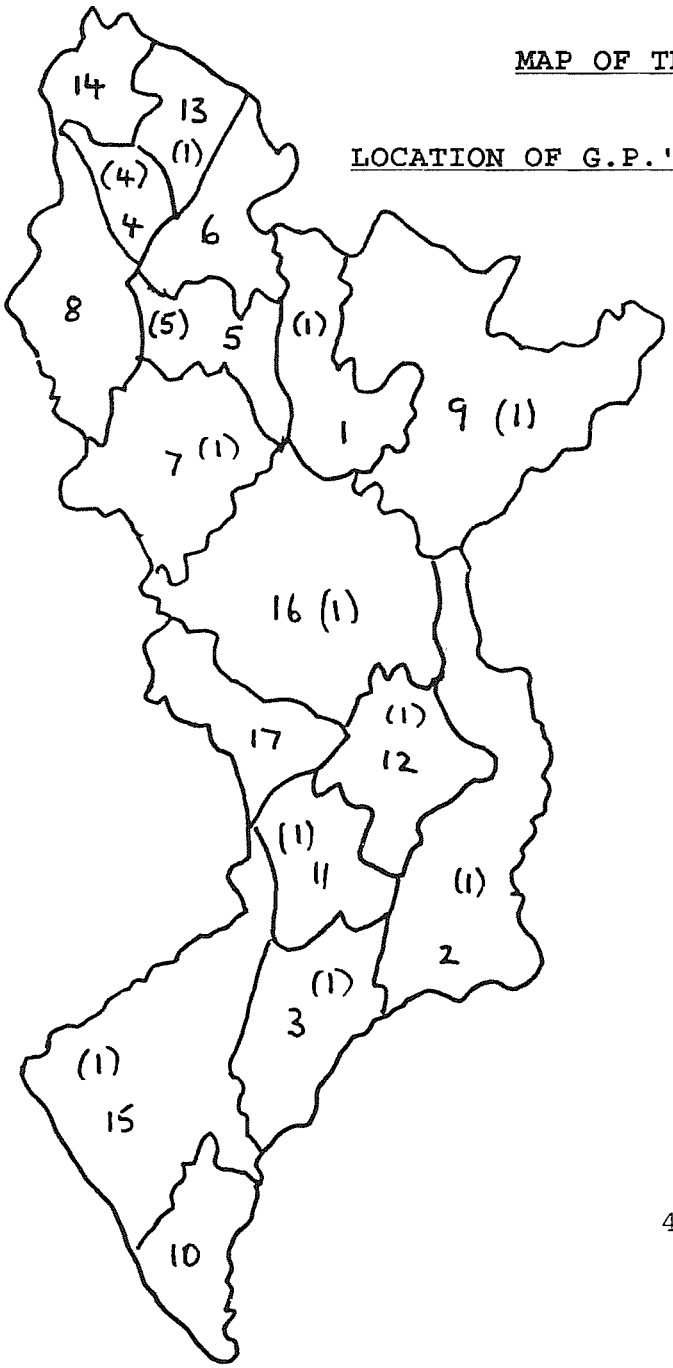
CHIEF EXECUTIVE'S DEPARTMENT	HOUSING AND HEALTH	LEISURE AND TOURISM	FINANCE	TECHNICAL & DEVELOPMENT
- CORPORATE POLICY PLANNING	- HOUSING ADVICE	- COUNTRYSIDE PROJECT	- ACCOUNTANCY	- DEVELOPMENT CONTROL
- BOROUGH SECRETARY & SOLICITOR	- SPECIAL NEEDS SERVICE	- TOURISM AND ARTS	- AUDIT	- BUILDING CONTROL
- COMMITTEE/LAND CHARGES	- HOUSING MANAGEMENT	- COMMUNITY DEVELOPMENT	- COMMUNITY CHARGE	- STRATEGIC PLANNING
- OFFICE SERVICES	- ENVIRONMENTAL HEALTH		- HOUSING BENEFITS	- TRAFFIC AND DEVELOPMENT
- PERSONNEL SERVICES	- DOG WARDEN		- INCOME	- DESIGN
	- HEALTHY EASTLEIGH 2000			

5.1 Family Health Services Authority

The Family Health Services Authority provides the administrative and planning support for local primary health care services. The Operations Manager for the Winchester and Central Hampshire Health District represents local GP's and primary health care teams in the Eastleigh Borough Council area. There is a total of 19 GP surgeries in the Borough.
These are identified by ward in the map below.

MAP OF THE BOROUGH

LOCATION OF G.P.'s - NUMBER BY WARD



1	Bishopstoke
2	Botley
3	Bursledon
4	Chandlers Ford
5	Eastleigh Central
6	Eastleigh North
7	Eastleigh South
8	Eastleigh West
9	Fair Oak
10	Hamble
11	Hedge End St Johns
12	Hedge End Wildern
13	Hiltingbury East
14	Hiltingbury West
15	Hound
16	West End North
17	West End South

The range of health promotion clinics offered by local surgeries is summarised below:

- Menopause
- Well Person
- Travel
- Primary Prevention
- Anti-Smoking
- Stress
- Alcohol
- Weight
- Hypertension
- Diabetic
- Osteoporosis
- Cholesterol
- Health Promotion
- Asthma
- Heart Disease Prevention
- Health Promotion for All

5.2 Social Services

The Area Manager for social services in Eastleigh is a member of the Healthy Eastleigh Steering Group. The social services area is co-terminous with the Borough Council Boundary. There are between 360 and 370 staff employed from the Eastleigh Social Services office. Outlined below is a summary of the management structure and service provision within the Borough.

Management Structure

Social Services have an Area Manager who operates through 2 senior officers, one in charge of the Children's Team and one in charge of the Adult's Team.

Children's Team

The children's team is divided into four parts:

1. Social Workers, including the Family Therapy Service.
2. The Family Resource Centre which provides a nursery service, family link and placement scheme.
3. Leigh House (an out - placement of social work staff in a Regional Health Authority building).
4. A Residential Children's home which also serves as an outreach centre for various children's services.

The Adult's Team

The Adult's team is grouped as follows:

1. Social Workers/Occupational Therapists.
2. Part 3 accommodation for elderly people.
3. A residential unit providing services for people with learning difficulties.
4. A residential centre for people with physical disabilities.
5. A day centre for people with learning disabilities.

5.3 Education Services

The Teacher Adviser for Personal, Social and Health Education represents Education services on the Healthy Eastleigh Steering Group.

Education is the County Council's biggest spending department. Most of the services which it provides are statutory responsibilities . The basic categories for this expenditure are:

Nursery and Primary Education
Secondary Education
Special Education
School Meals
School Crossing Patrols
Further Education Colleges
Adult Education
Youth Service
Careers
Support Services

Outlined below is a summary of the schools in Eastleigh Borough:

INFANTS	11
JUNIOR	10
PRIMARY	9
SECONDARY	5
COMMUNITY SECONDARY	2
SIXTH FORM COLLEGE	1
FURTHER EDUCATION COLLEGE	1
DENOMINATIONAL (INFANT/JUNIOR)	2

5.4 Health Services

Both Winchester and Southampton and South West Hants Health Authorities provide services to residents in Eastleigh Borough. The Healthy Eastleigh initiative has representation from the following health authority officers:

- Assistant Director Public Health (Southampton Health Authority)
- Assistant Director Public Health (Winchester Health Authority)
- Director of Health Promotion (Winchester Health Authority)

The assessment of health needs in the community and the commissioning of appropriate health services for local people is undertaken by purchasing authorities in the health service. The provision of services to the local community is undertaken by local community provider units within the service. The Healthy Eastleigh initiative has attempted to establish links with both the Purchasing Authorities within each health authority and the community unit as a service provider. The structures of the purchasing authority and the community units within Winchester and Southampton and South West Hants Health Authorities are outlined in the schedules below.

Southampton and South West Hants Health Authority
Purchasing Function

Director of Planning Director of Public Health

Director of Finance

Director of Business and Policy Director of Primary Health Care

Provider Function
Community Unit Departments

Children Services Elderly Services Health Promotion

Learning Disabilities Mental Health

Physical Disability Services

WINCHESTER HEALTH AUTHORITY

PURCHASING FUNCTION

DIRECTOR OF PLANNING AND CONTRACTS

DIRECTOR OF PUBLIC HEALTH

DIRECTOR OF ESTATES

HEALTH PROMOTION MANAGER

DIRECTOR OF FINANCE

PROVIDER FUNCTION - COMMUNITY UNIT DEPARTMENTS

COMMUNITY SERVICES MANAGERS
EASTLEIGH
ANDOVER
WINCHESTER

MENTAL HEALTH SERVICES

SERVICE MANAGER - LEARNING DISABILITIES

DENTAL SERVICES

DISTRICT SPEECH THERAPY SERVICE

DISTRICT PSYCHOLOGY SERVICE

HEALTH PROMOTION SERVICES

OCCUPATIONAL THERAPY SERVICES

5.5 The Voluntary Sector - Eastleigh Council of Community Service

The General Secretary of the Eastleigh Council of Community Service (E.C.C.S.) is a member of the Healthy Eastleigh Steering Group. The structure of the E.C.C.S. is outlined in the schedule below:

President

Chairman | **Vice-Chairman** | **Honourary Treasurer**

Executive Committee

Elected Members

Ex-Officio Members

Nominated Members

The Council provides a co-ordinating and support role for the voluntary groups within the Borough of Eastleigh. It co-ordinates community transport schemes and the local volunteer bureau. It has been a focus locally for the development of a number of voluntary sector developments including:

- Special needs Housing forum
- Mental Health Services User Group
- Children and Families Forum
- Carers Support Service
- Access Club
- Well Woman Centre

REFERENCES FOR CHAPTER TWO

Eastleigh Borough Council (1989) Report to Joint Local Authority/Health Authority Meeting

Winchester Health Authority (1988) Health Conference Report

CHAPTER THREE

REVIEW OF RECENT AND CURRENT INTER-SECTORAL ACTIVITY

1. INTRODUCTION

In Chapter One a review of the literature around inter-agency working was undertaken and a model of key features comprising effective collaboration was proposed by way of a framework for analysis for this research. In the second part of this chapter examples of good practice identified from a review of recent and current work will be explored. Initially, however, key themes to emerge from a review of the literature around Health for All and the Healthy Cities movement in the European region will be considered. This should provide further clarification of the key issues surrounding inter-agency approaches to health promotion.

In Chapter One the background to the Health for All movement both world wide and in the European region was explored. The establishment of the European initiative and the adoption of concrete regional targets in 1984 supported the development of both national and regional networks of cities and localities engaged in Health for All activity. Since 1987 thirty six European cities have affiliated themselves to the European Healthy Cities initiative (Draper, R. 1993) and a number of local authorities and health authorities have joined the Health for All network in the United Kingdom. A review of the literature in this area suggests that cities and localities involved in Health for All initiatives face key challenges in the development of health promoting services and environments:

" the ultimate challenge has been to bring together city departments and other organisations and groups in a shared effort to promote equity, to create healthier environments and to change the delivery of health services." (Draper, R. et al 1993)

Thus, the importance of inter-sectoral approaches to create health promoting environments, services and to reduce preventable mortality and morbidity among the local population is clearly defined.

A review of the literature around the European Health for All initiatives identifies four key means by which inter-sectoral collaboration has been secured. Wide representation across sectors of health, social care, local government, education and the voluntary sector have been proposed as an essential feature (Draper, R. 1993). Awareness of the political dimension and the need for the involvement of key decision makers in the community is another important facet of effective collaboration. It has been suggested that political commitment, in terms of both local authority involvement and the sanction of elected representatives can facilitate the identification of action and the implementation of feasible solutions.

Good communication among the project partners has been identified, from the experience of European Health for All initiatives, as highly desirable leading to a shared responsibility for identifying both local health needs and necessary action and outcomes. The mix of skills available as a result of inter-sectoral approaches is another important resource for initiatives to draw in the development of health promoting activity. Information exchange across agencies is proposed as another essential means of establishing shared priorities that are sensitive to local health needs and facilitate the process of planning, implementing and evaluating joint action.

The importance of inter-sectoral collaboration as a means of securing new, innovative approaches to health promotion has also emerged as a leading theme (Draper,R. 1993). It has been suggested that effective new approaches can be defined around six key categories:

- **communication** around the links between community health and a range of services
- **research** encompasses activity which increases level of understanding of health problems and the factors influencing health
- **training** across professionals and services around the impact of services on health
- **planning** across agencies to identify and meet local health needs
- **practical support** provided across agencies to facilitate community health promotion activity
- **community development** approaches stimulated to facilitate a participative approach to health promotion

The key issues identified above along with the themes identified from a review of the literature around inter-sectoral collaboration in Chapter One have been employed in the identification of models of good practice from a review of current and recent work considered below.

A comprehensive review of both national and European Health for All and health promotion projects has revealed a number of models of good practice in the field of inter-sectoral collaboration. It is proposed that analysis of these projects will assist in the research to be undertaken into Healthy Eastleigh initiatives. The definition proposed at the end of chapter one, of key features of effective collaboration, along with the themes identified in the earlier part of this chapter will be applied to assist in the analysis of selected

models of good practice. In the first part of this section a number of projects will be considered in detail and the key features of the effectiveness of their approach outlined. In the second half the focus will shift to propose a number of local authority based projects. The key themes to emerge from models of good practice proposed in this chapter will further assist in the analysis of Healthy Eastleigh activities.

2. DUBLIN HEALTHY CITIES PROJECT - HEALTH, ENVIRONMENT, LIFESTYLES PROGRAMME

The Dublin Healthy Cities Project was established as part of the World Health Organisation Health for All initiative in 1987. One of the key projects to emerge from the project is the Health, Environment, Lifestyles Programme (H.E.L.P.).

The programme is primarily aimed at disadvantaged areas and is an ongoing community led and community based project. A key focus for the programme is the stimulation of community health awareness and health action. At the heart of the programme is collaboration between the Health Authority and the Local Authority to develop and maintain community involvement in health. The programme comprises a number of different elements:

- a Health Forum
- an Educational Programme
- a monthly focus on a specific health, environment, lifestyle or social issue
- a Healthy Cities week
- involvement at issue level and committee level of Healthy Cities Project.

An inter-agency approach to the establishment of health forums represents the cornerstone of the Dublin initiative. Representatives from the health authority, local authority, community groups and the Healthy City Project play the key role in setting priorities and the planning of community health activities. The initial task of the forum is to implement the programme. As time goes on, however, and more people in the localities become involved and interested in the project the forum widens and discussion takes place on the range and quality of the services offered locally by the statutory agencies. Collaboration and an awareness of the areas of responsibility of the partner agencies is a key feature of the H.E.L.P. initiative. It would seem, therefore, that there exists a high level of awareness about the respective domains of responsibility across the agencies involved.

The project has the support of the health authority and the local authority at a senior management level. The Dublin Healthy City project has provided official sanction for this community health promotion initiative. The key elements of the H.E.L.P. programme, from the establishment of the health forum to the implementation of a health week, is planned and implemented jointly by the local authority and the health authority in collaboration with the local community. The "health week" established as a key part of the programme has facilitated a broad approach to health and inter-sectoral involvement in the health issues addressed. Outlined below are some of the topics included.

SPORT	ELDERLY
RECREATION	TRAVELLERS
HOBBIES	COMMUNITY GROUPS
ART AND CULTURE	SPIRITUAL
ENVIRONMENT	WOMEN'S GROUPS

TRAFFIC	PRE-SCHOOLS
HOUSING	POVERTY
UNEMPLOYMENT	DISABLEMENT
HOUSING	HANDICAPPED
SCHOOLS	CRIME
YOUTH	SAFETY
HEALTH ISSUES	

(DUBLIN HEALTHY CITIES PROJECT 1991)

The Health, Environment and Lifestyle Programme is being implemented in neighbourhoods throughout Dublin. In particular, the inter-sectoral approach adopted has stimulated both health awareness and community health development activity in inner city housing estates across the city. To illustrate the range of community involvement in the programme, the activities implemented in two neighbourhoods are outlined below.

Clondalkin is an area of 4000 local authority semi-detached houses spread over a number of estates. Ballymun is also a local authority housing area and has 9000 housing units in semi-detached, 8 storey and 16 storey tower blocks.

DUBLIN HEALTHY CITIES PROJECT

COMMUNITY ACTIVITIES

Parade.
Information Exhibition of Local Organisations.
Welfare Rights Entitlements.
Aids Quilt.
Karate Display.
Majorette Display.
Gymnastic Display.
Junk Collection.
Environmental Clean-Up.
Arbour Day.
Fitness Testing.
Football Competition between Mothers and Gardai.
Photographic Display.
Video of Week.
Cycling Trips.
Litter Watch Games.
Travellers' Clinics.
Youth and Alcohol.
Civil Defense Display.
Accidents/Road Safety.
Cycle Proficiency Testing.
Reflexology.
All GPs notified.
Music Session.
Crime Prevention Talk.
Massage Techniques.
Schools Football Blitz
Aerobics.
Schools Art Displays.
Condom Giveout.
Drugs Talk in Schools by Parents.
Arts Night.
Play about Health, specially written for week.
Reminiscing by Older Folk.
Church Service for Sick.
Talk on Aids, Nutrition, Drugs, Womens' Health.
First Aid.
Hill Walk.
Swimming.
Organised Walks.
Gardening Talk and Competition.
Ceili.
Smear Testing Clinics.
Mental Health Sessions.
Lone Parents.
Library Displays
Pre-school Session.
Speed Chess Event.

The Health, Environment, Lifestyles Programme illustrates an inter-sectoral approach to community participation in health. The focus of the programme is broad and enables the development of a comprehensive approach to addressing local health needs. Official sanction and resources for the programme have come from the Dublin Healthy City project. This has ensured commitment and involvement from the main statutory agencies, the local authority and health authority. An attempt has also been made, through the Community Health Week, to harness a shared vision of what community health action could mean in both the short and long term. Joint planning at both a strategic and community level is a key feature of the initiative. This project, therefore, illustrates a model of good practice in the implementation of an inter-sectoral approach to community participation in health.

3. DEVELOPING HEALTHY PUBLIC POLICY - OSTERGOTLAND, SWEDEN

The development of healthy public policy represents a key aim of Health for All. The development of inter-sectoral policies for health represents an important means of promoting health gain. The development of health policy in a county council area in Sweden provides clear illustration of how inter-sectoral collaboration can enhance this area of work.

In 1987 the Ostergotland County Council proposed that a healthy policy programme be developed. Up until this time the local health services had devoted resources to preventative activities. However, it lacked a clear, overall, political strategy for the health of the people of the county. Collaboration at elected member and senior management level was at the heart of the policy development. In the establishment of a policy it was proposed that:

"the implementation of the programme involve the entire council organisation and require broad based co-operation with the university, colleges, voluntary organisations and popular movements and with municipalities and authorities in the county."

(Ostergotland Healthy Public Policy)

Concepts Underpinning Health Policy Development

In the development of a comprehensive health policy for the Ostergotland area, two key Health for All principles were adopted. Firstly, the concept of health adopted represented a holistic approach and ensured an inter-sectoral approach to programme development and implementation would be called for. The development of health policy was taken forward in a spirit of co-operation across the county council and health care agencies. The second key concept relates to the involvement of the population. The development of health policy was proposed under the banner of involving whole communities and individuals in the implementation of health promotion programmes. As an extension of this the policy programme proposed that four basic ethical rules should be laid down for community health. These were to underpin all planning and implementation of health policy action programmes in the county council:

1. Not to harm
2. To respect the integrity of the individual
3. To employ the most effective methods possible in the work of prevention
4. To distribute the resources equitably

Health Policy Goals

Official sanctioning of the development of health policy was achieved at the highest possible level across county

council and health care services. The unique collaboration of the county council with the faculty of health sciences and community medicine enabled the Ostergotland county council to emphasise its role as a "Healthy County Council".

At a senior management, elected member level and across the healthy alliance a number of shared policy goals were developed:

Goal 1 - Ostergotland County Council - A Healthy Council
Goal 2 - Health care that is equally accessible to all the people of Ostergotland
Goal 3 - High quality health care
Goal 4 - Health care that satisfies the needs of the population
Goal 5 - Community participation in health care activities

Underpinning the development of policy goals, there was awareness of their potential role and the contribution of others within the alliance.

Measurable Outcome Targets of Health Policy

The development of measurable outcome targets of the health policy development is another key feature of the Ostergotland approach. The outcome measures developed for key programme areas illustrate both inter-sectoral involvement, commitment across agencies and official sanctioning at a senior level. As well as proposing outcomes for individual areas, three important conditions were proposed to apply to all programmes areas:

1. Implementation must involve integration of measures in existing health care activities
2. Implementation presupposes inter-sectoral collaboration, thus promoting community oriented health activities

3. The level of knowledge should be sufficient to create concrete action programmes immediately, even if knowledge within the areas will naturally be expected to develop.

The four health issues for which measurable outcomes were proposed are outlined below:

- Reduction in lifestyle related risks
- Reduction in the accident rate
- Reduction in musculoskeletal disorders
- Improved health care of the elderly

Organisation and Resources

Providing information across the statutory agencies and the community about the key areas and the health policy development was identified as a key initiative. Commitment and official sanctioning of the approach had been achieved through elected members and senior managers. To ensure that all sectors in the community had the opportunity to be involved and participate in the health programme, an innovative training programme was developed.

The concept of training health "messengers" across agencies and communities was developed. This enabled the involvement of all professional groups and the local population. Activities were implemented across all sectors of the community and in various ways ranging from public meetings, health bulletins and participative programmes.

Network Development

At the centre of both implementation and evaluation of programme development was the establishment of effective, multi-sectoral communication networks. A Health Policy group was established on an inter-sectoral basis with the involvement of the local community. Representatives both evaluated progress and undertook joint planning. An extension of this was the establishment of an Ostergotland Health Council. This comprised inter-sectoral representation at an elected member and senior manager level. Programme implementation at a local level was co-ordinated by local inter-sectoral committees.

The health policy approach adopted in Ostergotland, Sweden represents a key example of a planned approach to health programme development. In contrast to the H.E.L.P. initiative in Dublin outlined under 2 above, it represents inter-sectoral activity at a policy level. The policy programme has its origins in official sanctioning and a shared commitment at a senior level. The approach adopted enabled the development of shared goals and the establishment of comprehensive networks across agencies.

4. HEALTHY SHEFFIELD 2000

The Healthy Sheffield initiative was launched in July 1987 with the establishment of an inter-sectoral approach to the adoption of the World Health Organisation's Health for All initiative at a local level. By way of contrast with the models of good practice identified under 2 and 3 above, this initiative reflects an approach which has the development of demonstration projects for specific health issues underpinning it.

In 1987 a Healthy Sheffield Planning Team and executive was established to give direction to the project. The

Planning Team was given the responsibility of providing strategic direction and management. The Planning Team illustrates inter-agency collaboration across the statutory and non-statutory agencies in Sheffield. During 1989 representation on the Planning Team was as follows:

- Director of Health Promotion, Sheffield Health Authority.
- Head of Central Policy, Sheffield City Council.
- Assistant Director, Recreation, Sheffield City Council.
- Unit General Manager, Community Unit, Sheffield Health Authority.
- Community Relations Officer, Council for Racial Equality.
- District Nursing Officer, Sheffield Health Authority.
- N.H.S. Liaison Officer, Sheffield City Council.
- Consultant in Public Health, Sheffield Health Authority.
- General Manager, Sheffield Practitioner Committee.
- Assistant Director, Voluntary Action Sheffield.

Health Promotion Programme Steering Group

In February 1989 a Health Promotion Steering Group was established to provide a strategic role in prioritising Health Promotion Programmes and Demonstration Projects. A key part of the Group's function was to identify resources, ensure effective planning, implementation and evaluation of programmes of action. To illustrate the key features of programme development and the strengths of the inter-sectoral approach adopted in Sheffield, two programme areas will be analysed below.

(a) Food Programme

The Health Promotion Programme Steering Group identified the aim of the food programme as being:

"to develop and support health promotion activity which improves the health and well-being of Sheffield people by reducing the incidence of food related ill health, unnecessary suffering and chronic disability."
(Healthy Sheffield Review 1989)

Background to the Programme

Health promotion around food issues had been a priority for some time for health promotion and dietetics staff within Sheffield City Council and the Health Authority. In 1986 the Health Authority approved a food policy which also addressed food issues within the health authority and the wider community. In 1988 the City Council agreed a food policy which was concerned with food issues within the council and the wider community. Thus, official sanctioning across the key agencies had been achieved at a senior level and a shared vision of what needed to be addressed began to emerge. In 1988 a joint Food Programme Team was established between the Health Authority and the City Council. This signalled a real investment of resources to support the work and a joint approach to programme planning, implementation and evaluation. Representatives on the Food Working Group during 1989 were drawn from the City Council, the health authority's health promotion unit and the community unit.

The range of work undertaken during 1989 illustrates the multi-agency approach adopted. Some of the key elements of the programme are outlined below:

- A food resources review group was established to

review available educational and informational resources on food and recommend additions. Throughout the year such materials were used by schools, other organisations and the general public.

- An Infant Feeding Policy Group was established and a policy for Sheffield produced.
- Significant developments took place within schools. A pilot study of the eating habits of school children was undertaken. One recommendation of this study was that tuckshop provision should be reviewed, and, as a consequence, there have been investigations into the possibility of promoting healthier choices. A schools Nutrition Group was also established during 1989 and this group produced a nutrition bulletin for schools.
- The City Council Food Policy Review Panel met twice during 1989. Departments have been asked to set targets to ensure appropriate implementation of the food policy.
- During 1989 it was agreed that nutritional issues should be a feature of all food hygiene courses provided by the Council's Health and Consumer Services Department.
- Seven "Heartbeat" awards were made during the year to premises serving food which met the "Heartbeat" criteria.
- Within the Health Authority a substantial amount of work was undertaken on food issues within the Jessop Hospital for Women, including a food and health day and the establishment of a slimming club.
- A nutritionist was appointed within Health and Consumer Services.
- Funding was secured to appoint a Senior Health Promotion Officer with responsibility for food issues within the Health Promotion Centre (previously Health Education Unit), Sheffield Health Authority.

(Healthy Sheffield 1989)

The elements of the programme outlined above illustrate a comprehensive approach to health promotion activity around food. The range of activity implemented exemplifies the establishment of a mutli-sectoral approach to health promotion. An attempt has been made to maximise network awareness and develop participative activities which involve the agencies working on Healthy Sheffield.

(b) Smoking Programme

The aim of the smoking programme is to develop and support health promotion activities which help to improve the health and well-being of Sheffield people by reducing the prevalence of smoking and passive smoking.

Background to the Programme

Smoking was identified as a priority health promotion issue for staff both within the City Council and the Health Authority. In March 1988 Sheffield City Council adopted a smoking policy which was concerned with issues both within the council and the wider community. In 1986/7 the health authority adopted a corporate smoking policy which related primarily to the health authority. To co-ordinate efforts across the city and adopt a multi-agency approach to smoking prevention, a Smoking Working Group was formed under the auspices of the Health Promotion Steering Group. Outlined below are the key features of the programme during the period 1989/90.

HEALTHY SHEFFIELD

SMOKING PROGRAMME 1989/90

- Thirteen cessation courses were held for smokers wishing to give up.
- A training course was provided to train people to provide cessation courses.
- The development of plans for a Children's "Smokebusters" Health Club. After consultation it was agreed that this should be a general Children's Health Club with smoking as one of many issues to be considered. It is hoped that a new HS2000 Health Promotion Programme on children will be established in 1990 and that the Children's Health Club will be part of this work.
- Support to enable the establishment of a local "Parents Against Tobacco" group which will aim to prevent recruitment of children to smoking.
- Promotion of workplace smoking policies within the City Council, Health Authority and other work sites:

    - A review of the implementation of the Council smoking policy in December 1989 showed that the majority of Council departments had successfully formulated and implemented their own departmental policy. Some departments have encountered problems and assistance is being provided.
    - Health Authority units have implemented the smoking policy with varying degrees of success. It is proposed to review the situation in 1990 and provide further support for implementation.

- The promotion of smoke-free public transport (some buses are now "smoke-free") and a smoke-free World Student Games.

- Lobbying to secure further restrictions in promotion, advertising and sponsorship linked to tobacco and for increases in taxation to deter use.
- Provision of general health education materials on smoking to schools, other organisations and the general public, and organisation of local activity on National No Smoking Day (April 1989).

(Healthy Sheffield 1989)

The Healthy Sheffield Smoking Programme represents a comprehensive inter-sectoral approach to smoking prevention. The initiative received official sanction at a senior level across agencies and achieved the involvement of local statutory agencies and local businesses. The programme development phase has been achieved as a result of collaboration in planning, implementation and evaluation. The creation of a network of committed professionals and departments has been a key feature of the success of the programme.

5. BELFAST HEALTHY CITY PROJECT

Belfast joined the World Health Organisation Healthy City Project in the second round of project cities in January 1988. The initiative was developed as a result of collaboration between the Department of Public Health Medicine and the Environmental Health Department of Belfast City Council. In formalising the project a working group, involving other agencies, was established. This allowed for the participation of voluntary and community groups and other statutory agencies. Thus, official sanction of the initiative was achieved across agencies. The models of good practice in inter-sectoral collaboration outlined under 1 - 3 above illustrate a diversity of approach and focus to joint working. The elements of the Belfast initiative outlined below illustrate a focus on social and environmental issues and provide further contrast to the models of good practice already explored.

Employment

In 1991 the Belfast Healthy City initiative produced a strategy document which clearly proposed key social issues as areas of action. The initiative declared a wish to take action and:

"highlight some of those areas outside the traditional medical view"

(Healthy Belfast 1991)

which impinge on the city's health.
Lack of adequate weekly income to buy and cook healthy food and the loss of self-esteem which may arise out of long term unemployment are all factors which contribute to low health status. To adopt a practical, inter-sectoral approach to tackling this issue, the Healthy

City initiative joined with a government sponsored initiative.

In introducing the Making Belfast Work initiative government recognised the importance of employment initiatives in tackling the levels of social deprivation in parts of the city. While recognising that a major contribution to the improvement in the living and working conditions of an area must come from the people of the area themselves, government injected a financial commitment to support local developments. The government allocated £65 million over 3 years from 1991 to assist in morale raising, in increasing the private sector's contribution and developing local leadership. This money and support has enabled a large number of locally based employment and training initiatives, like the development of an adult education centre and initiatives focusing on a particular issue like the Immunisation Task Force.

The initiative is backed by 9 Action Teams each located within an area of multiple deprivation. The Healthy Belfast initiative is collaborating with and represents a key part of this approach. With a limited budget, the Action Teams act as catalysts in upgrading the quality of life of local people by attracting to these areas measures to increase the level of economic activity and employment to improve the environment and increase community involvement. Thus, an inter-sectoral approach has been adopted to tackle the issue of economic development and reducing unemployment in the city. a shared vision of what can be achieved and commitment to implementing action. The planning and implementation of local action plans is also undertaken on an inter-sectoral basis.

Living Conditions

Target 24 of the World Health Organisation Health for All initiative declares that:

" By the year 2000 all people of the region should have a better opportunity to live in houses and areas which provide a healthy and safe environment." In the development of the Belfast Urban Area Plan one of the key objectives was:

" to contribute to the general health of all the citizens of Belfast by improving the physical environment of the city."

Planning can have a positive or negative influence on a city's health. In terms of green space, road networks, public transport, location of housing estates and local amenities planning is a key function in determining a health promoting environment. A participative approach has also been adopted across agencies and involving local communities in schemes to assess the welfare of local people in relation to their immediate environment. The locally based health profiles embraced detailed study of selected areas and most importantly, an examination of what local people perceive to be the main influences upon their physical and psychological welfare.

The first area in which the profile was developed was the Moyard Estate in West Belfast. The study took place during 1984-85. Moyard was characterised at the time by social and economic deprivation. The area had a reputation for high levels of unemployment, poor housing and high levels of preventable mortality and morbidity. The Moyard Health Profile produced recommendations which are generalisable across the Healthy Belfast initiative. It identified:

- the advantages to be gained by agencies working together in the planning and implementation of services
- the importance of the public having improved access to health information
- primary health care should be made more accessible
- a need for joint training of health and social services staff
- the community should be involved in decisions affecting health.

In the 4 years since the Moyard Health Profile, services in the area have been greatly enhanced. Inter-sectoral collaboration along with community participation in health has resulted in the development of a strategy to improve housing conditions and develop a Health Liaison Committee. Official sanction for the work has been assumed by the Healthy Belfast Committee. Joint planning and implementation of initiatives has been a key feature and the approach has harnessed a shared vision around the development of a "healthy" community. The approach adopted in Belfast represents an innovative, inter-sectoral response to tackling social determinants of health.

6. HEALTH FOR ALL IN WALES

A strategic plan for the development of health promotion and Health for All activity in Wales was published in February 1990. Inter-sectoral collaboration underpins the plan and it represents a model of good practice in the way in which it seeks to harness the involvement of all agencies and sectors within the community. Outlined below are the key features of the Health for All initiatives being developed in Wales and the key contributions to health gain identified for each agency.

Summary of Health for All Initiatives

Three key Health for All initiatives were proposed for implementation across Wales. Outlined below are the key features of the initiatives and the key ways in which it was proposed different agencies could contribute to the achievement of health gain.

(a) Heart Beat Wales

The Heart Beat Wales initiative has six adult focused action areas:

- Nutrition
- Physical Exercise
- Coping and Stress
- Smoking
- Cardiopulmonary Resuscitation
- Relevant General Support Services

The project was set up initially as a 5 year U.K. demonstration project in heart disease prevention. However, the level of public and organisational support together with evident changes in awareness, attitudes and lifestyles indicated a need to continue the work beyond the first phase and to use its high profile to develop related activities. Since it was launched on St. David's day in 1985, considerable progress has been achieved by innovative work and fruitful partnerships with a wide range of organisations in the public, private and voluntary sectors.

Heart disease and the associated risk factors and lifestyle issues remain a formidable challenge. Many of the important behaviourial issues for adults, smoking, nutrition, exercise and stress fall under this heading. Heartbeat Wales was established as a multi-sector vehicle

to enable a community wide approach to lifestyle activities in the community setting. The key goals for the initiative are outlined below:

- Nutrition

"to improve nutrition and reduce overweight"

- Physical Exercise

"to improve physical fitness and participation in exercise"

- Coping and Stress

"to improve physical fitness and participation in exercise"

- Smoking

"to reduce substantially the use of tobacco"

- Cardiopulmonary Resuscitation

"to enhance first aid skills which reduce the impact of injuries, disease and premature death, particularly heart attacks"

(b) Good Health Wales

Heart Beat Wales is an appropriate vehicle for delivering many adult based programmes, it was not seen as suitable to address all health issues. Work on healthy sexuality, cancer prevention, alcohol and drugs was developed under the Good Health Wales banner. The following action and goals were identified:

- Alcohol and Drugs

"to reduce substantially the misuse of alcohol and other drugs"

- Healthy Sexuality and H.I.V. and A.I.D.S.

"to reduce the impact of unwanted pregnancy and morbidity and premature death from sexually transmitted diseases"

- Cancer Risk Reduction

"to reduce the incidence and impact of disease, disabilty and premature death from cancers by at least one quarter"

(c) Youth Life Wales

The importance of targeted programmes directed at children and young people was identified as a priority by the Health Promotion Authority for Wales. The Youth Life Wales initiative was established to cover all activities concerning children and young people (0 - 18) with the general aim being:

" to maximise the health potential of young people so that they may lead socially and economically fulfilling and mentally creative adult lives with the minimum of disability and social handicap."

The following action areas were identified:

- Nutrition
- Physical Exercise
- Smoking
- Alcohol and Drugs
- Healthy Sexuality and H.I.V. and A.I.D.S.

The goals identified for each reflect those outlined above under the Good Health Wales initiative.

An Inter-sectoral Approach

The three programmes outlined above represent key Health for All projects in Wales. Underpinning the achievement of the action areas and the goals proposed above is the principle of inter-sectoral collaboration. The need to collaborate across setting and sectors in the community is at the heart of the planned, strategic approach adopted by the Welsh Health promotion Authority. It recognises that health promotion can take place in a variety of different settings where people live, work, spend leisure time and receive services. These include:

- the home
- the workplace
- leisure facilities
- schools, colleges etc.
- health centres and hospitals
- commercial premises

An important feature of the strategic plan is the way in which the contributions to health promotion from individual agencies are clearly defined. The table below illustrates the range of activity proposed in terms of agency involvement and community settings.

FIGURE 3

HEALTH FOR ALL IN WALES - AGENCY INVOLVEMENT

SETTINGS / SECTORS	Home	Workplace	Leisure Facilities	Schools & Colleges, Libraries	Health Centres & Hospitals	Commercial Premises
Health	■	■	■	■	■	
Local Authority	■	■	■	■		■
Education	■	■	■	■		
Mass Media	■	■	■	■	■	■
Voluntary & Community	■	■	■	■	■	
Commerce & Industry	■	■	■			■
Non Departmental Public Bodies	■	■	■	■	■	■
Governmental	■	■	■	■	■	■
Employment		■	■	■	■	■

For each sector the potential contribution and collaboration around programmes for health gain are clearly defined. Outlined below are the areas for potential participation by the key agencies.

District Health Authority

- Establish an effective multi-disciplinary and inter-agency planning and action team, with high level support and reporting relationships, for health promotion programme.
- Giving feedback on the national health objectives and targets proposed by the Health Promotion Authority and adapting them for use at county level.
- Strengthen the effectiveness of district public health departments and health promotion or health education units by providing appropriate resources to lead local initiatives, to collaborate on national programmes and to support and develop good practices.

Local Authority
District Councils

- Collaborate with the DHA to develop Health for All strategy at town and village level.
- Develop policies on healthy eating, smoking, alcohol, exercise and HIV/AIDS for staff and clients within its services and establishments.
- Consider health issues when granting permission for developments such as new housing or the siting of tobacconists or alcohol advertisements.
- Highlighting the health benefits of local leisure, recreation and exercise opportunities.

Education

Primary and Secondary Education

- Take full advantage of the opportunities for health promotion and education provided by the National Curriculum.
- Supporting health promotion through the development of policies and check lists for good performance by schools.
- Clarifying the most appropriate and effective contribution to health education in schools by other professionals.

Adult and Community Education

- Incorporate health promotion into the Curriculum wherever possible.
- Develop policies on smoking, healthy eating, exercise, HIV/AIDS for staff and students.
- Encourage the provision and use of healthy leisure services and activities for students and staff.

(Health Promotion Authority for Wales 1990)

The strategic plan for health promotion activity in Wales represents a model of good practice in the way in which it seeks to clearly define contributions to programmes from all agencies. Official sanction for the approach has been achieved at a senior level both within the Health Promotion Authority and the other statutory agencies. A collaborative approach has been adopted to programme planning and implementation. One of the key strengths of the approach is the way in which the role and potential contribution of other agencies and sectors in the community is highlighted in the strategic plans. This indicates network awareness across agencies and represents positive evaluation of the role of all agencies.

7. COLLABORATIVE HEALTH PROMOTION IN THE LOCAL AUTHORITY SETTING

By way of contrast with the models of good practice identified in detail above, a number of multi-agency health promotion projects from the local authority setting will be outlined in summary form below. Prior to outlining the development and structure of Healthy Eastleigh, initiatives to develop around the United Kingdom will be outlined in summary form. These represent an inter-sectoral approach to health promotion and the management structures established for Health for All and health promotion and the range of the initiatives will be a particular focus.

An attempt has been made to outline the key features in order to assist in the analysis of the Healthy Eastleigh initiative. The references to the local authority initiatives below are taken subtantially from Ged Moran's paper, Local Collaboration in Health Promotion (Leeds Metropolitan University 1990).

Manchester

The city has a single-tier local authority, three District Health Authorities and one Family Health Services Authority. Manchester's multi-agency work on health emerged from a local Black Report on inequalities in health developed by the health and local authorities in 1985. Close working relationships results in the secondment of a Specialist in Public Health Medicine to work with the City Council. In 1987 the authorities adopted a "Healthy Manchester 2000" strategy. A Health for All Working Group was established with senior management, multi-sectoral representation. This included representation from Environmental Health, Health Promotion in the Health Authorities, Family Health Services Authority, Social Services, Council of Voluntary Services and Education. An inter-agency approach to the

following issues has developed:

- Smoking
- Accident Prevention
- Nutrition
- Consultation with the Local Community

Bradford

Bradford has a single tier authority, one Family Health Services Authority and two Health Authorities. An inter-sectoral District Health Promotion Planning Team was established in 1986, to act as a co-ordinating and monitoring group for health promotion strategy. Inter-sectoral sub-groups were established around the following:

- Primary Care
- NHS
- Equity to Health Care
- Local Authority Issues

A range of key issues were identified as activity areas:

- Food
- Smoking
- Home Safety
- H.I.V. and A.I.D.S.

A number of multi-agency forums were established through which individual areas of work are being progressed. A community health project has also been established to facilitate the involvement of local people in community health action.

Birmingham

Birmingham has a single tier local authority with 5 District Health Authorities and one Family Health Services Authority. Healthy Birmingham 2000 was launched in February 1990 . The initiative was proposed as an inter-sectoral approach to a local response to the World Health Organisation's Health for All initiative. The initiative is seen as being issue based and task orientated. The main emphasis of the approach has been around the development of a strategy which harnesses community involvement, development of primary health care and reducing inequalities in health.

Kirklees

Kirklees has two District Health Authorities and one Family Health Services Authority. Kirklees' interest in collaboration stemmed form meetings between Environmental Health Officers at the local authority and Health Promotion Officers from within the health authority. An inter-sectoral committee with representation from the statutory agencies and the voluntary sector was established and the Health for All initiative was launched in October 1988.

An action-based approach concentrating initially on one deprived area was developed during 1989, with the emphasis on joint working and consulting and involving local residents and voluntary groups. A number of initiatives have developed with a focus on specific health issues including the promotion of healthy lifestyles and the prevention of coronary heart disease.

Sandwell

Joint discussions between the health authority and the local authority during 1989 resulted in the development of the Healthy Sandwell initiative. A joint committee comprising membership from the local authority, health authority, family health services, education and the voluntary sector. An action plan was developed in collaboration with the Director of Public Health. This resulted in the development of a Coronary Heart Disease Prevention Programme which has the full support of the statutory agencies and voluntary sector.

Hull

Healthy Hull has a strongly multi-sectoral formal structure. A steering group was established in mid-1989 including representation from the statutory agencies, voluntary sector, churches, private sector and trade unions. Collaborative projects to develop since that time have included a health audit of local services, a healthy shopping scheme, a child accident prevention group and a health information group. An inter-sectoral approach to the development of individual areas of work has been a key principle of Healthy Hull. Community involvement in health has now been identified as a priority and work is now underway to develop a project in one locality.

Warwick/Warwickshire

Warwickshire covers one family health services authority, three district health authorities, five district councils and a county council. An inter-sectoral health planning group was established in 1987 with the representation of the statutory agencies and the voluntary sector. Joint strategy development was established around work linked

to H.I.V. and A.I.D.S. Efforts are being made to develop a co-ordinated strategy around all health issues. The World Health Organisation Targets for Health are being used to focus discussions. A county wide information exchange has been developed as a means of pooling ideas and sharing models of good practice.

Summary

The analysis of the models of good practice identified above has provided the opportunity to apply the elements of the model of effective collaboration proposed in Chapter One.

The five elements of the model have emerged as important features of effective joint working. In Chapter Four the early stages of the Healthy Eastleigh initiative will be considered by way of an introduction into the detailed analysis of the five Healthy Eastleigh projects providing the focus of this research.

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CHAPTER FOUR

HEALTHY EASTLEIGH PRIORITY AREAS OF WORK

JUNE 1990 - JUNE 1992

During the period June 1990 to November 1990 the Healthy Eastleigh Steering Group set about identifying priority areas of work for the first two years of the initiative, to run to June 1992. Outlined below is the process adopted to define priorities. In the second half of this chapter is a synopsis of the areas of work proposed. A number of the projects and areas of work to develop under each of the priority areas will form the focus of the research into inter-sectoral collaboration in Eastleigh.

1. PRIORITY SETTING

Three multi-agency workshops were held during August and September 1990 as a key means of setting priority areas of work which would harness inter-agency collaboration. Outlined below is an evaluation of the workshops and the key health issues to emerge (Kickham, 1990) Formal and informal feedback obtained from both the fieldworkers who participated and members of the Healthy Eastleigh Steering Group comprise the main source of the observations below.

Workshop Objectives

The workshops turned around three key objectives:

- to inform staff about Health for All as a global concept and raise awareness about the structure being developed in Eastleigh
- to initiate multi-agency activity around the Healthy Eastleigh initiative

- to obtain the views of local staff on local health needs to assist in the planning process for Health for All in Eastleigh

Process Evaluation of the Workshops

Five operational aspects of the workshops are evaluated below:

(a) Background information for participants
(b) Training and Venue
(c) Size and Mix of Groups
(d) Workshop Presentations
(e) Group Work and Discussions

The process of each of these is outlined below and key evaluation points are identified for each.

(a) Background Information

Three background papers were sent to each participant:

- The World Health Organisation 38 Targets for Health
- Key principles underpinning Health for All
- Evaluation form

Evaluation Points

- The Background papers provided participants with information for preparation prior to and for reference after the workshop.
- The 38 Targets meant more to some of the groups participating than to others. This indicated that for future staff development activities background information would be required which related to the local situation in Eastleigh and to the work practice and priorities of the agencies participating.

- The evaluation form was adapted form a training course evaluation form used by Eastleigh Borough Council. For future staff development and education activities, it was proposed evaluation indicators which related directly to Health for All targets and themes would need to be developed.

(b) Timing and Venue

Each of the workshops was held during the lunchtime period and spanned approximately 1.75 hours between 12.00 and 1.45 p.m. The first two workshops were held in the Committee Room at the Council Offices in Eastleigh and the third in the Meeting Room at Eastleigh Health Centre.

Evaluation Points

- Mounting the workshops during the lunchtime period seemed to work well and achieved the following attendance rates against the nominations received for each session.

(c) Size and Mix of Groups

An upper limit of 30 participants was set for each workshop and achieving multi-agency representation at each workshop was identified as a key objective.

Evaluation Points

- The table below indicates the agency mix of those who actually participated. The nominations received prior to the workshops are indicated in brackets.

TABLE 4

RANGE OF PARTICIPANTS AT EASTLEIGH HEALTH FOR ALL WORKSHOPS

WORKSHOP	HEALTH AUTHORITY	LOCAL AUTHORITY	SOCIAL SERVICES	FAMILY HEALTH SERVICES AUTHORITY	EASTLEIGH COUNCIL FOR COMMUNITY SERVICE	TOTAL
15 AUGUST	6 (8)	19 (19)	1 (1)			26 (28)
21 SEPTEMBER	8 (11)	12 (16)	1 (1)	2 (2)		23 (30)
28 SEPTEMBER	15 (15)	6 (13)	1 (1)	1 (1)	1 (1)	24 (31)

(Nominations are indicated in parenthesis)

- The nominations received were up to the limits set for the workshops. The "actual" number of participants at the workshops was lower. It can only be assumed that other factors prohibited some nominees attending on the day.
- Representatives from the local authority and health authority comprised the main participants at all 3 workshops. A good level of dialogue was achieved between these agencies. Strengthening links with staff across these agencies was identified as one of the most positive features of the workshops.
- The under-representation from the Social Services, Family Health Services and Education Authority diminished the level of inter-sectoral collaboration achieved.
- Future education and development work with the statutory agencies participating in Healthy Eastleigh would be needed to address the needs of individual staff groups. Raising levels of awareness and the relevance of Health for All within those agencies under-represented was identified as a pre-requisite to any future multi-agency activity.

(d) <u>Workshop Presentations</u>

Formal and informal feedback from workshop participants comprised the major source of information against which the effectiveness of the workshops was measured. In terms of formal feedback, the response rate for the evaluations is outlined below and this was achieved after reminders were sent out.

TABLE 5

WORKSHOP EVALUATION FORMS

	No. of Forms	Response Rate
15 August	17	65%
21 September	9	39%
28 September	10	42%

Two short presentations were given during the first half-hour of each session. The first focused on the origins of Health for All and the principles of Health for All as a global concept. The second presentation focused on the structure developed in Eastleigh and the issues identified so far by the Health for All Steering Group.

Evaluation Points

- A wide range of comments concerning the presentations was identified on the evaluation forms. For evaluation purposes these have been categorised below on a scale of Very Informative to Not Informative, with a category for those forms with No Comment against the presentation.

TABLE 6

EVALUATION OF WORKSHOP PRESENTATIONS

	Very Inform-ative	Inform-ative	Fairly Inform-ative	Not Inform-ative	No Comment
Workshop 1 15-8-90	2	7	4	1	3
Workshop 2 21-9-90	1	5	2		1
Workshop 3 28-9-90	2	3	2	1	2

- The table above, along with the informal comments and feedback received from participants indicated that the presentations were received positively and were found to be informative. There was an even distribution of positive and negative comments between agencies and a consistency between all three workshops.

(e) Group Work

After the presentation participants were requested to break up into small multi-agency groups comprising between 5 and 7 staff. Each group was requested to discuss their perceptions of local health needs and nominate a group member to report their views during the plenary session.

EVALUATION POINTS

- The comments received from the participants about the effectiveness of the group discussion focused on four key themes: those who found it very useful, those who found it useful but felt more support for

the group would have been helpful, those who felt that the groups needed a better brief and focus for the discussion, and those who expressed the view that the discussion was poor. These categories have been used below to analyse the comments.

TABLE 7

EVALUATION OF WORKSHOP GROUP DISCUSSION

	Very Useful	Use But Needed Direction	Groups Needed a Better Brief	Poor
15 August	9	5	2	2
21 September	6	2	1	
28 September	3	2	1	2

- The comments above were evenly distributed across the agencies represented at each workshop. Comparison between workshops is limited because of the poor response rate for the evaluation forms. However, the proportion of the total participants at each session who found the group discussion either "very useful" or "useful but needed direction" was consistent.
- The group discussion was, on the whole, found to be useful. However, comments were received from both participants and Steering Group members which identified the need for a more structured and focused approach to any future discussions.
- The group discussions achieved the key objective of obtaining staff views on local health needs. The wide-ranging discussion achieved at each of the workshops would seem to validate the unstructured approach adopted to the discussions. The range of

health needs identified exceeded the organisers' expectations. An analysis of those expressed at each of the workshops has identified five themes. The health needs expressed under each of these themes are outlined in the table below, the workshop(s) at which these were raised is also indicated.

TABLE 8

EASTLEIGH HEALTH FOR ALL WORKSHOPS - LOCAL HEALTH NEEDS

HEALTH PROMOTION Lifestyle Issues: Smoking W1, W3 Stress W1, W2 Drugs W1, W3 Exercise W2, W3 AIDS W2 Empowerment W2 Health Promotion for Young Mothers W2 Health Promotion in Schools W2, W3 Promote Individual, Family and Community Health W1 Home Safety W2	**COMMUNITY PARTICIPATION** Involve local people and groups W1, W2, W3 Develop links between the Community and professional staff W1, W2 Involve Local Industry W2, W3 Involve Minority Groups W2	**HEALTH INFORMATION AND RESEARCH** Identification of local target groups W1, W2 Establish a database of Health Activities currently under way W1
W1 = Health Need expressed at Workshop 1-15 August 1990 W2 = Health Need expressed at Workshop 2-21 September 1990 W3 = Health Need expressed at Workshop 3-28 September 1990	**STAFF EDUCATION AND DEVELOPMENT** Development of professional staff in the Community W1, W2, W3 Training on Health for All W2, W3	**SERVICE NEEDS** Provision of accessible leisure facilities W1, W2, W3 Provision of better public transport W1, W2, W3 Provision of better housing and more of it W1, W2, W3 Respite for Carers W2 Better Primary Health Care Services W1, W2 Better Environmental Protection W1, W2

- The main themes identified in the group discussion provided focus and confirmation of the proposed approach for Health for All in Eastleigh. The data collected supplemented the local planning process. The range of health promotion issues identified provided a focus of local health needs. Community participation and the need to develop firmer links between professional staff and local people was identified during all three workshops. The importance of staff development and training around the issue of Health for All was expressed, and this in turn can be related to some of the wide range of service needs expressed. Development work within individual agencies can build links between the expressed needs of the local community so that these impinge on the way in which services are provided. Finally, the identification of health information and research needs confirms this as a priority area of work for Health for All in Eastleigh.

Workshop Outcomes

The multi-agency workshops represent the first attempt to establish an inter-sectoral approach to health promotion activity in Eastleigh. They served as a first attempt to harness multi-agency commitment to Health for All at a local level.
The key benefits to come out of the workshops are summarised below:

Multi-Agency Collaboration - One of the key benefits to come out of the workshops was the opportunity they provided for fostering multi-agency collaboration and dialogue. The Workshops allowed local fieldworkers to share their perceptions of health needs and to develop contacts with workers from other agencies.

Establishing Health for All on the Local Agenda - The workshops provided the opportunity to broaden both the perceptions of health among the agencies involved and the discussion of health needs in Eastleigh. They represent the initial stage in establishing Health for All on the local agenda.

Impact on the Planning Process for Health for All - The workshops generated a wide range of local health needs and these will supplement the planning of priority areas of work in Eastleigh during the coming year.

Impact on Future Multi-Agency Activity - The workshops generated ideas on the future staff education and development needs of organisations participating in Health for All in Eastleigh.

2. PRIORITY AREAS OF WORK

As a result of the workshops and discussions with members of the Healthy Eastleigh Steering Group and the comments outlined in part 1 above priority areas of work and key objectives for the period September 1990 - June 1992 were developed (Eastleigh Borough Council 1990). Outlined below are the priority areas of work to develop and the key objectives proposed under each. At the end of this section a summary of the areas of work and the projects under each to provide a focus for the research into inter-agency work and the Healthy Eastleigh initiative.

Four inter-dependent priority areas of work were identified:

1. Information and Research
2. Staff Education and Development
3. Community Participation
4. Health Promotion

2.1 Information and Research

The development of an information strategy was identified as a priority area of work. It was proposed that both quantitative and qualitative health data were needed to inform strategic and operational planning, education and development work and monitoring and evaluation activities. The evaluation and analysis of existing sources of information was identified as a key starting point. A need to harness an inter-agency approach to information sharing was identified as a key objective.

Analysis of the Public Health Reports produced by Winchester and Southampton and South West Hants Health Districts was proposed as a first stage in the development of a comprehensive health database for Eastleigh Borough. The following objective was proposed for Information and Research activities:

- Establish an Information and Research Sub-Group to develop an information strategy for Healthy Eastleigh

2.2 Staff Education and Development

The need to consult with and inform staff about the development of Healthy Eastleigh 2000 was identified as a priority. It was proposed that education and development activities would need to involve staff from both the statutory and non-statutory agencies participating in the initiative:

Eastleigh Borough Council
Winchester Health District
Southampton and South West Hants Health District
Family Practitioner Committee
Hampshire Social Services
Hampshire Education Authority
Eastleigh Council of Community Service

It was proposed that an effort be made to continue the implementation of workshops and harness a multi-agency approach to staff education and development activities. The following objectives were proposed:

- Develop and support multi-agency staff education and development activities
- Develop and support staff education and development activities in individual agencies

2.3 Community Participation

Involving residents in the Borough and securing their views was identified as a priority area of work. It was proposed that the views of the local community would inform overall perspectives of need and provide more detail for the implementation of relevant programmes.

The development of locally based community health forums under the auspices of the Winchester Health Authority Community Health Initiative was proposed as one potential approach. The following objective was proposed:

- Establish a Community Health Initiative in one electoral ward area in the Borough of Eastleigh

2.4 Health Promotion

All of the agencies participating in Healthy Eastleigh were already involved in the development of health promotion activity. Outlined in the table below are the key objectives proposed for activity to June 1992.

- To establish multi-agency health promotion group to implement local community bases initiatives.
- To develop a smoking prevention programme.

2.5 Inter-sectoral Collaboration and the Healthy Eastleigh Initiative

The priority areas of work and objectives outlined above formed the basis of activities and projects developed during the first two years of the Healthy Eastleigh initiative. Outlined below are the individual projects which will be the focus of the research into inter-sectoral collaboration and the Healthy Eastleigh initiative. The aims and objectives of the individual projects will be outlined in detail in due course.

1. Community Participation Project.
2. Healthy Shopping Scheme.
3. Inter-Sectoral Smoking Prevention Programme.
4. Health Promotion Group
5. Shared Information Project.

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CHAPTER FIVE

RESEARCH DESIGN

1. INTRODUCTION

The five projects outlined at the end of the last chapter represent a variety of health issues and Health for All themes. They also involve members of the Healthy Eastleigh partnership agencies to varying degrees. As mentioned in previous chapters the focus of this research is to explore the extent to which inter-sectoral collaboration is being achieved in the Healthy Eastleigh initiative and to identify some of the opportunities and barriers to joint working at a locality level. The research methods to be applied are threefold:

- Interview
- Content Analysis
- Participant Observation

It is anticipated that both the qualitative and quantitative data collected in the course of the research will provide a comprehensive picture of inter-agency activity in Eastleigh. Before focusing down on the three elements of the research design, the benefits and rationale underpinning the development of a multi-method research design will be explored.

2. METHODOLOGICAL TRIANGULATION

Triangulation may be defined as the use of 2 or more methods of data collection in the study of some aspect of human behaviour. The use of multiple methods exhibits a number of advantages:

- Approaches adopting one research method provide only a limited view of the complexity of human behaviour and of the situations in which human beings interact. It has been observed that as research methods act as filters through which the environment is selectively experienced, they are never neutral in representing the world of experience (Smith, H.W. 1975).
- Exclusive reliance on one method may produce bias or reduce objectivity in data gathering. The use of a multi-method approach reduces bias and provides a means of increasing the validity of the data collected.

Two categories of triangulation have been identified - triangulation between methods and within methods. "Within" means replication of a study as a check on reliability.
The "between" methods approach embraces the notion of yielding similar data by use of different methods. It is proposed that the "between" methods approach be adopted for the research into Healthy Eastleigh. Triangular methods are identified as being appropriate for the research into inter-sectoral collaboration because:

- they are suitable when a more holistic view of outcomes is sought
- they have special relevance when a complex phenomenon requires elucidation
- they are appropriate when a variety of projects/areas of work are to be evaluated
- they provide checks and balances and reduce bias when participant observation is being employed.

It is proposed, therefore, that the multi-method approach being adopted for this research will be a sound one yielding reliable quantitative and qualitative data and facilitate the collection of a range of equally reliable subjective and objective data.

3. THE INTERVIEW AS A RESEARCH TOOL

As a research tool the interview can range from a formal approach in which set questions are asked and the answers recorded on a standardised schedule through to the non-directive interview in which the interviewer takes on a subordinate role and provides the respondent with the freedom to direct discussion. For the purposes of this research a formal approach will be adopted in which the participants in each of the Healthy Eastleigh projects will be asked a set of questions comprising a standardised schedule. This will increase both the reliability of the data collected and facilitate comparison across the project areas, and thus, the generalisability of the data collated.

The research interview has been described by Cannell et al as:

"a two-person conversation initiated by the interviewer for the specific purpose of obtaining research-relevant information and focused by him on content specified by research objectives of systematic description, prediction or explanation."

(Cannell, C.F. 1968)

As a research technique the interview may serve three purposes. Firstly, it may be used as the principal means of gathering information having a direct bearing on the research objectives. It is suggested that by providing access to what is inside a persons head the interview makes it possible to measure what a person knows, what a person likes or dislikes and what a person thinks. Secondly, the interview may be used to test a hypothesis or to suggest new ones. Thirdly, and in the case of the research into Healthy Eastleigh, it may be used in conjunction with other methods to supplement data collection and to validate.

Four kinds of interview can be identified:

- Structured
- Unstructured
- Non-Directive
- Focused

For the purposes of this research the structured interview, ensuring the content, questions and procedures are organised in advance will be applied. This will facilitate a consistent approach to be applied to each project and the collection of generalisable data.

In terms of analysis of the uses of interview, Kitwood proposes three views of it as a research tool. Firstly, it is proposed as a means of pure information transfer. He suggests that:

"if the interviewer does his job well and if the respondent is sincere and well-motivated, accurate data may be obtained."

(Kitwood 1977)

Secondly, it is suggested that the interview is a transaction which inevitably has bias which needs to be controlled. Finally, Kitwood suggests the interview is an encounter necessarily sharing many features of everyday life.

The interview in this research will predominantly use an open-ended question format. This will attempt to elicit as wide a range of information from the respondents as possible. Open ended questions have a number of advantages:

- they are flexible
- they allow the interviewer to probe so that she/he

may go into more depth

- they enable the interviewer to test the limits of the respondents knowledge
- they encourage co-operation and help establish rapport
- they allow the inter-viewer to make a truer assessment of the respondents attitudes

3.1 The Healthy Eastleigh Interview Schedule

In Chapter One a framework of the key features comprising effective inter-sectoral collaboration was proposed. The interview schedule outlined below has been developed around the five key themes with the specific objective of measuring the extent to which these features are being achieved through individual projects. The schedule comprises four sections:

- Getting Involved
- Establishing Networks and Planning
- Implementing Action
- Monitoring Progress

HEALTHY EASTLEIGH INTERVIEW SCHEDULE

Healthy Eastleigh 2000

Project/Area of Work:.....

Respondent's Name:.....

Organisation:.....

Date:.....

Preliminaries

Introductions

Thank respondent for participating

Explain purpose of the research

Agree Finishing Time

Explain that research outcomes will be available

Part One - Getting Involved

1. Were there any particular incentives that influenced you/your organisation in getting involved in the Healthy Eastleigh initiative?

2. What sort of commitment towards the ..... project was there at the top level of your organisation?

3. Does your organisation have any particular values or beliefs that make inter-agency working important to it?

4. What were your organisation's priorities when you became involved in the .....(identify particular Healthy Eastleigh Project)?

5. What sorts of qualities/skills and other factors do you think are important for inter-agency working?

6. Have these been a feature of the work developed around the ..... project?

7. How did you become involved in the project?

Part Two - Establishing Networks and Planning

8. How well did you know the other professionals/ organisations involved in the project at the outset? Prompt (List organisations and professionals for each project)

9. Were common goals/objectives established at the outset? What were they? How were they established?

10. Did all the professionals/organisations involved share the same priorities from the outset? If not how was a common agenda established?

11. How important do you think it is for agencies working together to share common values or beliefs? What values are important?

12. Did you feel there was a shared understanding of what individual agencies involved in the project could contribute to project objectives?

Part Three - Implementing Action

13. How were key stages of action agreed by all the agencies participating? How easy/difficult was this process?

14. Were lead agencies/fieldworkers identified for specific areas of action? Who were these?

15. What was your/your agencies role in the project ?

16. What kinds of resources is your organisation putting into the project and what are other agencies contributing?
(Money, People, Information, Authority, Legitimacy etc.)

17. Do you feel that everyone has played their part in contributing to the implementation of action?

18. Have there been any difficulties in implementing action?
What are these ?

19. Has there been a shared vision of what the individual agencies/fieldworkers can contribute in terms of activity?

Part Four - Monitoring Progress

20. Have there been early successes/results to the project?

21. Do all the agencies involved in the work communicate with each other?

22. How frequent are the contacts between those involved?

23. Is the project meeting its original objectives?

24. Are the goals/objectives of individual agencies being met through this joint working?

25. What are you achieving together?

26. Do you consider the work to be of long term benefit? What are the long term objectives of the work?

Thank You for Participating.

The questions in each section of the interview schedule have been designed to explore the extent to which the key features of inter-sectoral collaboration are being achieved and to yield additional features. Outlined below is a summary of the information being sought from each section.

The questions outlined in Section One aim to elicit information about the reasons for individual agencies and fieldworkers becoming involved in the project.

Question One deals specifically with the issue of incentives for individual agencies to participate in the work. Official sanctioning and the development of a "shared vision" were identified in Chapter One as key features of effective collaboration.

Questions Two and Three focus directly on the issue of senior management commitment and attempt to tease out shared values/beliefs of the organisations as pre-requisites to joint working.

The issue of shared priorities as a supportive feature to inter-agency working has been identified.

Questions Four and Five address the issues of priorities and attempt to glean the perceptions of those engaged in inter-agency activity. Part One also addresses the issue of how individuals became involved in areas of work.

The questions identified in Section Two of the Schedule focus on the establishment of networks and planning individual projects. The process for establishing priorities and the degree of shared objectives/goals across agencies is explored.

The implementation of action is the focus of Section Three of the interview schedule. The focus is on progressing joint work and questions focus on the process for establishing key areas of action and the roles of individual agencies. An attempt is also made to tease out some of the difficulties to emerge.

Section Four of the interview schedule focuses on evaluation and monitoring progress. An attempt is made to elicit information on successes and outcomes for the individual projects. The frequency of interaction across the agencies participating in areas of work is also identified. The perceptions of the individual respondent are also sought.

4. CONTENT ANALYSIS

Throughout the planning and development of the Healthy Eastleigh projects a wealth of documentation has been produced in the form of committee papers, strategy documents, project proposals, minutes of meetings. Analysis of this documentary evidence is proposed as the second element of this research design. By way of contrast to the interviews identified above this will provide the opportunity to examine the way in which inter-sectoral collaboration is being achieved through the formal documentary evidence.

4.1 Content Analysis as a Research Tool

Berelson defined content analysis as:

"a research technique for the objective, systematic and quantitative description of the manifest content of communication".

(Berelson 1952)

Within the context of this definition the meaning of communication is not restricted to spoken language, but is used to encompass both verbal and non-verbal behaviour. For the purposes of the research into Healthy Eastleigh it will be applied as a tool to classify and quantify data relevant to inter-sectoral collaboration from documentary evidence. Five key stages have been proposed as underpinning the process of content analysis (Sax, G. 1968)

4.2 Specification of Objectives

The key objective of identifying the extent to which inter- sectoral collaboration is being achieved in Eastleigh underpins the research.

4.3 Sampling

A wealth of documentary evidence has been generated under the Healthy Eastleigh projects. The types of documentation fall under the following broad headings:

- Committee Minutes
- Project Proposals
- Strategy documents

In researching each project an attempt will be made to analyse half of the documentary evidence to accrue around each project for the period June 1990 to June 1992. The data under analysis represents a primary source.

4.4 Determining Categories of Analysis

The focus of the analysis of documentary evidence is to glean objective data and apply quantitative measures to a wealth of written evidence generated through the project. Berelson proposes two key categories for content analysis and organises them in the following way:

A. "What is said" Categories

1. Subject matter: What is the communication about?

2. Direction: Is the communication for or against a particular subject or neutral toward it?

3. Standard: On what grounds is the classification by direction made? (Strength, Morality)

4. Values: What are the goals or desires which are sought?

5. Methods: What are the means employed to attain values?

6. Traits: What are the personality characteristics used to describe persons?

7. Actor: Who or what is the initiator of acts?

8. Authority: What person, group, or object is credited as the source of a statement or communication?

9. Origin: In what locality did the communication originate?

10. Target: Who is the intended recipient of the communication?

B. "How it is said " Categories

1. Form or type of communication

2. Form of statement: What is the grammatical or syntactical form of the communication? Is it fact, opinion, etc.?

3. How emotional or exciting is the communication?

4. Device: What devices are used to persuade or propagandise the reader?

In terms of the Healthy Eastleigh initiative a combination of the categories outlined above will be employed.

4.5 Units of Analysis

Whatever type of category is selected to best fulfil the requirements of the investigation, it still has to be analysed into components to which quantitative measures can be applied. Much of the quantitative analysis used in content analysis involves the determination of the frequency with which various units occur. Five major units are outlined below:

- the word represents the smallest unit in content analysis. This may also include phrases.
- the theme
- the characters
- the item - whole self contained communication
- space and time measures

4.6 Standardising Coding Procedure

The implementation of a consistent approach to the recording and analysis of documentary evidence requires standardised coding procedure. In terms of reliability it is important that the coding procedure enables the same material to be analysed in the same way twice.

4.7 Healthy Eastleigh - Framework for Content Analysis

The primary sources comprising the main focus of documentary evidence for the Healthy Eastleigh initiative were proposed earlier as being :

- Committee Reports
- Strategy Documents
- Project Proposals
- Evaluations
- Project Reports

Outlined below are the key categories of analysis to be addressed and the units of analysis to be applied to each. Underpinning the categories and the key features of analysis are the key features of inter-sectoral collaboration outlined in Chapter One:

4.8 Categories of Analysis

It is proposed that 8 key categories of analysis are applied to the documentary evidence supporting each of the Healthy Eastleigh initiatives. These are outlined below along with the justification/rationale for each. A balance of "what is said" and "how it is said" categories will be applied.

1. Form/Type of Communication - analysis of the type of communication will be undertaken. An attempt will be made to analyse both formal committee reports and project proposals, to include working documents such as notes from project working groups.

2. Target of Communication - analysis of the target audience for each communication will be undertaken in an effort to examine the types of communication proposed for different recipients.

3. Origin of Documentation - the origin of documentation will be analysed to identify a balanced measure of the key instigators of activity.

4. Subject Matter - the subject matter addressed by each item of documentation will be considered. For some of the evidence being analysed the focus will be one particular project, for others it will form part of a broader picture.

5. Values/Goals - analysis of the values/goals exhibited by the documentation will form a focus of this part of the research.

6. Methods - for attaining values and goals identified from the documentation.

7. Actors - identifying the key players/actors in terms of individual agency participation will form a key focus of the analysis.

8. Authority - analysis of person/group accredited with activity and sanctioning the activity.

Against each of the categories of analysis the focus will be the consideration of the five key features of inter-sectoral collaboration proposed in Chapter One:

- multi-agency programme development
- network awareness
- domain consensus
- shared vision and commitment
- official sanctioning

These features will also be the focus of the units of analysis which will enable the quantification of various characteristics/features. The following units of analysis will be employed:

- words: a frequency count of the number of times words relating to joint working are used will be an index of collaboration.
- themes: a frequency count of sentences in the documentation that indicate inter-sectoral collaboration.
- characters: the interaction and role of the major and minor "actors" will provide a measure of inter-sectoral collaboration in Eastleigh. This will include a focus on the agencies and professionals taking a lead in both operational and project management activities.
- space and time measures: analysis of the space, in terms of documentary analysis and time, in terms of staff commitment devoted to inter-sectoral collaboration.

The approach developed to assist in the analysis of documentary evidence is summarised in the schedule below. It is proposed that this systematic approach be adopted for each of the Healthy Eastleigh projects under scrutiny for this research.

It is proposed that approximately 50% of the documentary evidence for each of the projects will be analysed for the research into inter-sectoral collaboration. The documentation is stored within the Borough Council and full access is available to the researcher.

CONTENT ANALYSIS SCHEDULE

DOCUMENT:

PROJECT:

CATEGORIES OF ANALYSIS

TYPE OF COMMUNICATION:

TARGET OF COMMUNICATION:

ORIGIN OF DOCUMENT:

SUBJECT MATTER:

VALUES/GOALS:

METHODS FOR ATTAINING GOALS:

UNITS OF ANALYSIS

WORDS THEMES CHARACTERS SPACE TIME

5. PARTICIPANT OBSERVATION

Participant observation represents the third element of the research design into the Healthy Eastleigh initiative. This will provide the opportunity to utilise the observations of the researcher, who is a full participant in the initiative in her role as Healthy Eastleigh Co-ordinator. This will provide the opportunity to utilise the observations gathered through participation in the development of individual areas of work. It is proposed that by employing a multi-method approach to the research design, it will be possible to utilise the subjective data gathered through participant observation and counter-balance this by the data collated through the other research methods outlined above.

Participant observation exhibits a number of key benefits as a research tool. Bailey identifies the inherent advantages in the participant observation approach:

"Case study observations are less reactive than other types of data gathering methods. For example in laboratory based experiments and in surveys that depend upon verbal responses to structured questions, bias can be introduced in the very data that the researcher is attempting to study."

(Bailey, K.D. 1978)

It is also important to regard the observations as a counter-balance and the opportunity to provide subjective comment from one directly engaged in the work. This is the case in terms of the research into Healthy Eastleigh. The use of three research methods will provide sufficient counter-balances whilst enabling the opportunity to integrate observations of the project co-ordinator. The researcher has been involved throughout the development

of the five projects being explored. Notes and diaries of activity have been maintained throughout this process. An attempt will be made to utilise the unstructured observations gathered throughout this process and to structure and develop the subjective observations by the participant observer.

REFERENCES FOR CHAPTER FIVE

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CHAPTER SIX

COMMUNITY PARTICIPATION PROJECT

PROJECT OVERVIEW AND RESEARCH RESULTS

The Community Participation Project represents an initiative to involve local agencies and fieldworkers in identifying local health needs. As one of the five Healthy Eastleigh projects being researched to establish levels of inter-sectoral collaboration, two key areas will be outlined below:

- An overview of the project in terms of the project objectives and the processes implemented.
- Research Results: the outcomes of the interviews, content analysis and participant observation undertaken around the Bishopstoke Project, utilising the research tools identified in Chapter Five above, will be outlined.

1. PROJECT OVERVIEW

At its meeting in September 1990 the Healthy Eastleigh Steering Group identified the development of approaches and mechanisms to facilitate community participation in health as a priority area of work. A small working group was established to identify possible approaches to involve local people in identifying and taking action around local health issues. The membership comprised the following officers:

Health for All Co-ordinator
General Secretary - Eastleigh Council of Community Service
Community Health Initiative Project Worker (Winchester Health Authority)
Health Visitor
Community Development Worker (Eastleigh Borough Council)

During the initial discussions of the Working Group a number of options for action were discussed. These focused on developing a project with specific groups in the local population, client groups or a neighbourhood approach to identify local health needs. After a wide ranging discussion it was agreed that the development of a project with a neighbourhood focus would provide the opportunity to identify health issues relating to physical, mental, social and environmental dimensions of health.

A proposal to develop the project in one electoral ward area was presented to the Steering Group at its meeting in January 1991. The key elements of the project proposal are outlined below.

1.1 Project Objectives

- To inform local fieldworkers and residents about the Healthy Eastleigh initiative.
- To enable and facilitate the local population to express their health needs.
- To identify ways of involving local residents in the planning and implementation of initiatives to meet expressed needs.

A number of positive factors were identified to support the identification of the Bishopstoke neighbourhood as the pilot area:

- The area exhibits a good population mix.

SMALL AREA POPULATION FORECAST - BISHOPSTOKE

Age in Years	Male	Female	Both
0-4	354	340	694
5-15	701	634	1,335
16-29	929	877	1,806
30-44	1,272	1,178	2,449
45-59	704	787	1,491
60-64	302	304	606
65-74	332	386	718
75+	169	335	503
TOTAL	4,762	4,841	9,603

- The neighbourhood has a good mix of old and new houses and privately and council owned estates. This would seem to indicate a mix in terms of social class.
- A number of active special interest groups already exist in the neighbourhood.
- A local health visitor had already undertaken a community health profile.
- The area represents a discrete geographical patch which has a central focus in terms of shops and local facilities.

The project proposal identified three key stages to the project:

- Establish a profile of the Bishopstoke area in terms of local fieldworkers.
- Begin consultation process with fieldwork staff and provide information about Healthy Eastleigh and project objectives. It was proposed that a half day workshop for fieldworkers be a key part of the project development
- Gain commitment from fieldworkers and establish a multi-agency project planning group to plan and implement health needs assessment in the Bishopstoke area.

1.2 Staff Workshop

A network of local fieldworkers was established which involved representatives from both the statutory and voluntary sector. This is outlined in the table below:

AGENCY	STAFF
HEALTH AUTHORITY	Health Visitors District Nurses School Nurses Community Psychiatric Nurses Midwives GPs and Practice Nurses Mental Handicap Services
LOCAL AUTHORITY	Environmental Health Housing Leisure and Tourism Planning Support Services (Community Charge) Chief Executive's Department (Press Department)
SOCIAL SERVICES	Home Care Staff Social Workers (Across Team and Generic Groups)
EDUCATION AUTHORITY	Schools Community Education Youth Workers
OTHER	Local Police and Probation Service

A staff workshop was organised to involve all of the fieldworkers identified in the schedule above. The workshop was held on 24 May 1991 and enabled:

- Local fieldworkers to hear about Healthy Eastleigh.
- Local fieldworkers to hear about the principles underpinning community development in health.
- Local fieldworkers to exchange information around:

- What's going on in the area.
- What they perceive to be local health needs.
- How the Bishopstoke project could be a resource for local fieldworkers and residents.

The key outcomes of the workshop are identified below:

- Awareness Raising: The workshop provided the opportunity to raise levels of awareness among fieldworkers about Healthy Eastleigh, community development in health and the objectives of the Bishopstoke project.

- Networking: The workshop provided the opportunity for networking across agencies and professional groups.

- Community Profiling: The participants identified a range of activities and groups in the area.

- Project Planning Group: As a result of the workshop a project planning group was established comprising local fieldworkers.

1.3 Project Planning Group

The Project Planning Group comprised the following members:

- Health for All Co-ordinator (Local Authority)
- Community Development Adviser (Winchester Health Authority)
- Community Development Officer (Local Authority)
  Housing Officer (Local Authority)
- Health Visitor (Winchester Health Authority)
  Community Manager (Education Authority)
- School Teacher

- General Secretary (Council of Community Service)
- Divisional Youth Worker (Youth Service)
- Community Policeman
- Community Education Officer (Adult Education)

The Project Planning Group met on four occasions between June 1991 and January 1992. The key task of the group was to identify ways of identifying local health needs in the Bishopstoke community. After wide-ranging discussion, the group designed a brief health needs questionnaire for circulation to a sample of households in the area. It was suggested that this information could be supplemented by local fieldworkers undertaking interviews with local clients and groups. It was proposed that the survey would also provide the opportunity to pull together a range of local health concerns and priorities to enable the proposal of "community led" recommendations for action.

1.4 Questionnaire Design

The questionnaire was designed to address five key issues in identifying:

- Local health information needs.
- The priority health issues affecting the health of local people to assist in the development of health promotion and service planning.
- Local views on Bishopstoke as a place to live
- any problems to be tackled which affect health in the area.
- Residents who would be willing to participate in the planning of local programmes of action as a result of the survey.

1.5 Questionnaire Circulation

In consultation with the Corporate Policy Department, Eastleigh Borough Council, it was agreed that a systematic sample of 20% of household in the Bishopstoke area be selected for circulation from the register of local households. This amounted to 740 households. A covering letter was designed to go out with the questionnaire explaining the aims and objectives of the project and identifying the participating agencies. The questionnaires were circulated by second class post with a post paid envelope for return.

To obtain views from voluntary groups in the Bishopstoke area, the database of the Eastleigh Council of Community Service was interrogated and a sample of 20% of groups (9), was circulated with the questionnaire.

A total of 32 interviews were undertaken by members of the Project Planning Group. Interview guidance notes were produced to assist in this process and apply consistency to the approach.

1.6 Survey Results

The three approaches outlined above yielded a total of 219 responses. These are broken down as follows:

- 150 responses were received from the questionnaires circulated to local households.
- 37 responses were received from the questionnaires circulated to local households.
- A total of 35 interviews were undertaken with local groups/clients in Bishopstoke known to members of the Project Planning Group.

Outlined in the schedule below is a summary of the priority health concerns identified by local people in the Bishopstoke area. In the analysis of the priority issues affecting the health of local people two key categories of need have emerged:

Health Promotion Issues: those concerns expressed by local people which focus on lifestyle and behavioural issues.

Health Protection Issues: those concerns which focus on issues linked to service delivery and statutory agency activity.

These along with the information needs and "community" health issues are outlined in the schedule below.

SUMMARY OF KEY HEALTH CONCERNS IN BISHOPSTOKE

Key Information Needs

Healthy Eating
Exercise
Crime Prevention
Home & Road Safety
Benefit Entitlements

Factors Affecting Health

Health Promotion Issues

Healthy Lifestyles - Healthy Eating
Exercise
Smoking
Stress
Alcohol
Accident Prevention

Health Promotion Issues

Traffic Speed and Volume
Dog Fouling
Environmental Issues - Air Pollution
- Water Pollution
- Noise Pollution

Community Health Issues

Road Safety — Traffic Volume; Traffic Speed
Dog Fouling
Environmental Issues — Air & Noise Pollution; Water Quality
Planning & Highway Issues — Repair of Street Lights; Maintenance of Pavements; More Street Lighting
Community Facilities — Need Community Centre; More Activities for Teenagers

2. RESEARCH RESULTS

2.1 Analysis of Documentary Evidence

A total of eight items of documentary evidence (50% of the total) were analysed. The nature of the documents is outlined below:

Project Proposal: Document 1
Project Planning Group Minutes: 29 Nov.1990 - Document 2
Project Planning Group Minutes: 18 Feb.1991 - Document 3
Project Planning group Minutes: 8 April 1991 - Document 5
Paper outlining the Resource Implications of the Project: Document 4
Paper outlining outcomes of staff workshop: Document 6
Project Planning Group Minutes: 26 June 1991 - Document 7
Copy of the letter supporting the Community Health Survey: Document 8

For each item analysis was undertaken using the key headings identified in the content analysis schedule outlined in Chapter Five.

2.1.1 Types of Communication

The sample of documentary evidence represents a range of documents produced to support the Community Participation project. The Project Proposal was produced during December 1991 as a means of identifying the key aims and objectives of the project and key stages of action. It also identifies the rationale for selecting one particular area/neighbourhood in the Borough. The Planning Group minutes represent the outcomes of inter-agency discussions to progress the project and thus provide a good source of the action planning process

linked to the project. The paper on resource implications identified some issues around the investment of staff time and the other resources required to progress the project. Finally, analysis of the supporting letter to go out with the health questionnaire will yield information about the extent to which an inter-agency approach is adopted in this key stage of the project.

2.1.2 Target of Communication

The main target audiences of the documentary evidence are outlined below:

Minutes of Project Planning Group: Multi-agency Steering Group and Project Planning Group Members
Resource Implications Paper: Multi-Agency Steering
Pilot Project Proposal: Multi-Agency Steering Group
Letter Supporting Community Health Survey: Multi-Agency Steering Group and Local Community

2.1.3 Methods for Attaining Goals

Analysis of the documents revealed a range of characteristics around inter-sectoral collaboration. The key themes to emerge are outlined below.

The Pilot Project Proposal (Document 1) identified:

"Strengthening links between professional groups"
as a key element of the project. It indicated a focus for:

"Local fieldworkers from the statutory agencies to play a key role."

It would seem, therefore, that in the development of the project an expressed commitment to inter-sectoral collaboration can be identified. Specific commitment in

terms of the methods required for attaining project goals can be identified:

"Statutory agencies have equal commitment and responsibility for the planning and implementation of the project and future activity."

One of the key objectives identified for the project also highlighted multi-agency working as a key principle:

"To inform local fieldworkers about Health for All and the Eastleigh".

Analysis of the Working Group Minutes (Document 2) similarly indicated a commitment to a multi-agency approach. Fieldworkers identified in the minutes represented the local authority, health authority and the voluntary sector. This item of documentary evidence indicated:

"A one day workshop be organised for staff working in the area".

This was seen as a key way of securing commitment across the agencies from the outset of the project. In terms of establishing links with the individual fieldworkers and their managers this piece of documentary evidence would seem to indicate that the responsibility for ensuring this happened rested with the Health for All Co-ordinator. Therefore, in terms of establishing the required network to move the inter-agency approach forward, responsibility was placed upon one agency and one participant.

The issue of inter-agency commitment and the need to ensure this as a key feature of the process for attaining project goals and objectives was identified as a feature

of Document 3. The Working Group identified above regarded this as a key feature:

"The Group discussed resources and the staff commitment required to progress the project."

Document 3

Resource investment across agencies was also identified from the analysis of this document. In the context of progressing this issue it was suggested that **both**:

"A brief paper outlining the resources and staff commitment required to progress the project" **and** "an outline for the staff workshop" be devised.

Thus, reinforcement of the key theme of "official sanction" and inter-sectoral collaboration can be clearly identified from the content analysis. The local authority and the health authority were identified as key agencies to progress these issues. This approach also identifies joint working.

The paper outlining the Resource Implications of the project again reinforces the inter-sectoral approach required in the planning and implementation of key stages of action. It also reveals a multi-agency commitment in terms of resource investment:

"It is proposed that local managers of the agencies participating in Health for All be requested to commit approximately 2 hours per week of fieldworkers time to the project".

Document 4

There was also explicit recognition of the different ways of working and areas of responsibility of the different agencies. This would seem to indicate both "network awareness" and "domain consensus" across the agencies.

For example in Document 4 it was recognised that:

"Some of the agencies identified will have fieldwork staff assigned specifically to the area. For those agencies whose staff are not assigned to geographical patches,the local manager will be invited to nominate a fieldworker to participate".

Document 4

Issues linked to financial commitment to ensure an inter-agency approach is adopted are also identified:

"The statutory agencies participating in Health for All and Healthy Eastleigh be requested to allocate funds to the project for initial pump priming".

Document 4

Analysis of Document 5 indicated collaboration between the local authority and the health authority in terms of moving forward with the implementation of action points. Contacting middle managers and practical tasks e.g. room booking, were shared amongst members of the Project Planning Group. Attendance identified in the minutes also indicated an inter-agency commitment to the Initiative.

Document 6 identified the outcomes of the staff workshop (24 May 1991). A key first stage of the project was identified as being:

"The establishment of a committed network of fieldworkers drawn from all the statutory agencies".

Document 6

The range of agencies and fieldworkers represented at the workshop, identified from the analysis of this document is a key feature of inter-sectoral collaboration. The table below indicates the range of fieldworkers who participated.

FIELDWORKER ATTENDANCE AT WORKSHOP

AGENCY	STAFF
HEALTH AUTHORITY	Health Visitors District Nurses School Nurses Community Psychiatric Nurses Midwives GPs and Practice Nurses Learning Disability Services
LOCAL AUTHORITY	Environmental Health Housing Leisure and Tourism Planning Support Services (Community Charge) Chief Executive's Department (Press Department)
SOCIAL SERVICES	Home Care Staff Social Workers (Across Team and Generic Groups)
EDUCATION AUTHORITY	Schools Community Education Youth Workers
OTHER	Local Police

Four key outcomes of the workshop were also identified in this paper:

- Awareness raising among local staff about the Health for All initiatives the need for Community involvement and the objectives of the Bishopstoke Project.
- Networking among staff from different agencies working in Eastleigh and Bishopstoke.
- Starting the process of developing a profile of the group and activities in Bishopstoke.
- Establishment of a Project Planning Group

These outcomes clearly indicate the key features of official sanctioning, network awareness and domain consensus identified in Chapter One and also indicate shared investment of resources as a key element.

The membership of the Project Planning Group indicates an inter-sectoral approach. The minutes of the first meeting of the Group comprise Document 7. Analysis of those in attendance reveals that not all of the members proposed for the Group in Document 6 above actually attended. Representation from only half of the membership was achieved (5 out of 10 members). This would seem to indicate a gap between expressed commitment and practical oarticipation. However, in terms of the outcomes of the meeting a range of action was proposed which illustrates a balance of time investment across the agencies. For example all:

"Group members agreed to consult with their colleagues in their own agency (to give consideration to the best ways of involving all population groups)".

Document 7

The outcome of the Project Planning Group discussions was the design of a brief health needs questionnaire and a covering letter to be sent to a sample of households in the neighbourhood. This was identified as a key means of identifying some of the priority health concerns in the area. Document 8 comprises the covering letter dispatched to those households involved in the survey. Once again analysis of this document would seem to indicate a multi-agency commitment to the project. The names of all the agencies involved in the Project Planning Group were identified around the edge of the letter. The content of the letter also reinforces an inter-sectoral approach:

"All local agencies in the Eastleigh area have joined together to support the World Health Organisation's Project - Health for All by the Year 2000".

Document 8

and those progressing the project were identified as: "a group of staff drawn from local agencies working in and around Bishopstoke".

Document 8

It would seem, therefore, that the qualitative analysis of the documentary evidence for the Bishopstoke Project would seem to indicate a high level of inter-sectoral collaboration. Features of official sanctioning of the work and an inter-agency approach to project development have been identified. It also appears from the analysis above that a shared vision of the project and recognition of the potential contribution of individual agencies were key elements of the work. However, in terms of practical commitment and attendance/representation at Project Planning Group meetings a lower level of inter-sectoral collaboration was identified.

2.1.4 Quantitative Analysis & Documentary Evidence

An attempt has also been made to apply quantitative measures to the analysis of the documentary evidence above. The results of this approach are outlined in the table below.

TABLE 9

COMMUNITY PARTICIPATION PROJECT - QUANTITATIVE ANALYSIS OF DOCUMENTARY EVIDENCE

DOCUMENT	TOTAL NO. OF SENTENCES	TOTAL NO. OF WORDS	INTER-SECTORAL COLLABORATION	
			SENTENCES (% OF TOTAL)	WORDS (% OF TOTAL)
DOCUMENT 1	35	659	12 (34%)	291 (44%)
DOCUMENT 2	12	223	8 (66%)	113 (51%)
DOCUMENT 3	7	118	5 (71%)	87 (74%)
DOCUMENT 4	27	231	27 (100%)	23 (10%)
DOCUMENT 5	8	121	5 (63%)	51 (42%)
DOCUMENT 6	11	236	6 (55%)	77 (33%)
DOCUMENT 7	52	401	30 (58%)	223 (56%)
DOCUMENT 8	9	157	5 (56%)	93 (59%)

3. INTERVIEW RESULTS

The interview schedule outlined in Chapter Five was used to explore levels of inter-sectoral collaboration and the value of joint working with members of the Bishopstoke Project Planning Group. The following participants were interviewed:

Health Visitor
General Secretary - Council of Community Service
Adult Education Worker

This represented approximately a third of the membership of the Project Planning Group.

The main themes to emerge from the responses to each question are outlined below.

Question One - Were there any particular incentives that influenced you/your organisation in getting involved in the Community Participation Project?

The three respondents felt that the objectives of the project fitted neatly with some of the priorities within their own agency. One respondent suggested that:

"Involving local people was something every agency wanted to do".

Two of the fieldworkers interviewed suggested that the project supported work around the Government's White Paper on Health: The Health of the Nation. Responses to this question would seem to indicate that the fieldworkers and agencies participating in the initiative felt participating in the project was supportive to their priorities.

Question Two - What sort of commitment towards the Bishopstoke Project was there at the top level of your organisation?

Two out of the three respondents felt there was a high level of commitment to the work, one suggested very high and one respondent felt there was "not that much commitment" from the senior managers in their organisation. This would seem to indicate the overall the staff participating in the project felt supported and provided "official sanction" for their involvement.

Question Three - Does your organisation have any particular values or beliefs that make inter-agency working important to it?

All the respondents felt that their organisation valued inter-agency working. One respondent suggested that :

"Working together helps you to achieve a community wide perspective".

There was also a sense that joint working facilitates the process of identifying local health needs and supports agencies in identifying those in the community in most need of support.

Question Four - What were your organisation's priorities when you became involved in the Community Participation Project?

A range of priorities were identified, these included the following:

Identification of health needs
Community Education

Involving local people in community health activity
Health Promotion

It would seem that the priorities identified by individual fieldworkers fit closely with the aims and objectives of the Healthy Eastleigh initiative.

Question Five - What sorts of qualities/skills and other factors do you think are important for inter-agency working?

The following qualities were identified by respondents:
Honesty
Clear Focus
Trust
Communication
Understanding and appreciating people's roles
Responsibility
Listening

The qualities and skills identified above reinforce the features of domain consensus and network awareness outlined in Chapter One.

Question Six - Have these been a feature of the work developed around the Community Participation Project?

The three respondents felt that the qualities and skills identified above had been a feature of the project.

Question Seven - How did you become involved in the project?

All of the respondents had been approached by their line manager to become involved in the project. This would seem to indicate a high level of commitment and official sanction for the work from the outset.

Question Eight - How well did you know the other professionals/organisations involved in the project at the outset?

Apart from the Community Education Worker, all of the respondents knew one another before their involvement in the project.

Question Nine - Were common goals/objectives established at the outset? What were they? How were they established?

All the respondents felt that common goals and objectives were established at the outset. These clearly reflected the project objectives identified earlier in this chapter. The Project Planning Group discussions were identified as the key means for agreeing these areas of work. However, one respondent suggested that whilst project objectives had been identified:

"The process for meeting the objectives was not identified until some way into the Planning Group discussions".

Question Ten - Did all the professionals/organisations involved share the same priorities from the outset? If not how was a common agenda established?

Two of the three respondents felt that there was not a common agenda from the outset. One suggested that there was a need:

"To develop an understanding of where we're coming from!".

Wide ranging discussions in the Project Planning Group were identified as the key means of establishing common priorities.

Question Eleven - How important do you think it is for agencies working together to share common values or beliefs? What values are important?

Two of the three respondents felt it was very important for agencies to share common values and beliefs. The other three respondents suggested that the process adopted for the community participation project had meant that shared priorities could be developed across agencies with slightly or even very different values or beliefs. One respondent suggested however, that sharing the same beliefs helps:

"To make things happen more quickly and smoothly".

Question Twelve - Did you feel there was a shared understanding of what individual agencies involved in the project could contribute to project objectives?

Three of the respondents suggested that there was not a full understanding of what individual agencies could contribute from the outset. One suggested that the staff workshop and the discussions of the Project Planning Group had assisted in the development of a shared understanding.

Question Thirteen - How were key stages of action agreed by all the agencies participating? How easy/difficult was this process?

Regular contact between those participating in the project was identified as a key means of agreeing key stages of action. The Project Planning Group with

representation across the agencies was identified by all respondents as the main vehicle for endorsing areas of action. However, two of the respondents suggested that this process had taken some time. For example one respondent replied:

"It took some time to identify what exactly we were going to do. The discussions did help to clarify what we could all contribute".

Question Fourteen - Were lead agencies/fieldworkers identified for specific areas of action? Who were these?

The three respondents replied that lead agencies were proposed for particular stages of action. All the fieldworkers indicated that each individual member of the Project Planning Group had played a role conducting the survey and implementing areas of action. Two respondents felt, however, that the Health for All Co-ordinator (Local Authority) and the Community Development Adviser (Health Authority) had played an important role in sustaining the development and implementation of project objectives.

Question Fifteen - What was your agencies' role?

All the respondents felt that they had a role to play in carrying out the community survey and conducting interviews. The respondents working for the health authority suggested that perhaps they played a key role in responding to the specific health concerns raised around healthy lifestyles.

Question Sixteen - What kinds of resources is your organisation putting into the project and what are other agencies contributing?

All of the respondents cited their time as the main resource investment in the project. There was recognition that the Health for All Co-ordinator's time had been invested and that finance had been committed to support printing costs by the Health Authority.

Question Seventeen - Do you feel that everyone has played their part in the implementation of action?

Two of the respondents felt that everyone had played their part and that inter-agency commitment had been secured. Three of the respondents were critical of the lack of time they had as individuals to give to the project.

Question Eighteen - Have there been any difficulties in implementing action?

Two of the three respondents felt that there had been some difficulties in implementing the action. These were entirely focused on the lack of time experienced by the fieldworkers. One respondent suggested that their involvement was:

"An add-on to their main role".

This would seem to indicate that whilst senior management expressed commitment, the staff participating were given no additional time to support their involvement.

Question Nineteen - Has there been a Shared Vision of What the Individual Agencies/Fieldworker can Contribute in Terms of Activity?

All the respondents felt there was a shared vision of what individuals could contribute. One respondent qualified this by suggesting it was "to a certain extent".

Question Twenty - Have there been early successes/results to the project?

Respondents suggested that the outcomes of the community health survey and the action to come out of the survey had been clear indicators of the project's success. Two of the respondents identified the involvement of local people in the public meetings as a positive outcome.

Question Twenty One - Do all the agencies involved in the work communicate with each other?

Whilst all of the respondents suggested that the agencies communicate with one another, two of the fieldworkers interviewed suggested this was generally through the Health for All Co-ordinator.

Question Twenty Two - How frequent are the contacts between those involved?

The monthly Planning Group meetings were identified as the main contact between the agencies.

Question Twenty Three - Is the Project meeting its original objectives?

All of the respondents responded positively. Two, however, suggested that this process had been slow and had taken longer than they had envisaged.

Question Twenty Four - Are the goal/objectives of individual agencies being met through this joint working?

All of the respondents felt that their involvement in the project provided a positive contribution to the achievement of their own objectives and those of their organisation.

Questions Twenty Five & Twenty Six - What are you achieving together? Do you consider the work to be of long term benefit? What are the long term objectives of the work?

All of the respondents felt the work to be of long term benefit and felt they were achieving some of the project objectives. In particular, they felt they were raising awareness among fieldworkers and the community of local health concerns. One respondent suggested, however, that they were unsure of their ability to commit time long term to the initiative. However, another respondent suggested that they saw the project:

"Supporting the work we try to do around health promotion long term".

4. DISCUSSION AND SUMMARY

The results of the content analysis and the interviews with project participants identified above indicate a high level of collaboration across the agencies participating in the Community Participation project. Reinforcement of the key features of collaboration identified in Chapter One and a measure of the extent to which they are being achieved in the development of this particular project are provided. Official sanctioning of the inter-agency approach was endorsed by both the fieldworkers involved in the project and reinforced by

the analysis of documentation. The multi-agency Steering Group provided positive endorsement for the project proposal and constituted the main target audience for the documentation. Fieldworkers indicated they had been supported by their managers to participate in the work. However, in practical terms the problem of having no additional time was identified by fieldworkers.

In the development and implementation of the project and stages of action there appears to be a high level of inter-agency collaboration. The approach adopted of mounting a multi-agency workshop and establishing a project planning group enhanced joint working. There was an indication, however, that a lead role was undertaken by the Community Development Adviser and the Health for All Co-ordinator. This seemed to support the implementation of action and ensured a tight focus to the work.

Recognition and positive evaluation of the contribution of other agencies and fieldworkers was a feature of this project. The action stages gleaned from the content analysis and the responses to the interviews indicated a high degree of "network awareness" and "domain consensus".

The results of the research into this project indicate a positive approach to collaboration. However, on the negative side resource investment and the lack of time experienced by some of the fieldworkers was identified as a problem in implementing a multi-agency approach. This was identified as an issue linked both to the implementation of action to date and to the further development of the work.

REFERENCES FOR CHAPTER SIX

Eastleigh Borough Council (1990) Pilot Project Proposal

Eastleigh Borough Council (1990) Project Planning Group Minutes Nov. 1990

Eastleigh Borough Council (1991) Project Planning Group Minutes Feb. 1991

Eastleigh Borough Council (1991) Resource Implications - Community Participation Project

Eastleigh Borough Council (1991) Project Planning Group Minutes April 1991

Eastleigh Borough Council (1991) Outcomes of Staff Workshop May 1991

CHAPTER SEVEN

HEALTHY SHOPPING SCHEME

1. PROJECT OVERVIEW AND RESEARCH RESULTS

In 1991 The Healthy Eastleigh Steering Group identified the prevention of Coronary Heart Disease as a key priority. The promotion of Healthy Eating as a key risk factor linked to the disease was identified as a potential area for joint project development. Outlined below is a project overview of the key elements of the Healthy Shopping Scheme.

1.1 Project Proposal

Discussions during the summer of 1991 between the Health for All Co-ordinator in the Borough Council and Southampton Health Promotion Services resulted in the development of a proposal to establish a collaborative approach with local food retailers to promote healthy eating. Funding to support the Eastleigh Healthy Shopping Scheme was successfully sought from the Wessex Regional Health Authority's Community Projects Scheme. The key elements of the project proposal are outlined below.

1.2 Project Aims

- To raise knowledge and awareness of healthy eating choices.
- To encourage the purchase of healthy basic staple foods, particularly by those who are on a low income.

1.3 Project Objectives

- To highlight for shoppers the healthy staple foods on supermarket/grocery shelves.
- To highlight low priced staple foods so healthy eating can be achieved on a low income.
- To increase knowledge and awareness of the basic principles of healthy eating.
- To encourage food stores in the Borough to stock a wider range of healthier foods.

1.4 Project Steering Group

A project steering group was established with the following representation:

Health For All Co-ordinator (Local Authority)
Health Promotion Services Manager (Health Authority)
Health Promotion Specialist (Health Authority)
Community Dietitian (Health Authority)
Health Visitor Manager (Health Authority)

The project criteria were developed by the group.

1.5 Project Implementation

The Steering Group discussed the launch of the scheme with a chain of convenience stores in the local authority area. Discussions were progressed with the Marketing Manager of the stores and agreement was reached to launch the scheme in the 8 convenience stores in the Borough and then to involve other food stores.

The process adopted to implement the scheme involved the following stages:

- Agreement from store manager to participate in the scheme.

- Discussion with members of the Project Group and staff at the store to label foods and outline key elements of the scheme.
- Stores to have highlighted healthy foods on their shelves and information leaflet available for local shoppers.
- Evaluation of scheme to be undertaken in collaboration with the two key agencies (Local Authority and Health Authority).

Outlined below are the outcomes of the research undertaken into inter-sectoral collaboration and the development and implementation of the scheme. The extent to which a collaborative approach has been developed across the two lead agencies for the initiative has been addressed by means of interview, content analysis and participant observation. The research tools employed are those identified in Chapter Five.

2. RESEARCH RESULTS

2.1 Analysis of Documentary Evidence

A total of six items of documentary evidence (50% of total) were analysed. The nature of the documents is outlined below:

DOCUMENT 1: WORKING GROUP MINUTES - DECEMBER 1992
DOCUMENT 2: WORKING GROUP MINUTES - JANUARY 1992
DOCUMENT 3: WORKING GROUP MINUTES - MARCH 1992
DOCUMENT 4: WORKING GROUP MINUTES - APRIL 1992
DOCUMENT 5: WORKING GROUP MINUTES - JULY 1992
DOCUMENT 6: PROJECT PROPOSAL

For each item analysis was undertaken using the Content Analysis Schedule outlined in Chapter Five. An attempt has also been made to identify units of analysis to apply

quantitative measures to the documentary evidence. This has allowed for consideration of categories of analysis as a means for identifying characteristics of joint working and units of analysis which attempt to quantify the extent in terms of space/time measures illustrating collaboration. The results of this analysis are outlined below under the key headings identified in the schedule.

2.2 Types of Communication

The documentary evidence comprised minutes of the Working Group and the Project Proposal. The Healthy Shopping Working Group provides the function of making decisions about the scheme and operational issues and receives approval and endorsement of proposals from the Healthy Eastleigh Steering Group. The minutes of the inter-agency Working Group represent collaboration across those agencies participating in the scheme and are, therefore, a product of collaboration.

The Project Proposal was developed as a result of collaboration across Health Promotion Services and Health for All at the Borough Council. The document was put together for consideration by the Steering Group. It outlines the background, aims and objectives and the stages of implementation for the scheme.

2.3 Target of Communication

The target audience of all the documentary evidence for the Healthy Shopping Scheme was the multi-agency Working Group for and the Health for All Steering Group. Thus, in terms of inter-sectoral collaboration the documents were produced with an inter-agency audience in mind.

Origin of Documents

With the exception of the Project Proposal, all of the documents were produced by the Health For All Co-ordinator based at the Local Authority. This would seem to indicate that a sole agency approach to recording and documenting the outcomes of discussions was adopted. The Project Proposal came about as a result of collaboration between Health Promotion Services in the Health Authority and the Local Authority.

2.4 Methods for Attaining Goals

The overall aim of the initiative was identified in the Project Proposal as being:

"to make healthier dietary choices easier for all people regardless of social class or where they shop".

The key objectives of the scheme were identified in the project review above. The documentary evidence indicated a shared approach in terms of the implementation of key tasks and illustrated inter-sectoral collaboration as a key method for attaining goals. Examples from the text of the Working Group Minutes provide illustration of the Joint approach adopted:

"The Health for All Co-ordinator (Local Authority) and Health Promotion Specialist (Health Authority) reported the outcome of their meeting with the Marketing Manager..... (Food Retail Chain)".

Working Group Minutes - March 1992

"The Community Dietitian (Health Authority) and the Health for All Co-ordinator (Local Authority) agreed to produce the core list of Healthy Foods".

Working Group Minutes - March 1992

A multi-agency approach was also indicated by the documentary evidence in terms of agreeing future action:

"The Group agreed that starting with (the stores) in the Southern Parishes would present considerable benefits".

Working Group Minutes - January 1992

The key features of an "inter-agency approach to programme development" identified in Chapter One are clearly illustrated in the documentary evidence cited above.

In terms of "network awareness" and the degree of formalisation of the collaboration, the Working Group Minutes illustrate that individuals in the Group are aware of the skills and potential contribution of the other partners. For example, the co-ordinating and link role provided by the Health For All Co-ordinator can be identified:

"The Health for All Co-ordinator agreed to co-ordinate the circulation of copies of the pack to members of the Group. They agreed to come to the next meeting with comments and amendments".

Working Group Minutes - March 1992

Analysis of the documentary evidence also indicated the investment of staff time, expertise and resources. It would also seem that there was appreciation of the respective contributions of the participating agencies. For example, analysis of the documentary evidence defined clearly the role, in terms of professional expertise of the community dietitians. The dietitians, in taking on the role of producing a "core list of healthy foods" were able to contribute a key role. In terms of the Local Authority role, analysis of the Working Group minutes revealed that the Health for All Co-ordinator was able to

forge links with other schemes already underway with a Coronary Heart Disease prevention focus, eg. the local authority Heartbeat Award for catering establishments.

In the development of shared goals and values for joint working, analysis of the documentary evidence seemed to indicate an inter-dependence in the implementation of the scheme across the agencies had developed. For example, in the planning and implementation of the Healthy Shopping scheme the documentation analysed illustrated a shared approach in the preparatory stages of the initiative, with the Health for All Co-ordinator and the Health Promotion Specialist jointly meeting with potential participants. In the implementation of the scheme, collaboration between the Health for All Co-ordinator, community dietitians and the Health Promotion Specialists was a feature. For example, a Group approach was adopted for reaching agreement on where and when stores should be approached and involved:

"The Group agreed that starting with the .....store in the Southern Parishes of the Borough would present considerable benefits".

Official sanctioning was explicit in terms of the Health Authority staff with the Health Promotion Services Manager participating in the scheme and attending Working Group meetings. The project proposal was developed collaboratively between the Health for All Co-ordinator and the Health Promotion Manager with the explicit involvement of his expertise, staff and resources.

2.5 Quantitative Analysis of Documentary Evidence

An attempt has also been made to apply some quantitative measures to the analysis of documentary evidence. The table below identifies each of the items of documentation

TABLE 10

HEALTHY SHOPPING SCHEME - QUANTITATIVE ANALYSIS OF DOCUMENTARY EVIDENCE

DOCUMENT	TOTAL SENTENCES	TOTAL WORDS	INTER-SECTORAL COLLABORATION	
			SENTENCES (% OF TOTAL)	WORDS (% OF TOTAL)
DOCUMENT 1	6	123	3 (50%)	72 (59%)
DOCUMENT 2	18	224	4 (22%)	42 (19%)
DOCUMENT 3	13	65	5 (38%)	47 (72%)
DOCUMENT 4	11	72	10 (91%)	44 (61%)
DOCUMENT 5	8	114	5 (63%)	71 (62%)
DOCUMENT 6	12	162	11 (92%)	151 (93%)

and quantifies in terms of the number of words, sentences as a percentage of the total document illustrating collaboration.

3. INTERVIEW RESULTS

The interview schedule outlined in Chapter Five was used to further explore levels of collaboration in the development and implementation of the Healthy Shopping Scheme. All the members of the Healthy Shopping Scheme Working Group were interviewed:

Health Promotion Specialist
Health Visitor
Health Promotion Services Manager
Two Community Dietitians

Outlined below are the key themes to emerge from their responses to each question.

Question One - Were there any particular incentives that influenced you/your organisation in getting involved in the Healthy Shopping Scheme?

All of the respondents identified priorities within their own organisation which matched the objectives of the Healthy Shopping Scheme. For example, those staff from Health Promotion Services identified the scheme as being part of:

"The Coronary Heart Disease Prevention Strategy".

and fitting neatly with the:

"Key areas in the Health of the Nation".

Thus, it would seem that the notion of reciprocity and participants meeting some of their own organisational objectives through the collaboration and joint working was a key incentive for participation in the Healthy Shopping Scheme.

Question Two - What sort of commitment towards the Healthy Shopping Scheme was there at the top level of your organisation?

One respondent suggested a "very high" level of commitment, two a "high" level, one respondent suggesting an "average" level of support and one suggesting "not enough" commitment at a senior level. This would seem to indicate, on balance, a good level of official sanctioning and senior support for the development and implementation of the scheme.

Question Three - Does your organisation have any particular values or beliefs that make inter-agency working important to it?

All respondents suggested that a recognition that health promotion activity was everybody's business and that collaboration helped towards achieving health gain in the community was part of the philosophy of their organisation. One respondent suggested that:

"The need to develop healthy alliances to achieve the Health of the Nation"

was a key belief being promoted within the health authority. This would seem to indicate a belief both locally and nationally that working together could assist in the achievement of objectives. The need to understand each others roles across the statutory agencies and the outcome of improved service quality as a result of collaboration was also proposed:

"Understanding the roles and contribution of other services is something we value. Combining with other agencies to create a better service is something that's recognised."

Question Four - What were your organisation's priorities when you became involved in the Healthy Shopping Scheme?

The following priorities were proposed by members of the Working Group:

- Healthy Lifestyles
- Health of the Nation
- Children and the Elderly
- Health for All Principles
- Coronary Heart Disease Prevention and Community Projects

The responses from those interviewed therefore indicated a high level of overlap between the objectives of the Healthy Shopping Scheme and those of the individual agencies represented in the Working Group.

Question Five - What sorts of qualities/skills and other factors do you think are important for inter-agency working?
Question Six - Have these been a feature of the work developed around the Healthy Shopping Project?

The following skills and qualities were identified by the five respondents:

- Firm Leadership
- Regular Contact
- Communication
- Listening
- Negotiation

- Clear Priorities
- Being able to Juggle with time
- Commitment from all partners
- Joint ownership
- Honesty
- Good Working Relationships
- "Two Way" Benefit

The skills identified above reinforce and further expand some of the features of inter-sectoral collaboration identified in Chapter One. All respondents felt these had been a feature of the work developed around the project.

Question Seven - How did you become involved?

Four of the respondents had been approached by their line manager to participate in the project. One participant had been invited to participate by the Health for All Co-ordinator.

Question Eight - How well did you know the other professionals from the outset?

All of the staff involved in the Working Group had worked together previously worked together, apart from one of the community dietitians who was new to the area. Respondents felt that this had enhanced the workings of the Group from the outset.

Question Nine - Were common goals/objectives established at the outset? What were these? How were they established?

All of the respondents felt that common goals/objectives had been set for the scheme at the outset. These reflected the objectives identified in the project

overview identified above. Joint discussion through the Working Group was proposed as the main way of agreeing objectives. This would seem to indicate a collaborative approach to planning the initiative and the main tasks.

Question Ten - Did all the professionals involved share the same priorities from the outset? If not how was a common agenda established?

Two of the respondents felt that there were common priorities from the outset. The three respondents who felt priorities had not been shared from the outset identified discussion through the multi-agency Working Group as the key way of setting a common agenda.

Question Eleven - How important do you think it is for agencies working together to share common values or beliefs?

All respondents felt it was important for agencies to share common values or beliefs. One respondent suggested:

"It helps to move things along more quickly".

Amongst those values identified as being important were a commitment to inter-agency working and a recognition that health promotion activity is the business of a number of agencies. This would seem to reinforce the feature of "network awareness" and "domain consensus" identified in Chapter One.

Question Twelve _ Did you feel there was a shared understanding of what individual agencies involved in the project could contribute to project objectives?

Four of the five respondents replied positively to this

question. This would seem to indicate a high level of awareness of the potential contribution to action of individual agencies. The respondent who suggested there was not a shared understanding expressed doubt about the commitment of individuals within the Group to take part in implementing the action. This raised for them: "Doubts about how we sustain and expand the scheme long term".

Question Thirteen - How were key stages of action agreed by all the agencies participating ? How easy or difficult was this process?

All respondents identified the multi-agency Working Group as the key means for identifying and agreeing key tasks and areas of action. The process was identified as being relatively easy. For example one of the respondents suggested:

"It was fairly easy to agree key tasks because the Healthy Shopping Scheme is quite straight forward and task oriented".

This would seem to indicate the nature of the Healthy Shopping Scheme facilitated joint working as a result of the development of clear objectives and stages of action.

Question Fourteen - Were lead agencies and fieldworkers identified for specific areas of action?

All respondents suggested that this had been the case. For example the expert role of the community Dietitians was flagged up and the co-ordinating role of the Borough Council through the Health For All Co-ordinator. This once again reinforced the benefits of individuals engaged in joint working understanding the contribution in terms

of skills and organisational structure brought by potential partners.

Question Fifteen - What was your Agencies role in the project?

The Community Dietitians identified their expert role in providing advice and support for the scheme and taking part in the implementation of key elements of the project. The Health Promotion staff suggested that they had a part to play in the implementation of the scheme and in providing resources and expertise eg. graphics. The Health Visitor identified both raising awareness about the scheme among the families she worked with and linking up with colleagues. One of the respondents expressed concern that they had not been able to participate as fully as they would have liked to.

Question Sixteen - What kinds of resources is your organisation putting into the project and what are other agencies contributing?

The comment by one respondent reflected the responses from all those interviewed:
"We're all putting our time and effort into the scheme to a lesser or greater extent".

Resources were identified in terms of staff time and expertise, information and official sanctioning of the project. In the identification of what other agencies were contributing, all the respondents indicated that the other services involved were contributing equitably. There was also a clear understanding the level of, for example expertise contributed by individual within the Group would vary according to skills and training.

Question Seventeen - Do you feel that everyone has played their part in contributing to the implementation of action?

Three respondents felt that everyone was playing their part. This would seem to indicate that the collaboration was going well. Of the two who were doubtful they expressed concern that they themselves had not contributed as much to the implementation of action as they would have liked.

Question Eighteen - Have there been any difficulties in implementing action? What are these?

All felt that on the whole action had been implemented without difficulty. However, two respondents expressed concern about the lack of time allotted to this collaborative project. They also felt that inter-agency commitment across the agencies in terms of involving more fieldworkers was required.

Question Nineteen - Has there been a Shared Vision of what the Individual Agencies/Fieldworkers can Contribute in Terms of Activity?

All those interviewed responded positively to this question. One respondent suggested there was a shared vision but "not necessarily the time to realise it!".

Question Twenty - Have there been early successes/ results to the project?

All replied that there had been early successes. These were identified as the launch of the scheme and the number of stores already participating in the Healthy Shopping Scheme. One respondent felt that the successes:

"Illustrate what can be achieved because it's a very practical project".

Question Twenty One - Do all the agencies involved in the work communicate with each other?
Question Twenty Two - How frequent are the contacts between those involved?

All five respondents identified a high level of communication between those involved in the project. This was identified as a very positive feature of the collaboration. The frequency of the contact was directly linked to the Working Group meetings, every 6 weeks.

Question Twenty Three - Is the project meeting its original objectives?

The five respondents all replied that they felt the project was meeting its original objectives. Concern was expressed by one of the respondents as to how the scheme would be sustained and expanded long term.

Question Twenty Four - Are the goals/objectives of individual agencies being met through this joint working?

All of the respondents felt that their involvement in the scheme was supporting the achievement of the objectives of individual agencies. Specific examples of how the work was supportive were identified:

"It supports our Coronary Heart Disease Strategy " and

"The project is creating links with retailers and the community and this is a priority".

Questions Twenty Five & Twenty Six - What are you achieving together? Do you consider the project to be of long term benefit? What are the long term objectives of the project?

Three suggested that the project was of long term benefit and felt it was meeting the project objectives. Two felt that this was dependent on their being adequate time to invest in implementing the scheme across the agencies. This comment raises issues around the long term commitment across the agencies to working in this way and the shared investment of resources to meet project objectives.

4. DISCUSSION AND SUMMARY

Analysis of the documentary evidence and the results of the interviews undertaken would seem to indicate that inter-sectoral collaboration is being achieved in the implementation of the Healthy Shopping Scheme. Official sanction for the scheme was secured from the two key agencies participating in the scheme, the local authority and the health authority. In the development of the project the documentary analysis and interview outcomes also indicated a multi-agency approach. However, the responsibility for co-ordinating the initiative and recording documentary evidence would seem to rest with one of the partner agencies.

Analysis of the process for implementing the scheme indicated a recognition of the key roles of the community dietitians. This would seem to indicate a high level of network awareness and domain consensus. It would appear that the key objectives identified for the project provided a clear focus to the work and facilitated the development of shared goals and values. Concern was

identified, however, about the ability of the staff participating to sustain the project long term. The issue of commitment in terms of staff time was again, as in the Bishopstoke Project, would potentially reduce levels of collaboration. It would seem, however, that, despite the shortage of staff time to invest in the project, a high level of intersectoral collaboration is being achieved in the development and implementation of the Healthy Shopping Project.

REFERENCES FOR CHAPTER SEVEN

Eastleigh Borough Council (1992) Working Group Minutes - December 1992

Eastleigh Borough Council (1992) Working Group Minutes - January 1992

Eastleigh Borough Council (1992) Working Group Minutes - March 1993

Eastleigh Borough Council (1992) Working Group Minutes - August 1992

Eastleigh Borough Council (1992) Working Group Minutes - July 1992

Eastleigh Borough Council (1992) Project Proposal December 1991

CHAPTER EIGHT

INTER - SECTORAL SMOKING PREVENTION PROGRAMME

1. PROJECT OVERVIEW

Activity around smoking prevention was identified as a key priority by the Healthy Eastleigh Steering Group in June 1992. The development of a collaborative smoking prevention programme was identified as the most effective way of achieving participation across agencies and smoking reduction. The programme represented the first attempt at planning a programme across the majority of alliance partners simultaneously to achieve a common goal. It also provided the first opportunity to determine targets for activity and to explore mechanisms for monitoring progress. A planning group was established creating a formal alliance between the local authority and health services with the following representation:

- Healthy Eastleigh Co-ordinator (Local Authority)
- Health Promotion Officer (Health Authority)
- Smoking Prevention Co-ordinator (Health Authority)
- Health Promotion Manager (Health Authority)

The following members of staff, whilst not being members of the Project Planning Group, were consulted and involved in the development of the project:

- Teacher Adviser for Personal and Social Education
- Primary Care Facilitator
- Health Promotion Administrator (Family Health Services).

Four categories of preventive activity were identified:

1.1 Preventing the uptake of smoking.
1.2 Educational and motivational approaches to encourage cessation.
1.3 Advice from health care workers
1.4 Provision of smoke - free environments

Settings for prevention activity were identified as: schools, retailers, workplaces, eating places, GP surgeries, media, and the general public in the community. A range of interventions were proposed that met with current advice on good practice, were achievable within current resources and were quantifiable in some degree. The main interventions are summarised below.

1.1 **Preventing the uptake of smoking**

The Teacher Adviser planned to develop smoking prevention activity with one of the secondary schools in the Borough and its four feeder primary schools. Funding from the Education Authority Grants for Education, Support and Training budget provided supply teacher cover for staff meetings. The aim was to identify current smoking prevention activity and to develop new initiatives within the National Curriculum using a lifeskills approach. Teachers from each of the schools met in October 1992. After a wide ranging discussion about smoking prevention, including smoking policies and curriculum development approaches, the staff agreed to go back to their schools and have further discussions with staff, governors and pupils.

The planning group considered the possibility of an intervention aimed at retailers to increase the number of shops refusing sales of cigarettes to children, and to encourage them to give out an explanatory leaflet to

those children attempting to buy cigarettes. As new legislation was due in 1992 this seemed a good opportunity to involve local retailers, and Trading Standards Officers who are responsible for enforcing the legislation in Hampshire. The Children and Young Persons (Protection from Tobacco) Act became law in March 1992, which is part of the Government's campaign to reduce smoking by 11-15 year olds. The Act requires prominent warning notices to be displayed on retail premises and vending machines, and any retail outlet selling tobacco products which does not display the notice can be fined up to £1000.

1.2 Educational and Motivational approaches to encourage cessation

National No-Smoking Day 1993

No-Smoking Day represents an important annual opportunity to raise public awareness about smoking and to encourage existing smokers to give up. Data was available about the coverage achieved by the 1992 campaign from both Winchester and Southampton Community Health Services staff. The Southampton campaign received a Health Education Authority Award for being the most creative and media-worthy publicity event in 1992. The Healthy Eastleigh Health Promotion Group planned to run events across the Borough in March 1993, and to learn from the Southampton experience in order to maximise contacts with the public and focus media attention.

1.3 Advice from Health Care Workers

A range of interventions were considered with the Family Health Services Authority to assist local general practices to develop recording systems to identify smokers, increase the number of smoking cessation support

groups available, and to increase the numbers of primary care staff trained in methods of motivational interviewing for smoking cessation. The new health promotion guidelines for primary care were anticipated during the planning phase. These included a requirement by GP's to register the smoking status of the practice population and to indicate, where appropriate the kinds of intervention around smoking cessation they had implemented.

1.4 Provision of Smoke Free Environments

The creation of smoke-free environments has positive effects on the population as a whole, and on individual smokers. Smoke-free environments reduce the health effects of passive smoking, litter and fire risk. For smokers, time spent working or relaxing in smoke-free environments increase the proportion of time spent not smoking, thereby reducing consumption, providing compensatory uptake is not increased at home or elsewhere. Three key settings were identified for the Eastleigh programme:

Smoking Policies in Schools - The aim was to encourage the development of written smoking policies in schools, which would relate to all staff and school users, including those in the school out of hours, or not in direct pupil contact. The involvement of parents and schools governors represents an important part of policy development. Consultation between all interested parties comprised an important stage in establishing commitment to the policy.

Smoking policies in Workplaces - The aim was to increase the number of workplaces with informal agreements in operation, and to increase the proportion who formalise them with a written smoking policy. In addition,

contacts with workplaces would introduce the Look After Your Heart Workplace Charter, and support employers who were interested in pursuing its wider aims.
The Charter provides companies with a framework to support the development of work based activities across a number of health issues. Smoking, stress, healthy eating and physical activity initiatives are a particular focus of the Charter.

Smoking Policies in Eating Places - The aim was to increase the number of eating places providing smoke-free areas for customers. In addition, contacts with catering establishments would introduce the Heartbeat Award and provide support to any establishment that was interested in obtaining the Award. The Heartbeat award comprises three key criteria:

- the provision of no smoking eating area
- the provision of healthy eating options on the menu
- ensuring all food handlers are Food Hygiene trained

1.5 Programme Implementation

The planning group identified the need to collate baseline data on the basis of which targets for local activity could be set. The first task of the group was, therefore, to set about designing an approach to accurate data collection that would be quick, cheap and easily repeatable, in order to determine the current baselines and to monitor the effect of interventions. It was decided that a telephone survey would be undertaken with a sample of retailers, eating places and workplaces, GPs and schools. The results of the survey would identify the level of need for intervention and facilitate the identification of targets for the coming year.

The use of telephone surveys to collect health information has increased in the last decade, as they can reach a large number of individuals at between one quarter and one half of the cost of face to face surveys. A review of the use of telephone surveys to collect dietary information has indicated that well designed and well administered telephone surveys are as good as and possibly better than other methods. The Community Intervention Trial for Smoking Cessation in the U.S.A. and Canada validated a telephone survey instrument, the Health Care Professional Survey Part 1, which is used to evaluate the effectiveness of the programme in promoting smoke-free environments in health care facilities. They compared a telephone survey with a site visit to collect the same data, and found that there was a high level of agreement, indicating that both methods were tapping the same data (Van Dover LJ et al 1992).

The Environmental Health Department database lists workplaces, retailers and catering establishments by ward, providing address and telephone numbers, and in some instances, contact names. It was agreed that a sample of 20% would be contacted for each category of establishment. The survey for these establishments was conducted from the council offices in Eastleigh and undertaken by the Health for All Co-ordinator, Health Promotion Specialist from the Health Authority and the Smoking Prevention Co-ordinator from the Health Authority. An interview schedule was developed and piloted at the council offices. This provided the opportunity to define a consistent approach in conducting the interviews. Questionnaires were drawn up for respondents in each of their respective settings. The Retailers' Survey asked whether respondents were concerned about the numbers of children under 16 who attempted to buy cigarettes from their shop; whether signs were prominently displayed and whether they would

be interested in giving an explanatory leaflet encouraging smoking prevention to those children attempting to buy cigarettes. Food retailers were also asked if they provided any information on the nutritional content of food, and whether they were interested in further information on the Eastleigh Healthy Shopping Award. Respondents were also given an opportunity to raise any other health issues of concern. The Workplace Survey asked about the provision of information to staff about healthy living, healthy food choices on the canteen menu, exercise opportunities and fitness testing, as well as whether there was an official written smoking policy, informal agreements and smoke-free areas on the premises. The Catering Survey asked whether no-smoking areas were provided for the public on the premises. In addition questions about provision of healthy food choices, nutritional content of food and awareness of the Heartbeat Award scheme were also asked.

The General Practice Survey asked whether practices had a computer, whether smoking information is recorded on the computer, and whether this information can be retrieved.

The telephone calls for the school survey and the GP survey were conducted by Winchester Health Authority staff and the Family Health Services Authority. These surveys aimed to contact all schools and GPs in the area.

1.5.1 Survey Results

The surveying not only provided baselines upon which to make sensible judgements of possible effects of interventions and coverage of programmes to aim for but also gave useful indications of the type of approaches that would be well received. The sections outlined below identify the response rates achieved and the sampling frame that was used. The key results are outlined by type of establishment.

Secondary School Activity

Activity with both teachers and pupils is being planned with a secondary school and its primary feeder schools in Eastleigh. One of the feeder schools has established an enthusiastic group of "smokebusters" and is currently participating in designing the leaflet for the scheme with local retailers. The initiative with local teachers is being led by the Teacher Adviser and comprises support in the development of smoking policy and the integration of smoking prevention activity into the curriculum by employing a lifeskills approach.

Retailers' Survey

71 calls were made of which 39% (28) were non-responders (no reply, disconnected, staff unavailable), and 16% (11) did not sell cigarettes. Of the 45% (32) responders, 69% were concerned about the number of children who attempted to buy cigarettes. 91% said they prominently displayed information but there was some interest in obtaining clearer signs. 44% said they would like to participate in a scheme providing a leaflet to those children attempting to buy cigarettes.

24% indicated they provided information about the nutritional content of foods, and 59% were interested in the Healthy Shopping Award.

National No-Smoking Day 1993

During the 1992 campaign community health staff recorded information on the numbers of contacts with the general public where smoking was discussed in the course of special events and levels of media coverage were also identified. The campaign in the southern part of the Borough (Southampton Health Authority Area), was run over

the whole week and yielded 709 contacts, with six slots of air time totalling four hours. The campaign in the northern part of the Borough (Winchester Health Authority Area), was run on National No Smoking Day only, yielded 101 contacts and two inches of news coverage. For the 1993 campaign events and initiatives were planned throughout the week targeting schools, colleges, workplaces, shopping centres, High Street shops, leisure centres, surgeries and maternity units. The Winchester Campaign yielded 1412 contacts across the health authority area, of which 412 were within Eastleigh Borough, four times the contacts of the previous year. Whole page news coverage was achieved in the local Eastleigh newspaper.

General Practice Survey

Of the 15 practices in the Borough, 87% (13) were computerised, 53% (8) recorded smoking information, 47% (7) could retrieve information on smoking status. Only 13% (2) ran smoking cessation clinics, although all but one ran some form of well-person clinic. The new GP Health Promotion Clinic Bandings will come into force in July 1993. Recording of smoking status will now be a basic requirement for all practices in Band One to record smoking information, and for this information to be identified in future practice reports.

Schools Survey

None of the five secondary schools had a written smoking policy, although they all operated some form of informal agreement, and four had a smoke free staff room. All of the primary schools contacted in the Borough had informal agreements and smoke free staff rooms. The telephone enquiry enabled discussion with individual schools which highlighted a difference between primary, junior and

secondary schools in their attitudes towards the need for and perceived value of a written smoking policy. Infant and primary schools generally felt that there was no need for a written policy as informal agreements tended to work well in small schools where teaching and non-teaching staff were well known. One primary and one infant school were working towards a written policy in their handbooks in discussion with the school governors. In secondary schools informal policies relating to non-teaching staff were less clear. Smoking was thought to occur outside or in the caretaker's room, but not in front of the pupils. There was more awareness of the value of a written policy and all five expressed interest in any developments to support them in working towards a written policy.

Individual informal discussions have taken place with a number of schools contacted in the telephone survey to work towards a formal written smoking policy, and Hampshire County Council Education Department has issued a Guidance Note for schools on smoking policy. Additional support with the development and monitoring of their smoking policy, has been given to a special school in the area for emotionally and behaviourally disturbed boys aged 11-16.

Workplace Survey

Of the 93 (72%) respondents, 19% provided health information to their staff, and 37% had an official smoking policy, 32% had informal agreements to control smoking, 65% of the workplaces provided some smoke-free areas on the premises. One third had heard of the Look After Your Heart campaign, and 13 confirmed interest in knowing more. After discussion with the LAYH Workplace Co-ordinator these were sent a copy of the Health Education Authority information and a visit was offered.

Catering Survey

Of the 42 (75%) respondents, 29% provided non-smoking areas for the public. 23% had heard of the Heartbeat Award and 39% were interested in more information. These establishments were followed up by the Heartbeat Award co-ordinator in the Environmental Health Department at the Borough Council.

1.5.2 Target Setting

From the baseline data, and expressions of interest in involvement in future interventions, it was possible to set activity targets. These were set by those staff involved in the surveying, and who would largely be responsible for implementing the interventions. Therefore they were based on the information about the levels of activity required, and assessment of time and resources to achieve them. Subsequently, these were approved by the Healthy Eastleigh Joint Committee and translated into targets for the coming year. The targets identified are outlined below.

Healthy Eastleigh Targets for Smoking Prevention Programme.

Retailers' Materials

90% of retailers displaying new signs.
50% of retailers participating in a scheme to provide explanatory leaflets.

National No-Smoking Day

1500 contacts with the public across the Borough over the week of National No Smoking Day.
100% increase in column inches of press coverage.
Maintain level of radio coverage.

Smoking Policies in Schools

100% of secondary schools having a written smoking policy.
100% of secondary schools having a smoke-free staff room.
5 (36%) of primary schools having a written smoking policy.

Smoking Policies in Workplaces

50% of workplaces having a written smoking policy.
75% of workplaces having designated smoke-free areas.

Smoking Policies in Eating Places

60% of catering establishments having designated smoking and non-smoking areas.
15-20 catering establishments obtaining Heartbeat Award.

RESEARCH RESULTS

2. ANALYSIS OF DOCUMENTARY EVIDENCE

A total of three reports were analysed (50% of total). The nature of the documents is outlined below:
Document 1: Steering Group Report
Document 2: Healthy Eastleigh Joint Committee Report (June 1992)
Document 3: Healthy Eastleigh Joint Committee Report (October 1992)

The terms of reference and membership of the Steering Group and Joint Committee are outlined in detail in Chapter Two. In summary however, the Steering Group comprises officers from the partnership agencies and directs areas of work, providing an operational focus. The Joint Committee comprises elected members of the

local authority and members of the health authorities and provides a strategic direction for the Healthy Eastleigh Initiative.

For each item analysis was undertaken using the content analysis schedule outlined in Chapter Five. An attempt has also been made to identify units of analysis and quantify levels of inter-sectoral collaboration in these documents. Outlined below are the key outcomes of this analysis. These are identified under the key headings/categories outlined in the schedule.

2.1 Types of Communication

All three items of documentary evidence are formal committee reports. Their key aim is to outline the main elements of the smoking prevention programme and to identify project progress.

2.2 Target of Communication

For Document 1 the main target audience was the "officer" led Steering Group. Documents 2 and 3 were developed for the Joint Committee and the Steering Group. The main target for these documents was, therefore, the members of the management group of the Healthy Eastleigh Initiative.

Origin of Documents

The documents represent an inter-agency approach. All three reports were written by the Healthy Eastleigh Co-ordinator. However, in the development of each, consultation was undertaken with the Smoking Prevention Co-ordinator from the Health Authority.

2.3 Methods for attaining Goals

The overall aim of the programme was identified in Document 1 as being:

"To reduce death and disease caused by smoking".

Document 1

A number of ways were proposed as the key means of doing this:

"● Publicity: taking a public stand on the health costs of smoking.
● Reducing the number of people who smoke
● Increasing the number of people who stop smoking".

Document 1

Analysis of the Steering Group Report (Document 1) indicated that a multi-setting and multi-agency approach to achieving the desired outcomes of the programme. The key elements of the programme were identified under 3 categories of prevention activity:

"1. Prevention of uptake of smoking
2. Educational and motivational approaches to encourage cessation.
3. Advice from health care workers".

Document 1

Further analysis of the key elements of the programme indicate the intention of an "inter-sectoral" approach to programme development, one of the key features of effective multi-agency working in Chapter One. For each of the 3 elements identified above key settings or arenas were proposed and these also illustrate both "multi-agency programme development" and "domain consensus". For example key settings were proposed for different elements of activity:

PREVENTION OF UPTAKE OF SMOKING

SCHOOLS

LOCAL RETAILERS

EDUCATIONAL AND MOTIVATIONAL APPROACHES
TO ENCOURAGE CESSATION

NATIONAL NO-SMOKING DAY

WORKPLACES

EATING PLACES

ADVICE FROM HEALTH CARE WORKERS

PRIMARY CARE

The summary of key areas of action and the main resource implications of each provides further illustration of the intended multi-agency approach to both programme development and the implementation of action. The summary outlined below, taken from Document 1, illustrates a high level of domain consensus, recognition of the skills/professional expertise required to implement particular approaches.

Eastleigh Smoking Prevention Programme
Summary of Key Areas of Action

Schools

- Develop a model for education based smoking prevention activity linked to health related skills with the Toynbee Secondary School Cluster.
  Summer Term 1992
- Implement health related skills programme in the Toynbee Cluster.
  September 1992
- Survey local schools to establish those with a smoking policy.
  June - September 1992
- Implement programme to increase the number of schools in the Borough with a smoking policy.
  September 1992

Resource Implications

Staff Time: The Smoking Prevention Co-ordinator (Winchester Health Authority), Health for All Co-ordinator and Teacher Adviser.
Finance: Education Training Monies (G.E.S.T. 12a)

Retailers

- Establish current practice and concerns of retailers around cigarette sales to children.
  June - August 1992
- Establish target for increased participation of local retailers in smoking prevention programme and implement programme of action.
  August 1992

Resource Implications

Staff Time: Smoking Prevention Co-ordinator, Health Promotion Officer (Eastleigh - Winchester Health Authority).
Health for All Co-ordinator.

National No-Smoking Day

- Collate baseline data around activities for National No Smoking Day (NNSD) 1992 to enable the identification of a target for activity for NNSD 1993.
  August 1992

Resource Implications

Staff Time: Eastleigh Health Promotion Group, Health Promotion Officer and Health for All Co-ordinator.

Workplaces and Eating Places

- Establish baseline levels of activity around smoking prevention.
  June - August 1992
- Implement programme of action to increase levels of smoking prevention activity.
  August 1992

Resource Implications

Staff Time: Smoking Prevention Co-ordinator, Health Promotion Officer (Eastleigh), Health for All Co-ordinator.

Primary Health Care

- Review recording procedures for smoking status and health promotion clinics being run by general practice. This will provide baseline information on the current levels of smoking prevention activity in primary care and facilitate the identification of appropriate targets.
  June - August 1992

Resource Implications

Staff Time: Smoking Prevention Co-ordinator, Primary Health Care Facilitator, Health Promotion Adviser (F.H.S.A.).

In terms of a "shared vision and commitment" this piece of documentary evidence illustrates a proposed/intended approach to the Programme. The Steering Group received and approved this report in February/March 1992. The Joint Committee Reports of June 1992 (Document 2) and October 1992 (Document 3) illustrate both "official sanction" and a "shared vision and Commitment" to the programme aims and objectives. The Joint Committee comprises multi-agency representation (outlined in Chapter 2). The recommendations proposed at the beginning of each document and approved at the Committee meetings themselves illustrate official sanctioning of the proposals:

"It is recommended that this Committee approve the key elements of the Eastleigh Smoking Prevention Programme proposed in this report".

Document 2

"It is recommended that this committee note the progress of the Smoking Prevention Programme and approve the targets for activity proposed for the coming year".

Document 3

In terms of the multi-agency collaboration identified in the "Detailed Considerations" section of the report, it was proposed:

"Discussions have been initiated across agencies to develop an inter-sectoral approach to smoking prevention in the Borough".

Document 2

The outcomes of the collection of baseline data are outlined in Document 3 and illustrate an inter-sectoral

approach to the identification of local targets for action. Telephone survey methods were applied as a means of identifying current smoking prevention activity and for identifying appropriate future activity. The summary of the local targets outlined in the first part of this chapter clearly illustrates both "network awareness" in terms of the areas of responsibility from individual agencies and "domain consensus" in the recognition of the skills to be contributed by each agency.

On the less positive side, an indication of the time scale and potential difficulties, in terms of securing time commitment is alluded to:

"In most cases the detail of the intervention programme needs further planning and agreement with local staff".

Document 3

Qualitative analysis of the documentary evidence would seem to indicate a high level of inter-sectoral collaboration in the development of the programme. Features of official sanctioning of the work, network awareness and domain consensus have been clearly identified. However, indication that further discussion is required to develop a multi-agency approach to programme implementation has been indicated. It was also difficult to clearly identify commitment and a shared vision of the work.

2.4 Quantitative Analysis of Documentary Evidence

An attempt has also been made to apply some quantitative measures to the analysis of documentary evidence. The table below identifies each of the items and quantifies in terms of the number of words and sentences illustrating collaboration.

TABLE 11

SMOKING PREVENTION PROGRAMME - QUANTITATIVE ANALYSIS OF DOCUMENTARY EVIDENCE

DOCUMENT	TOTAL SENTENCES	TOTAL WORDS	INTER-SECTORAL COLLABORATION	
			SENTENCES (% OF TOTAL)	WORDS (% OF TOTAL)
DOCUMENT 1	54	950	15 (28%)	330 (35%)
DOCUMENT 2	8	93	3 (38%)	31 (33%)
DOCUMENT 3	40	326	14 (35%)	123 (38%)

3. INTERVIEW RESULTS

The small core group of fieldworkers involved in the development of the programme were interviewed. This group comprised the following staff:

- Health Promotion Specialist
- Smoking Prevention Co-ordinator
- Teacher Adviser - Health Education

The key themes to emerge from the interviews are identified below.

Question One
Were there any particular incentives that influenced you/your organisation in getting involved in the Healthy Eastleigh initiative?

A number of incentives were identified for getting involved in the Healthy Eastleigh initiative and the Smoking Prevention Programme. Smoking prevention was identified by the staff from the health authority and a priority within Education. Thus, working collaboratively with the local authority around this issue was proposed as an incentive to meet individual agency objectives. The links with Education were seen as a means of supplementing "cross Phase development" linked to the national curriculum.

Question Two
What sort of commitment towards the Smoking Prevention Programme was there at the top level of your organisation?

Expressed commitment from senior management to the development of the Smoking Prevention Programme was identified as being from "very high" to "none".

Question Three
Does your organisation have any particular values or beliefs that make inter-agency working important to it?

All the respondents felt that there were values and beliefs within their organisation which made inter-agency work important to it. For example, it was suggested that the:

"Whole person approach" to health promotion enhanced and supported an inter-agency approach. It was also suggested that the recognition by agencies that health and health promotion was "everybody's business" provided further illustration of values supportive of inter-agency work.

Question Four
What were your organisation's priorities when you became involved in the programme?

"Health gain" was identified as a key priority by one respondent. This had been further reinforced as a major focus by the Health of the Nation. The development of a "whole community" approach to health promotion was another key priority. The development of initiatives to reduce mortality and morbidity caused by coronary heart disease was identified as an important theme of health promotion activity.

Question Five
What sorts of qualities, skills, other factors do you think are important for inter-agency working?

Communication and good inter-personal skills were identified as key qualities required for inter-agency work. Other features identified are outlined below:
"Open mindedness".
"Ability to influence senior management".
"Support for new ways of working".

When asked whether these had been key features of the work developed around the Smoking Prevention Programme, respondents suggested that good communication had been along with a willingness to work in different ways.

Question Seven
How did you become involved in the project?

One of the respondents was approached directly by the Healthy Eastleigh Co-ordinator to get involved in the programme. The others interviewed were approached by their respective line managers.

Question Eight
How well did you know the other professionals/ organisations involved in the project at the outset?

All members of the core group knew one another and had previously collaborated on areas of health promotion activity.

Question Nine
Were common goals/objectives established at the outset?

All those interviewed felt that common goals had been established at the outset. These were identified in general terms as the "reduction of smoking prevalence and uptake". Group discussion was identified as the main process by which programme objectives were established. One respondent did suggest, however, that the Steering Group had played a part in identifying some of the core features of the programme.

Question Ten

Did all the professionals/organisations involved share the same priorities from the outset? If not how was a common agenda established?

It was suggested that around the issue of smoking prevention all the professionals involved in the programme shared the same objectives and that this had been achieved through discussion and by consensus. Two respondents, however, suggested that there were obviously other priorities and areas of work within their own area of responsibility which were not shared by all the group members.

Question Eleven

How important do you think it is for agencies working together to share common values and beliefs?

All those interviewed felt it was important for agencies working together to share the same values and beliefs. A commitment to inter-agency working was proposed as perhaps the most important pre-requisite. One respondent qualified her response by suggesting that developing "understanding" across those involved in the work was as important, if not more important than sharing common values.

Question Twelve

Did you feel there was a shared understanding of what individual agencies involved in the project could contribute to project objectives?

All of those interviewed suggested there was a shared understanding of what individuals and individual agencies involved in the work could contribute.

Question Thirteen
How were key stages of action agreed by all the agencies participating? How easy/difficult was the process?

All respondents suggested it had not been difficult to agree action. One respondent felt that this had been so largely because a small group of individuals was steering and co-ordinating the work. Discussion between group members had facilitated the development of areas of action.

Question Fourteen
Were lead agencies/fieldworkers identified for specific areas of action?

The identification of lead professionals and agencies for specific areas of work was identified as a key theme of the development of the programme.

Question Fifteen
What was your own/your agencies role in the project?

A number of different tasks were identified by those interviewed:

"Liaise with schools to add educational credibility".
"Undertake initial survey to collect baseline data".
"Provide district-wide co-ordination".

Question Sixteen
What kinds of resources is your organisation putting into the project?

Respondents identified their time as the key resource investment of their agency. One respondent identified the arrangement of "Staff Cover" time as a key contribution by their agency. This facilitated the

involvement of schools and their staff in the development of the programme.

Question Seventeen
Do you feel everyone has played their part in contributing to the implementation of action?

All the respondents felt that everyone had played their part in the implementation action. One respondent suggested that because:

"we all knew one another"

a mutual responsibility to get things done seemed to emerge.

Question Eighteen
Have there been any difficulties in implementing action? What are these?

The main difficulty identified was the shortage of staff time. This seem to stem from the range of other work, in addition to the Eastleigh project, being undertaken by members of the project group. One respondent identified a difficulty in:

"sustaining the involvement of schools when there are other priorities"

as a key problem. The commitment of senior managers was also identified as a potential difficulty. Whilst on the one hand there was explicit support for the work, there was no additional support or time to facilitate the fieldworkers involved.

Question Nineteen
Has there been a shared vision of what the individual agencies/fieldworkers can contribute in terms of activity?

All the staff interviewed felt there was a shared vision of what individual agencies and fieldworkers could contribute. Lack of time to "realise all the elements" of the project was identified as a problem in response to this question.

Question Twenty
Have there been early successes/results to the project?

Involvement with local schools and the development of a leaflet for use with local retailers were identified as key successes to come out of the programme. The links established with the local authority, Environmental Health Department, were identified as "significant steps forward."

Question Twenty One
Do all the agencies involved in the work communicate with each other?

All of the respondents suggested that the agencies involved in the programme communicate with one another. One respondent suggested that there were different levels of communication and that these were not all operating satisfactorily:

"At an operational level we communicate but I'm not convinced that our senior managers talk to one another to develop a strategic vision of the work".

Question Twenty Two
How frequent are the contacts between those involved?

Frequent contact was identified by all those interviewed. This was proposed as the key means of for planning and implementing areas of work.

Question Twenty Three
Is the project meeting its original objectives?

All the respondents felt that the programme was meeting its original objectives to a "lesser or greater extent". Two respondents expressed the view that it was a slow process and that the real outcomes of the work would not be identified for some time. One respondent expressed doubts about the core groups ability to sustain elements of the programme over time.

Question Twenty Four
Are the goals/objectives of individual agencies being met through this joint working?

All suggested that some of the objectives and goals of individual agencies were being met through this joint working. The key goal was identified as the reduction of smoking prevalence and this was shared across all the agencies participating.

Questions Twenty Five and Twenty Six
What are you achieving together?
Do you consider the work to be of long term benefit?

The development of a "comprehensive approach to smoking prevention" was identified by one respondent as key achievement. Securing the commitment of a number of agencies to the development of a joint programme was identified as another key success. All the respondents

suggested that the work was of long term benefit. One respondent suggested that the programme supported:

"other activities being progressed in schools to develop a whole person approach to health education."

Another respondent suggested that the involvement of workplaces and catering establishments in the creation of "smoke free environments" was of key importance.

4. DISCUSSION AND SUMMARY

The Smoking Prevention Programme represents the development of a strategic approach to a key health issue as part of the Healthy Eastleigh initiative. An attempt is made to establish a programme which adopts a multi-setting, planned approach to the development of smoking prevention initiatives. The comments identified from the interviews with programme participants and from the analysis of documentation revealed an overwhelmingly positive picture in terms of the practical outcomes and value of the collaboration. The benefits of adopting such an approach were proposed around the outcome of a "holistic" approach to smoking prevention. All of the participants had worked together previously and the definition of areas of work and the development of an understanding of who should do what presented little difficulty.

However, the lack of time to implement the programme was identified as a problem area. Each of the project participants were undertaking the programme in addition to their normal work programme. Whilst those interviewed indicated they had support from their line managers, this had meant no additional resources. Analysis of the documentary evidence indicated a clear vision of objectives, targets and areas of work. The key themes to emerge will further expand the viable model for collaboration proposed in Chapter Twelve.

REFERENCES FOR CHAPTER EIGHT

Eastleigh Borough Council (1992) Steering Group Report - March 1992

Eastleigh Borough Council (1992) Healthy Eastleigh Joint Committee Report - June 1992

Eastleigh Borough Council (1992) Healthy Eastleigh Joint Committee Report - October 1992

CHAPTER NINE

HEALTHY EASTLEIGH GROUP

1. PROJECT OVERVIEW

In September 1990 the Healthy Eastleigh Steering Group agreed that a multi-agency Health Promotion Group should be established to plan implement and evaluate health promotion activities in the community. It was agreed that the group should comprise fieldworkers drawn from the partnership agencies involved in Healthy Eastleigh. The Group held its first meeting in October 1990 and achieved the following representation:

- Health Visitor
- Healthy Eastleigh Co-ordinator
- Community Health Initiative Worker
- Health Visitor Manager
- Elderly Team Manager (Social Services)
- Local GP
- General Secretary -Eastleigh Council of Community Service
- Community Nurse - Services for People with learning difficulties
- Community Dental Therapist
- Community Chiropodist
- Community Physiotherapist
- Midwifery Manager
- Clinical Psychologist

Members to join the group since that time have included representatives from Community Education, Health Promotion Services, local MIND Group and Social Services Mental Health Team. After wide ranging discussion and a number of monthly meetings it was agreed that the focus of the group should be to provide community based health

promotion activity which focuses on the health priorities identified by the Healthy Eastleigh Steering Group. A workshop was held early in 1991 to allow members of the Health Promotion Group to identify the best way of achieving regular community health promotion activity from the group. It was agreed that a monthly health stall and press coverage around particular health issues would be the core activities undertaken by the group. The focus would be to achieve community involvement and a multi-agency commitment to the core purpose of the group. The main health issues addressed by the Health Promotion Group during the first phase of the Healthy Eastleigh initiative are identified in the table below.

Health Issues

Accident Prevention
Physical Activity
Healthy Eating
Dental Health
Smoking Prevention
Cancer Prevention
H.I.V./AIDS

Outlined below, to provide an illustration of the Group activities, is an evaluation of one of the health promotion initiatives undertaken and a review of the Group's activities during 1992.

1.1 Evaluation of Child and Home Safety Health Promotion Market Stall - January 1991

To coincide with a national campaign focusing on child and home safety, the Eastleigh Health Promotion Group undertook a day long promotion at the local market to raise awareness about accident prevention. The evaluation outlined below is structured under a number of headings addressing practical aspects of this health promotion initiative and the key outcomes.

1.1.1 Key Objectives

The market stall had three key objectives:

- To provide information and raise awareness about child and home safety among local people.
- To obtain feedback from local people on the health topics they would like to see addressed in future activity.
- To provide members of the multi-agency Health Promotion Group with the opportunity to "team build" around a practical task.

1.1.2 Practical Aspects of the Day

Process evaluation will focus on the practical aspects of running the stall with reference to two key areas:

(A) Resources for the stall.
(B) Staffing for the stall.

Evaluation points will be identified under each of these categories.

(A) Resources

The Eastleigh Council of Community Service provided the use of the Eastleigh Market Charity Stall for the day. The main resources obtained for the stall are identified below, along with a brief account of some of the practical implications for future activities.

Banner for the Stall

To raise the profile of the Group both for this and future activities it was agreed that a banner for the stall be obtained. A donation of hardboard was obtained

from the local DIY store and the artwork was produced in the Environmental Health Department at Eastleigh Borough Council. An 8ft. x 2ft. banner with "Eastleigh Health Promotion Group" printed on it was hung at the back of the stall.

Tables for the Stall and Stall Cover

Folding tables were borrowed free of charge for the day from the Old Town Hall Centre in Eastleigh. A plastic sheet was borrowed from the Building Services Department at the Hampshire County Hospital in Winchester.

Leaflets and Stickers

Resources in the form of leaflets and stickers were obtained from Winchester and Southampton Health Promotion Units. These were supplemented with leaflets and materials from the Royal Society for the Prevention of Accidents (ROSPA).

1.1.3 Staffing the Stall

A rota by which group members could volunteer to staff the stall over 2 hour periods was circulated at the Health Promotion meeting on 7th December 1990. It was proposed that three members of staff should be on the stall for 2 hour periods. Both the Fire Service and St. John's Ambulance were approached to participate. The following range of staff was involved in running the stall:

- Healthy Eastleigh Co-ordinator
- Community Health Initiative Worker
- 4 Health Visitors
- 2 District Nurses
- 2 Social Workers

- 1 Dental Therapist
- 1 Environmental Health Officer
- Team Leader - Mental Handicap Services
- Representative from the Fire Service throughout the day

Evaluation Points

(A) Inter-agency representation at the health stall was achieved. For future activities it was agreed that this would need to be sustained and developed.

(B) Involving other services such as the Fire Service proved a useful way of increasing the impact of this event.

(C) Some staff were more at ease than others in approaching the public. For future events this would seem to indicate a need for the Group to identify staff training needs to undertake particular health promotion approached

1.1.4 Were the key objectives achieved?

In considering the achievements of the Health Promotion Market Stall reference will be made to the three key objectives identified for the day.

i) Provision of Information and Awareness Raising about Child and Home Safety

The market stall was effective in providing information and raising awareness about child and home safety. A crude indicator of the level of information provision is the number of leaflets distributed to local people from the stall. Supplies of 21 different leaflets focusing on a wide range of issues linked to child and home safety

were available on the stall. A total of 543 leaflets were distributed to the general public.

The provision of information to the local press was another key means of providing information and raising awareness. A press release was written by the Chair of the Health Promotion Group and the Healthy Eastleigh Co-ordinator and circulated through the Public Relations Department of the Borough Council. Articles about the stall were featured in two local newspapers.

Evaluation Points

- For future activities it is proposed the Group consider methods of recording more detail about the public they contact, eg. age, sex. occupational groups.

ii) Feedback from Local People

A questionnaire was devised for use on the stall. The main objective of this was to obtain feedback from local people about key issues relating to child and home safety and health promotion in general.

1. Local perceptions of the main safety hazards in the home.
2. Local feedback on the measures already taken to avoid accidents.
3. Views from local people on what further action should be taken to promote safety in the home.
4. Feedback on the health issues people would like to see addressed in future activities.

A total of 99 questionnaires were completed. A wide range of hazards and safety measures were identified under 1 and 2 above. These highlighted issues such as

the use of fire guards and safety gates. Amongst those interviewed it would seem to indicate a high level of awareness and knowledge.

The views expressed about further action which should be taken identified 3 key issues:

- The need for more information provision at a local level.
- The need for better support networks for mothers.
- the need for more home safety equipment to be available on loan.

This information provided useful indicators for future planning.

Evaluation Points

1. The information provided by the questionnaire was a useful way of obtaining an indication of levels of knowledge and awareness about safety issues.
2. The unstructured nature of the questionnaire limited the range of information provided and hindered a detailed analysis.

1.1.5 Benefits/Outcomes

Three key benefits/outcomes for the initiative are outlined below:

- The market stall raised the profile and identity of the Eastleigh Health Promotion Group among local people.
- Child and home safety has been placed on the agenda with local people and staff. Collaboration between the Child Accident Prevention Group (Soton Health Authority) ensured that along with the market stall,

efforts were made to raise awareness about child safety among local health visitors, mother and toddler groups and child minders.

- An inter-agency approach to the activity of the Health Promotion Group was established.

Eastleigh Health Promotion Group - Evaluation of Health Stalls During 1992

As the second part of the background section to the Health Promotion Group Initiative, the table below identifies the issues addressed, the agencies involved and the number of contacts achieved. This provides an overview of the multi-agency and multi-issue approach adopted by the Group, prior to identifying the research results from the analysis of documentary evidence and interviews with project participants.

HEALTHY EASTLEIGH HEALTH PROMOTION GROUP

DATE	HEALTH ISSUE	TOTAL CONTACTS	AGENCY PARTICIPATION
JANUARY 1992	ACCIDENT-PREVENTION	80	COMMUNITY NURSES *LOCAL AUTHORITY FIRE BRIGADE
FEBRUARY 1992	PLAY IT SAFE	292	AS ABOVE
MARCH 1992	NATIONAL NO SMOKING DAY	101	COMMUNITY NURSES *LOCAL AUTHORITY
APRIL 1992	PHYSICAL ACTIVITY	70	FITNESS CENTRE STAFF COMMUNITY NURSES LOCAL AUTHORITY STAFF
APRIL 1992	LOOK AFTER YOURSELF	85	AS ABOVE
MAY 1992	DENTAL HEALTH	236	DENTAL SERVICES COMMUNITY NURSES
JUNE 1992	EXERCISE	88	HEALTH PROMOTION STAFF *LOCAL AUTHORITY LEISURE CENTRE STAFF

DATE	HEALTH ISSUE	TOTAL CONTACTS	AGENCY PARTICIPATION
JULY 1992	HOME/GARDEN/WATER SAFETY	118	COMMUNITY NURSES FIRE BRIGADE HEALTH VISITORS/DISTRICT NURSES
AUGUST 1992	YOUTH STAND	84	YOUTH SERVICES HEALTH PROMOTION SERVICES
SEPTEMBER 1992	HEALTHY EATING	FIGURES UNAVAILABLE	COMMUNITY DIETITIAN HEALTH PROMOTION *LOCAL AUTHORITY
OCTOBER 1992	CANCER PREVENTION	FIGURES UNAVAILABLE	WESSEX CANCER TRUST
DECEMBER 1992	HIV/AIDS PREVENTION	FIGURES UNAVAILABLE	HIV PREVENTION CO-ORDINATOR GENITO URINARY MEDICINE
JANUARY 1993	ELDERLY/HEALTH/HOME	80	COMMUNITY ADVISOR HOME SAFETY DISTRICT NURSING

*LOCAL AUTHORITY = HEALTH FOR ALL CO-ORDINATOR

2. ANALYSIS OF DOCUMENTARY EVIDENCE

A total of seven documents were analysed. The nature of the documents is outlined below:

- Healthy Eastleigh Group Minutes: 21-6-91 - Document 1
- Healthy Eastleigh Group Minutes: 11-11-91 - Document 2
- Healthy Eastleigh Group Minutes: 16-12-91 - Document 3
- Healthy Eastleigh Group Minutes: 17-2-92 - Document 4
- Healthy Eastleigh Group Minutes: 17-3-92 - Document 5
- Healthy Eastleigh Group Minutes: 28-7-92 - Document 6
- Healthy Eastleigh Group Minutes: 4-92 - Document 7

For each item analysis was undertaken using the content analysis schedule outlined in Chapter Five. The key themes to emerge from this analysis are given below.

2.1 Type of Communication

Six of the seven documents are minutes from the meetings of the Health Promotion Group. The seventh document comprises a strategic overview of the objective setting process for the Health Promotion Groups throughout the Winchester Health Authority area.

2.2 Target of Communication

The minutes of the Health Promotion Group and the Strategic Report were all intended for the multi-agency membership of the Health Promotion Group.

Origin of Document

The first three documents were produced by the Healthy Eastleigh Co-ordinator, who chaired the Group during this period. After this time the chair passed to a member of

the Community Nursing Department (Documents 4 - 6 inclusive). Document 7 was produced by the Deputy Manager of the Health Promotion Department, Winchester.

2.3 Methods for Attaining Goals

Analysis of the Health Promotion group minutes indicated a key feature of inter-sectoral collaboration. The attendance at the meetings and the apologies received indicate both levels of commitment in terms of Group participation. For example, analysis of Document 1 indicated a range of agencies/professionals attending the Group:

- Healthy Eastleigh Co-ordinator
- Health Visitor Manager
- Leisure Services Representative
- Lecturer - Eastleigh College
- Community Physiotherapist
- Dental Therapist
- Hospital Manager

This would seem to indicate a good representative mix in terms of multi-agency collaboration. However, analysis of the apologies received indicated a range of professionals who, for whatever reason, were unable to attend:

- School Nurse
- Council of Community Service Manager
- Community Development Officer
- Mental Health Social Worker
- Health Visitor - Central Eastleigh

Analysis of the other sets of minutes indicated a consistent theme of a core group of attenders and non-attenders. Whilst clearly, in terms of an inter-sectoral

approach to health promotion planning is being achieved, not all agencies are fully participating in the process.

Analysis of the range of health promotion issues tackled by the Group would seem to illustrate that both "network awareness" and "domain consensus" were key features of the Group activity. For example, the expertise of particular members of the Group was of vital importance in moving areas of work forward:

"Drinkwise Day

(Fieldworker from the voluntary sector) had reported that their stall had been successful. There had been a lot of information available and samples of free/low alcohol drinks for adults".

Document 1

This illustrates the lead role played by the local "alcohol experts" in promoting the Health Education Authority led Drinkwise Day.

In terms of broader issues linked to health there was further evidence that Group members recognised the skills of each other:

"Redundancy - A group may be started (by the Voluntary Sector) for professional people who have been made redundant."

Document 2

"(Physiotherapist reported she had) attended a one day conference recently, "Rehabilitation Targets to 2000". One talk by the rehabilitation consultant stressed the importance of the prevention of back injury. 40% of GP

referrals are for back pain. 80% of the general public will suffer at least once in their lives. The Group discussed writing to the Rehabilitation Unit to outline our aims and request general support".

Document 2

"The topic of the next stall is to be accident prevention in line with the T.V. series Play it Safe! Health visitors will specialise in temperature control in babies".

Document 3

"(The Health Promotion Specialist for Look After Yourself and healthy lifestyles) will contact the Regional LAYH Office to find out if the exhibition will be available to promote LAY/Physical activity on World Health Day."

Document 4

As well as planning jointly and developing collaboration activities in the community, the development of information sharing and the creation of an inter-linking network can be identified from the analysis of documentary evidence. "Information Exchange", an opportunity for members of the Group to share work and keep colleagues updated is a feature of all the Health Promotion Group minutes analysed. This would seem to provide further evidence of a cohesive, support network created around health promotion which both recognises the need for collaborative and independent working.

The identification of a shared vision and commitment to the Group's activities represents a slightly more difficult task in terms of the analysis of documentary evidence. The way in which a shared approach to the

establishment of a monthly health stall was created can be clearly illustrated by the planned approach adopted to the monthly themes developed.

"July 30th - Home, Garden and Water Safety
August 28th - Youth Stand
Sept. 24th - Enjoy Health Eating"

Document 6

However, some difficulties can be identified in terms of commitment to the Group and Group activities. For example, difficulties in staffing the stalls can be identified:

"Healthy Lifestyles Stall
Despite a specific request for more help there were still more volunteers required for the market stall on Thursday, 27th June. 50% of the volunteers so far were health visitors. It was hoped that the stall could be staffed the whole day".

Document 1

Issues around the commitment and managerial support for the Group's activities can also be identified. For example, the co-ordination and chairing of the Group were issues of concern. In Document 5 the Health Visitor Manager expressed her concern about group co-ordination:

"The Chair is coming to the end of her allocation to the Group on 31st March. After that she will be working only four days a week, so will be less available for the Group. It was felt there was a need for a co-ordinator for the group. It was suggested everybody write to the sector manager to endorse this point."

Document 5

However, on the positive side, Document 7 indicated multi-agency collaboration and official sanction from the health authority for the Group and specifically identifies District-wide support for the Group and Health for All.

2.4 Quantitative Analysis of Documentary Evidence

Outlined below is the analysis of the frequency of words and sentences linked to collaboration identified from each item of documentary evidence.

TABLE 12

HEALTH PROMOTION GROUP - QUANTITATIVE ANALYSIS OF DOCUMENTARY EVIDENCE

DOCUMENT	TOTAL SENTENCES	TOTAL WORDS	INTER-SECTORAL COLLABORATION	
			SENTENCES (% OF TOTAL)	WORDS (% OF TOTAL)
DOCUMENT 1	30	629	9 (30%)	117 (19%)
DOCUMENT 2	16	127	7 (44%)	65 (51%)
DOCUMENT 3	31	195	13 (42%)	82 (42%)
DOCUMENT 4	30	221	12 (40%)	78 (35%)
DOCUMENT 5	47	635	15 (32%)	202 (32%)
DOCUMENT 6	18	258	6 (33%)	86 (33%)
DOCUMENT 7	27	350	8 (30%)	103 (29%)

3. INTERVIEW RESULTS

The interview schedule outlined in Chapter Five was used to further explore levels of collaboration in the development and implementation of activities linked to the Health Promotion group. The core membership of the Health Promotion Group was interviewed:

- HEALTH VISITOR CO-ORDINATOR
- HEALTH PROMOTION SPECIALIST
- SOCIAL SERVICES REPRESENTATIVE
- DENTAL THERAPIST
- VOLUNTARY SECTOR REPRESENTATIVE
- HEALTH VISITOR (SOUTHERN PART OF BOROUGH)

Outlined below are the key themes to emerge from their responses to each question.

Question One
Were there any particular incentives that influenced you and your organisation in getting involved in the Healthy Eastleigh Initiative?

A number of incentives were identified by those interviewed. For example, one respondent suggested that group involvement provided:

"the opportunity to feel like part of the Borough and the Healthy Eastleigh initiative".

Another respondent suggested that it provided the chance to:

"establish links and networks".

All the respondents identified either networking or "getting to know" other fieldworkers as a key incentive for participating in the Group.

Question Two
What sort of commitment towards the project was there at the top level of your organisation?

All but two of the respondents felt that commitment for their involvement in the Group was high. One of those who suggested it was not, indicated that this was because her management team had not been involved in the decision for her joining the Group.

Question Three
Does your organisation have any particular values or beliefs that make inter-agency working important to it?

A number of values/beliefs were cited which indicated a commitment to inter-agency work. For example, one respondent suggested that her organisation believed that:

"influences on health are multi-faceted"

another suggested that it:

"made a positive contribution to treatment and care"

Commitment to and the value of collaboration was also identified:

"voluntary and statutory organisations working together is a key belief".

Overall, it appeared that working together was regarded as being of implicit value and terms like "essential" and "vital" were expressed.

Question Four
What were your organisation's priorities when you became involved in the Health Promotion Group?

Developing health promotion in the community and the key areas identified in the Health of the Nation were amongst the priorities identified. A commitment to building alliances and networks to achieve improved health among the population was a key issue identified.

Question Five
What sorts of skills/features do you think are important for inter-agency working?

Good communication across agencies was by far the most important skill/quality required for inter-agency work identified by the respondents. Among other skills identified were:

"flexibility, having a view of the greater good!"

"willingness to work together"

"time, listening, valuing each other"

"enthusiasm, wanting to learn from others".

Question Six

Have they been a feature of the work developed around the Healthy Eastleigh Health Promotion Group?

The respondents felt that on the whole the features identified above had been characteristics of the work developed from the Group. One respondent, however, expressed doubt about overall commitment to the joint working.

Question Seven

How did you become involved in the project?

Six of the respondents had been "volunteered" by their managers and one had been approached by the chair of the group to join.

Question Eight

How well did you know the other professionals/organisations involved in the project at the outset?

Five respondents said they did not know other members of the Group when they joined. The other two respondents said they knew some of the members of the group, but not others.

Question Nine

Were common goals/objectives established at the outset? What were they? How were they established?

Two of the seven interviewed felt that common goals/objectives had not been identified at the outset. The other five respondents felt that common objectives had been established through group discussion and consensus.

Question Ten

Did all the professionals/organisations involved share the same priorities from the outset? If not how was a common agenda established?

Only one respondent felt that professionals and organisations shared the same priorities. One respondent expressed the view that:

"we were coming from different directions".

Group discussion and identifying the key priorities for the health stall, for example, were identified as key ways of establishing a common agenda.

Question Eleven

How important do you think it is for agencies working together to share values or beliefs?

Differing views were expressed in response to this question. The response ranged from "very important" to "quite important but not essential". The notion of developing a common understanding was a theme mentioned by two of those interviewed. Valuing joint working was identified as being of key importance to inter-agency work.

Question Twelve

Did you feel there was a shared understanding of what individual agencies involved in the project could contribute to project objectives?

Conflicting views were expressed in response to this question. Two respondents felt there was not a shared understanding of what individual agencies could contribute to project objectives. Two felt that understanding of the potential role of other agencies was

developing as the group activities developed. Three responded that from their perspective there was not a shared understanding of what individual agencies could contribute.

Question Thirteen
How were key stages of action agreed? How easy or difficult was this process?

Discussion and consensus within the Group was identified as the key means of agreeing action by all the agencies participating. One respondent suggested that this process was:

"piecemeal and progress was slow".

On the whole respondents expressed the view that the process for agreeing action was slow rather than difficult.

Question Fourteen
Were lead agencies/fieldworkers identified for specific areas of action?

All the respondents expressed the view that lead agencies had been identified for specific areas of action. However, two respondents felt that the same "core" members of the Group took on this role. This seemed to indicate that not all the Group members were taking on responsibility or playing a key part in group activities.

Question Fifteen
What was your agency's role in the project?

Those interviewed felt their role in the group was to bring their own professional expertise and to highlight the health issues of most concern to them. For example,

one respondent suggested that to:

"promote positive mental health initiatives"

was her main role, another proposed:

"developing coronary heart disease prevention awareness in the Group's activities"

as her main interest area.

Networking and feeding information back to their own agency was identified as a feature of their participation in the group by one respondent.

Question Sixteen
What kinds of resources is your organisation putting into the project?

Staff time was identified as the main resource being invested in the group by those interviewed. One respondent also identified resources, in terms of health education materials (leaflets etc.), as a key contribution by their agency.

Question Seventeen
Do you feel that everyone has played their part in contributing to the implementation of action?

All respondents expressed some doubt as to whether everyone had played their part in contributing to the implementation of action. A resounding "No" was expressed by three respondents.
The other group members interviewed felt that they were either:

"unsure about everyone playing their part"

or felt that:

"responsibility was unevenly shared because of other pressures."

Following on from this, responses to Question Eighteen indicated that there had been difficulties in implementing action. Lack of time was proposed as the major problem. It emerged from the responses that all except one of those interviewed had become involved in the group as an "add on" to their normal role.

Question Eighteen
Have there been any difficulties in implementing action? What are these?

The main difficulty identified was the shortage of staff time. This seem to stem from the range of other work, in addition to the Eastleigh project, being undertaken by members of the project group. One respondent identified a difficulty in:

"sustaining the involvement of schools when there are other priorities"

as a key problem. The commitment of senior managers was also identified as a potential difficulty. Whilst on the one hand there was explicit support for the work, there was no additional support or time to facilitate the fieldworkers involved.

Question Nineteen
Has there been a shared vision of what the individual agencies/fieldworkers can contribute in terms of activity?

All the respondents felt there was an understanding of what individual agencies/fieldworkers could contribute to the group. However, concerns about whether or not this was translated into health promotion activity were explicitly expressed by two respondents. They indicated that it did not necessarily mean:

"we get around to implementing action."

Question Twenty
Have there been early successes/results to the project?

All the respondents felt that the establishment of the monthly health stall was a practical outcome of the initiative. However, one respondent felt that the stall had only continued because of the efforts of a few members of the group.

Question Twenty One
Do all the agencies involved in the work communicate with each other?

Four of those interviewed suggested that contact was rare outside the meetings themselves. Two respondents said that they did have regular contact with group members. One member was unsure about levels of contact outside group meetings.

Question Twenty Two
How frequent are the contacts between those involved?

The six weekly meetings were identified as the most frequent contacts between group members. Two of the respondents said that although they had contact with group members outside meetings, it was difficult to measure the frequency.

Question Twenty Three
Is the project meeting its original objectives?

Three respondents said that they felt the group was meeting its original objectives. However, one respondent suggested that this was only in a narrow sense. Two respondents suggested that they were unaware of what the original objectives were.

Question Twenty Four
Are the goals/objectives of individual agencies being met through this joint working?

On the whole, respondents felt that it was a difficult task for the group to meet the individual objectives of the agencies participating. One respondent suggested that there were:
"too many conflicting needs."

However, whilst expressing these difficulties, three of those interviewed suggested that the group's activities were contributing to the objectives of individual agencies in a:

"limited way."

Question Twenty Five
What are you achieving together?

Getting to know other professionals in the area and creating a network of staff was identified by two respondents as one of the group's achievements. Raising health awareness within the local community was identified as another outcome of the group's activities. Although, it was suggested that this was extremely difficult to measure.

Question Twenty Six
Do you consider the Project to be of Long Term Benefit?

Five of the respondents expressed a very positive response to this question. One of the respondents suggested that:

"it's got to be of long term benefit!"

A number of respondents suggested that the Health of the Nation had now made it imperative that agencies work together to implement health promotion activity.

4. DISCUSSION AND SUMMARY

The research findings outlined above reveal a range of positive and negative features linked to inter-sectoral collaboration and the Healthy Eastleigh Group. On the positive side the perceived enthusiasm for working across agencies and the networking which occurred as a result indicate effective collaboration. The high level of understanding of the roles of individuals and their potential contribution to the groups activities was another positive characteristic of the initiative.

On the negative side the lack of resources and time for members of the group was identified as an inhibitor of the full potential of the project outcomes. The need for "contracted" time for operational staff to become involved in this initiative was a key finding. The need for more explicit objectives to direct group action was another expressed concern.
The range of agencies identified from the analysis of the minutes of the group, indicate a high level of commitment and collaboration. However, the interviews undertaken revealed anxieties about the fact that one or two key people co-ordinate activity and as a result levels of cross agency participation are reduced.

The research undertaken into the Health Promotion Group, revealed, therefore, both positive and negative features linked to inter-sectoral collaboration. The key findings will further extend the viable model for collaboration developed in Chapter Twelve.

REFERENCES FOR CHAPTER NINE

Winchester Health Authority (1991) Healthy Eastleigh Group Minutes 21-6-91

Winchester Health Authority (1991) Healthy Eastleigh Group Minutes 11-11-91

Winchester Health Authority (1991) Healthy Eastleigh Group Minutes 16-12-91

Winchester Health Authority (1992) Healthy Eastleigh Group Minutes 17-2-92

Winchester Health Authority (1992) Healthy Eastleigh Group Minutes 17-3-92

Winchester Health Authority (1992) Healthy Eastleigh Group Minutes 28-7-92

Winchester Health Authority (1991) Healthy Eastleigh Group Minutes 4-92

CHAPTER TEN

EASTLEIGH SHARED INFORMATION PROJECT

1. PROJECT OVERVIEW

The need to share information to assist in the local planning of services and the development of appropriate health promotion activity, was identified as a key priority by the Healthy Eastleigh Steering Group during the Autumn of 1990. The Steering Group charged a small core group to identify some of the key issues/priorities around information sharing and to develop tools and mechanisms for information sharing. This group comprised the following membership:

- Healthy Eastleigh Co-ordinator
- Consultant in Public Health Medicine (Winchester Health Authority)
- Information Officer (Public Health Department Southampton and South West Hants Health Authority)
- Mapping Project Officer (Winchester Health Authority)

As an initial starting point the Healthy Eastleigh Co-ordinator examined each of the World Health Organisation Targets for Health and identified the key information requirements against each to assist in locality needs assessment.

It became clear that the range of information required impacted on a number of the partner agencies involved in Healthy Eastleigh and that benefits would be gained from securing wider participation in the development of a shared information project. Participation was secured from Social Services (both at a local and county level) and Information Services (Hampshire County Council).

Links were also established with the Geo-Data Institute at Southampton University and IBM. It was felt that the involvement of these external bodies could enhance the robustness and reliability of whatever information sharing tool was developed. The involvement of Hampshire County Council, IT Services opened up the opportunity to utilise existing information sharing technology in the shape of HantsNet (A county wide information database already used extensively by social services, local authorities and health authorities).

Discussions during the early part of 1991 culminated in the development of a "care group" approach to establish a mechanism to share both qualitative and quantitative data across agencies. The inter-agency group agreed that sub-groups should be established to undertake the task of pooling current data. All agencies agreed that by addressing information sharing in the context of care groups, e.g. Children and Families, the Elderly, would facilitate the development of a more focused approach and ensure that service planning and health promotion planning issues linked to that population group could be addressed. In February 1992 a Task Group was established to focus on information relating to Children. It was suggested that the development of a shared database around this client group would provide a model for application to other care/population groups. Membership of the group is outlined below:

Eastleigh Shared Information Project
Children's Task Group

- Healthy Eastleigh Co-ordinator
- Director of Public Health (Winchester Health Authority)
- Social Services Planning Officer (Hants County Council)

- Planning Officer - Education (Hants County Council)
- Information Officer - Public Health (Southampton and South West Hants Health Authority)
- I.T. Services Manager - HantsNet

The group achieved the establishment of a small scale prototype of a shared database focusing on information linked to Children's needs and services. Population data, indicators of need such as one parent families, children with learning difficulties, information on services for children represent examples of the data stored on the pilot database.

Outlined below are the results of the research undertaken into levels of collaboration achieved in the Shared Information Project. These will detail the outcomes of the analysis of documentary evidence and the interviews undertaken with project participants.

Research Results

2. ANALYSIS OF DOCUMENTARY EVIDENCE

A total of eight documents were analysed. The nature of the documents is outlined below:

Shared Information Group Minutes: 23-8-91 - Document 1
Shared Information Group Minutes: 6-9-91 - Document 2
Shared Information Group Minutes: 8-10-91 - Document 3
Children's Task Group Minutes: 7-1-92 - Document 4
Report of the Children's Task Group: 14-2-92 - Document 5
Report on Information Requirements: March '92 - Document 6
Report on Information Requirements: April '92 - Document 7
Shared Information Group, Agenda & Papers: May 92 - Document 8

For each item analysis was undertaken using the content analysis schedule outlined in Chapter Five. Outlined below are the key themes to emerge.

2.1 Type of Communication

Three of the documents are minutes of meetings linked to the Eastleigh Shared Information Project. Three of the items are reports relating to different aspects of the project, information requirements and a progress report from the Children's Task Group. The agenda and supporting papers of a meeting of the Shared Information group comprise Document 8 for this element of the research.

2.2 Target of Communication

All of the documents, with the exception of Document 3, were targeted at members of the Eastleigh Shared Information Project Group and members of the Children's Sub-Group. Document 3 was put together for a wider audience to include senior officers within the Health Authority, Social Services and the Local Authority.

Origin of Document

The origin of each document is outlined below:

Documents 1, 2, 4, 5, 6 and 8 were produced by the Deputy Director - Public Health, Winchester who played a key role in the project.

Document 3 comprises contributions from all the key officers participating in the project.

Document 7 was produced by the Healthy Eastleigh Co-ordinator.

2.3 Methods for Attaining Goals

Analysis of the documentary evidence indicated both positive features illustrating collaboration and less positive features. The key findings of this analysis are outlined below.

Attendance at the Project Group meetings would seem to indicate a high level of inter-agency commitment. Analysis of Documents 1,2 and 4 illustrated practical support in terms of Group participation, with representation from the lead participants in the project exhibiting high levels of participation:

- Southampton and Winchester Health Authorities
- Social Services
- Borough Council
- Hampshire County Council

However, involvement from Primary Care and the Family Health services was not apparent. It would seem that there was official sanction at a senior level within the organisations for those who were represented. For example, the Deputy Director of Public Health was the representative from one of the Health Authorities and this would seem to indicate a high level of support and management commitment to the project. In terms of joint planning of the project, evidence can be identified which illustrates both individual agencies taking a lead in elements of the work and a general awareness of the skills and potential contributions of the participating agencies across the group:

"3. A list of current projects by Southampton Health Authority has been documented, similar lists need to be drawn up by each agency so that:

- current projects that fit into the joint initiative project can be identified.
- reinventing the wheel can be avoided
- an overall view of resource commitment and impact of any new projects can be assessed".

Document 1

Evidence can also be identified which illustrates the adoption of a truly collaborative approach to project planning:

"Project Plan

Work had been done on identifying and prioritising a manageable number of prototype applications:

- The Elderly
- Child Accidents and Children with Special Needs
- Mental Health
- Coronary Heart Disease

After discussion it was proposed that the following applications should be selected for prototype development

- The Elderly
- Child Accidents and Children with Special Needs"

Document 2

Document 3 provided further illustration of a shared approach to planning and the development of the project. Outlined below is the format of a morning workshop to provide an overview of the need for a shared information project and illustrates a multi-agency approach.

INTER-AGENCY COLLABORATION

10.10	Inter-agency Collaboration Director of Public Health, Winchester.
10.40	Social Services Perspective Area Manager
10.55	Eastleigh Borough Council Health for All Project (Health for All Co-ordinator)
11.10	Coffee
11.25	Hampshire HantsNet I.T. Manager - Hants County Council
11.40	Geodata Institute's Role University of Southampton

The need for collaboration and the official sanctioning and commitment to the work can also be identified from the transcript of the presentation of Winchester Health a Authority at this event:

".....The Winchester Health Authority, Family Health Services Authority, Eastleigh Borough Council and the voluntary sector have formed a joint project group which brings together the different agencies in one particular locality.
In addition the health authority and Eastleigh Borough Council have a public commitment to the principles set out in the World Health Organisation Health for All 2000 initiative."

Document 3

Awareness of the respective roles/responsibilities and interests of the individual agencies is another feature of the documentation. For example, the range of issues identified in Document 2 for the Children's Project illustrates a recognition of the range of responsibilities of each agency:

" It was proposed that the project should cover:

- services for children with disabilities/special needs and should cover child accidents
- school age children
- current provision
- required and planned provision
- all services provided by all agencies, the private sector and voluntary agencies
- a resource inventory
- indicators of need
- use of resources"

Document 2

There was also clear recognition and domain consensus around the contribution of Hampshire County Council. The proposal of Hantsnet, a county information database, as the vehicle for holding the shared database, was recognised as an "expert" contribution to the Project group. For example in Document 3 explicit identification of the role of Hantsnet and Hants County Council can be identified:

"Hantsnet role - to act as a central filing cabinet for information from a wide range of sources and formats, to act as a vehicle for wide public service access to this information in a simple, standard way and to enable rapid communication between public service professionals".

Document 3

In terms of the information needs identified this also reinforces both network awareness and domain consensus in the development of this project. In Document 7, for example, the Health for All Co-ordinator identified a range of information needs which supported the potential health promotion dimension of the project "road accidents by ward and immunisation data" were identified as priorities for information sharing for the Healthy Eastleigh initiative.

Analysis of the documentation around project implementation revealed less evidence of an inter-agency approach. For example, Document 5, the report of the Children's Task Group, indicates that Winchester Public Health Department and the Hantsnet team are the key movers in progressing the work. This is particularly evident in terms of the development of the prototype and maintaining the momentum of the project. For example, in identifying the information individual agencies want it was clear that the task of pulling this information

together fell solely on the Public Health Department in Winchester:

"The participating agencies have put forward a list of the information about indicators of need relating to children that they want. These are being combined into a single paper (by Public Health) which will show areas of overlap and those areas that are particular to a single agency."

Document 5

Analysis of the documentation revealed a lack of financial investment to ensure the smooth progress of the project. This in turn may indicate a lack of commitment and sanctioning of the project in terms of resourcing.

2.4 Quantitative Analysis of Documentary Evidence

Outlined in the Schedule below is the quantative analysis of the documentation in terms of inter-sectoral collaboration.

TABLE 13

EASTLEIGH SHARED INFORMATION PORJECT - QUANTITATIVE ANALYSIS OF DOCUMENTARY EVIDENCE

DOCUMENT	TOTAL NO. OF SENTENCES	TOTAL NO. OF WORDS	INTER-SECTORAL COLLABORATION	
			SENTENCES (% OF TOTAL)	WORDS (% OF TOTAL)
DOCUMENT 1	39	415	16 (41%)	209 (50%)
DOCUMENT 2	50	980	31 (62%)	440 (45%)
DOCUMENT 3	Inter-agency	Workshop Programme		
DOCUMENT 4	34	630	28 (82%)	403 (64%)
DOCUMENT 5	30	540	28 (93%)	509 (94%)
DOCUMENT 6	Information	Needs Listed		
DOCUMENT 7	9	47	9 (100%)	47 (100%)
DOCUMENT 8	14	37	7 (50%)	19 (50%)

3. INTERVIEW RESULTS

Interviews were undertaken with four members of the project group, representing the main agencies participating:

- Information Technology Manager (County Council)
- Director of Public Health (Winchester Health Authority)
- Information Officer (Southampton Health Authority)
- Planning Officer (Social Services)

The key themes to emerge from the interviews are identified below.

Question One
Were there any particular incentives that influenced you/your organisation in getting involved in the Healthy Eastleigh initiative?

A number of key incentives for getting involved in the project were identified. These included an awareness of the need to share information and the common interest across agencies around information. The "cost effectiveness" of tackling the issue with other agencies was also identified as a priority. The need for information in the context of "Joint Finance and Joint Planning" was also proposed as a key incentive for information.

Question Two
What sort of commitment towards the Shared Information Project was there at the top level of your organisation?

Very high levels of commitment from the top level of their organisation were expressed by two respondents, with the other two suggesting official sanction was high.

Question Three

Does your agency have any particular values or beliefs which make inter-agency working important to it?

All respondents suggested that their host organisation had values and beliefs which made inter-agency work important to it. One respondent suggested it was an integral feature of his organisation's mission statement. The development of quality services was another "belief" supporting/promoting joint working. Key issues and commitment to Community Care and Joint Planning were identified as important values and beliefs supporting the development of this sort of approach.

Question Four

What were your organisation's priorities when you became involved in the project?

The following priorities were identified by respondents at the time they became involved in the project:

- Health for All and inter-agency working
- to foster better working relationships between agencies
- Community care and the Childrens Act
- Commitment to inter-agency working

Question Five

What sorts of qualities, skills, other factors do you think are important for inter-agency working?

A number of qualities and important factors were identified as being important to interagency working, these are outlined below along with the number of respondents expressing them.

- the need and desire to learn from other agencies (1 Respondent)
- Creating a non-threatening environment (2 Respondents)
- Being Clear and identifying objectives (4 Respondents)
- Being optimistic (1 Respondent)
- Having knowledge and understanding of other agencies (4 Respondents)
- Being a pioneer and having a vision of the longer term and a "bigger picture" of the potential of inter-agency work (2 Respondents)

When asked for question six if the qualities they had expressed had been a feature of the Shared Information Project, the response was mixed. The issue of clarity and the creation of clear objectives was identified by one respondent as being weak. On the whole the respondents felt that the qualities had to a greater or lesser extent been a feature of the Project. However, "having knowledge of the other agencies" was identified as perhaps weak.

Question Seven
How did you become involved in the project?

Two of the respondents had been initiators of the project, one had been introduced by a colleague and the fourth respondent had been instructed by their line manager to become involved. This would seem to indicate a high level of interest and commitment to the goals of the project.

Question Eight
How well did you know the other professionals/organisations involved in the project at the outset?

Only one of the respondents knew none of the project group when they became involved in the project. The other respondents knew one or two of the project participants from previous work.

Question Nine
Were common goals/objectives established?

Three of the respondents felt that either no or very vague goals were set from the outset. This would seem to indicate a lack of clarity underpinning the project.

Question Ten
Did all the professionals/organisations involved in the project share the same priorities at the outset? If not how was a common agenda established?

All four respondents expressed the view that none of the project participants shared the same priorities from the outset. Three felt that a truly common agenda was never really established.

Question Eleven
How important do you think it is for agencies working together to share common values and beliefs?

All four respondents indicated that they felt it important for individual agencies to share common beliefs. One suggested that it means "you get more out of the joint working more quickly".

Question Twelve
Do you feel there was a shared understanding of what individual agencies involved in the project could contribute to project objectives?

All the respondents felt that there was not a really clear understanding of what individual agencies could contribute to in the project.

Question Thirteen
How were key stages of action agreed by all the agencies participating? How easy/difficult was the process?

Consensus was identified as the key way by which key areas of action were agreed. One respondent compared this process to "pulling teeth". There was an indication from all of the respondents that this had not been an easy process.

Question Fourteen
Were lead agencies/fieldworkers identified for specific areas of action?

All respondents suggested that lead agencies were identified for elements of the work. One respondent indicated that they felt, however, that this resulted in just one or two of the participants in progressing the project, creating an imbalance in the joint working approach.

Question Fifteen
What was your own/your agency's role in the project?

Time investment in terms of chairing meetings, developing prototypes and communicating back to other colleagues were identified by the respondents.

Question Sixteen
What kinds of resources is your organisation putting into the project?

Staff time and expertise were identified as the main resource investments by the respondents.

Question Seventeen
Do you feel everyone has played their part in contributing to the implementation

Only one respondent suggested that not everyone had played their part. The other three respondents whilst suggesting that they felt everyone had played their part, suggested that the true contribution of each agency had not been clarified or maximised.

Question Eighteen
Have there been any difficulties in implementing action? What are these?

A number of difficulties were identified by the respondents, these spanned the following issues:

- lack of resources, time, money
- lack of clarity and understanding
- Unsystematic approach

Question Nineteen
Has there been a shared vision of what the individual agencies/fieldworkers can contribute in terms of activity?

Apart from the role of I.T., all the respondents felt that there had not been a shared vision of what individual agencies could contribute. In particular comments were made about the lack of clarity of the potential role of individual agencies.

Question Twenty
Have there been early successes/results to the project?

The development of the Childrens Database Prototype was identified by all the respondents as an early success. The establishment of the two sub groups for Children and the Elderly was identified by one respondent as an indication of success.

Question Twenty One
Do all the agencies involved in the work communicate with each other?

Two respondents suggested that not all the agencies communicate with one another outside the project group meetings. They felt this impacted and contributed to the slow progress being made.

Question Twenty Two
How frequent are the contacts between those involved?

The frequency of contact was identified as being approximately two monthly at the project group meetings. This, it was suggested impacted on both levels of trust and understanding between those participating and contributed to the slow progress.

Question Twenty Three
Is the project meeting its original objectives?

The lack of clarity of the objectives of the project was identified by the respondents as a key issue in response to this question. One respondent suggested that the broader aims of wanting to explore the possibilities of information sharing across agencies had been discussed. However, the identification of specific, long term outcomes was more difficult to gauge.

Question Twenty Four
Are the goals/objectives of individual agencies being met through this joint working?

All of the respondents felt that information sharing was a priority for their individual agency. Doubts were expressed, however, about the extent to which the project had progressed far enough to actually contribute to the individual objectives of their agency.

Questions Twenty Five and Six
What are you achieving together? Do you consider the work to be of long term benefit?

"Putting information sharing on the local agenda" was identified by one respondent as a key achievement of the project. Another identified: "getting to know other agencies information needs" as an achievement of the project. The long term benefits of the initiative were more difficult for respondents to identify. One respondent summed up this difficulty:
" I suppose the long term benefits of this project are dependent on individual agencies investing time and money in setting up the technology for information sharing to happen".

4. DISCUSSION AND SUMMARY

The research into the Shared Information Project has identified both positive and negative features in terms of progress. The identification of information sharing as an important issue across agencies to assist in both operational and strategic planning illustrates effective levels of collaboration. However, in terms of moving the initiative forward a number of difficulties were identified. The lack of clarity of objectives appears to have undermined progress. The efforts to focus on

individual client groups, for example Children's Services, represents an attempt to set targets for action. However, the issue of available time to invest in the project on the part of individual group members was identified as a problem. The way in which the findings of the research have supplemented/expanded the model of effective collaboration proposed in Chapter One will be explored further in Chapter Twelve.

REFERENCES FOR CHAPTER TEN

Winchester Health Authority (1991) Shared Information Group Minutes 23-8-91

Winchester Health Authority (1991) Shared Information Group Minutes 6-9-91

Winchester Health Authority (1991) Shared Information Group Minutes 8-10-91

Winchester Health Authority (1992) Children's Task Group Minutes 7-1-92

Winchester Health Authority (1992) Report of Children's Task Group 14-2-92

Winchester Health Authority (1992) Report on Information Requirements

Winchester Health Authority (1992) Report on Information Requirements

CHAPTER ELEVEN

THE RESEARCHER AS FULL PARTICIPANT OBSERVER

The research design outlined in Chapter Five indicated that the researcher was a full participant in the Healthy Eastleigh initiative in her role as Healthy Eastleigh Co-ordinator. In Chapters 6 to 10 the results of the interviews and the content analysis of documentation were outlined, focusing on five projects. In an attempt to triangulate and to increase levels of internal and external validation, full participant observation is the third research method which needed to be employed. This will be used to complement the other research methods employed and provides the opportunity to utilise the subjective observations of the Healthy Eastleigh Co-ordinator. Outlined below are the main themes to emerge from the unstructured observations of the researcher. These focus on the five projects and refer to the key features of inter-sectoral collaboration proposed in Chapter 1. The observations are the culmination of notes and comments collated by the researcher in the course of the development of each project. For each of the projects an attempt has been made to glean and structure the observations around what has worked and approaches that have been less effective. It is anticipated that this data will illuminate further both levels of collaboration and act as a counter-balance to the outcomes of the research identified in previous chapters.

1. COMMUNITY PARTICIPATION PROJECT

A number of positive features were identified from participant observation which illustrate high levels of inter-sectoral collaboration. These are identified under five key headings below.

1.1 Official Sanction of the Project.
1.2 Agency Participation.
1.3 Contributions of Individual Agencies.
1.4 Practical Support.
1.5 Resource Investment.

1.1 Official Sanction of the Project

In the development of the Community Participation Project a high level of support from members of the Healthy Eastleigh Steering Group and Joint Committee was observed. A commitment to community participation as a key theme of the Initiative was expressed by the committee members. A clear statement of this work as a high priority in terms of policy was identified.

The project proposal was approved by the Steering Group members and implicit in this was the support expressed in Group meetings for the proposed approach to involve local residents. Positive comments in terms of official sanction were recorded.
For example, reference to the need to consult with local people was expressed as an Authority priority by the health authority representatives. From the local authority perspective it was suggested that identifying local needs and involving the community was in keeping with the approach to develop tenant's associations being adopted by the Housing Department.

In practical terms the Steering Group committed resources for publication, printing and postage costs for the survey of local residents. It was observed that this conveyed to the fieldworkers that the approach was valued by managers both strategically and operationally.

1.2 Agency Participation

The sustained participation of those involved in the Project Group, comprising fieldwork staff, and the enthusiasm expressed by those who involved in the initial workshop for fieldwork staff represents a high level of inter-agency commitment. At the initial workshop an "enthusiasm" and a willingness to be participate on the part of local staff was observed. A feeling of commitment was recorded.

In the establishment of the Project Planning Group, as a result of the Workshop, continued commitment of fieldworkers was observed. Attendance at the Group meetings and the informal contact between meetings indicated a willingness to be involved and a commitment to work with other agencies. The presentations at and participation in the public meetings that were held with the local community, indicated further joint working. Informal contact between the participant observer (the Healthy Eastleigh Co-ordinator) and the agencies participating indicated a willingness to support the project and "work together" and to convey a "united front" to the local residents. Perceptions of a "shared vision" of where the project was going and what could be achieved together were noted.

The inter-agency approach was particularly evident at the first public meeting. The purpose of the meeting was to share the results of the health needs survey with the local community.

A "united front" across the agencies involved was observed. The willingness of members of the Project Planning Group to attend and play a part in the presentation of the results of the survey was

particularly striking. For example, presentations were made by the Health for All Co-ordinator, the health visitor participating in the project, the Crime Prevention Officer from the local police station, the adult education organiser from the local school and the general secretary from the local council of community service. This conveyed both the holistic approach being adopted to identifying local health needs and the practical commitment of local services.

1.3 Contributions from Individual Agencies

The notion of "reciprocal trading" and individual agencies being clear about their role and how the project could support their activities/objectives was identified through unstructured observation. Individual agencies also identified support for their own organisational objectives. Instances were identified where working on the Community Participation Project could facilitate the development of sole agency goals. For example, a health visitor involved in the project commented that her involvement in the project would assist in the establishment of her First Time Mothers Group. Statements around how the projects could support the development of other health related initiatives were noted. For example the potential stimulation of community interest in crime prevention initiatives was noted by one project participant. Participation by the local housing officer housing assisted both in identifying issues linked to housing and health and supported the work the housing department was progressing in setting up local housing forums.

Not all of the observations made relating to the Bishopstoke Project are as positive. Outlined below are some of the more negative features observed in relation to inter-sectoral collaboration. These once again are outlined under specific themes.

1.4 Practical Support

The chairing of the Project Planning Group and minute taking and administration linked to the project was consistently undertaken by the Healthy Eastleigh Co-ordinator. On a number of occasions it was indicated that the mantle of responsibility for these functions would be willingly passed to other members of the group. A resistance and unwillingness to take on these roles was observed. Informal interaction with members of the Group indicated that their involvement was in addition to their normal workload. No additional time from their host agency was forthcoming to help promote this inter-agency approach. The mailing and administration of both the questionnaires sent to a sample of households and the letters sent to every household in the Bishopstoke area fell to the local authority. Invitations by the Health for All Co-ordinator for help and support were met favourably, however time constraints on those participating prevented a sharing of this work. The lack of "contractual" commitment in terms of staff time on the part of the agencies participating was observed.

1.5 Resource Investment

Staff time was committed to the project in terms of attending project group and public meetings. However, unstructured observation and discussion revealed that this was not met with a commensurate reduction in other areas of work for the fieldworkers. For example, the health visitor and the housing officer still had the same client caseload to contend with as well as participating in the project. In addition to this the procurement of resources to support administrative costs and pump priming for the activities to come out of the project, proved long winded and cumbersome.
Whilst at the initial stages of project development the

need to identify resources was agreed by the Healthy Eastleigh Steering Group, in practical terms securing resources happened through informal interactions between agencies and in a piecemeal way. For example, the funding for the hire of the school hall for public meetings had not been allocated at the outset. This meant that negotiation on the cost and the budget from which this allocation would be resourced proved to be protracted.

2. HEALTHY SHOPPING SCHEME

The positive features relating to the development and implementation of the Healthy shopping Scheme from the unstructured observations of the Healthy Eastleigh Co-ordinator are identified below under five headings:

2.1 Official Sanction.
2.2 Multi-Agency Approach to Project Development
2.3 Domain Consensus
2.4 Practical Tasks
2.5 Scheme Implementation

2.1 Official Sanction

Expressions of commitment to the aims and objectives of the Healthy Shopping Scheme by the Steering Group were observed. The proposal to involve local food retailers in the promotion of healthy eating messages was one which appealed across the agencies participating in Healthy Eastleigh. The reports submitted to the Steering Group outlining the proposed initiative were met favourably. Collectively and individually the partner agencies identified the benefits of addressing healthy eating. For example, the health authority representatives expressed the positive comments around the way in which the project would contribute to Health of the Nation

targets. The social services representative identified the promotion of healthy eating specifically focusing on the needs of those on a low income as an area they were particularly interested in.

2.2 Multi-Agency Approach to Project Development

The lead in the development of the project proposal and securing the funds for the initiative was taken by the local authority. However, high levels of commitment and collaboration from other agencies, particularly the Health Promotion service in Southampton were observed in the developmental stage of the project. A sense of joint ownership and commitment to the project was observed from the early stages. A willingness and enthusiasm to participate was clearly identified. The investment in terms of time from the key partners in the project was evident. For example, a high level of consultation took place across the agencies in the development of the application to Wessex Regional Health Authority for project funds. Whilst the application was compiled in draft form by the Health for All Co-ordinator, comments were sought from the other agencies in expanding and refining its content.

2.3 Domain Consensus

Positive observations were made in terms of the inter-actions between members of the Project Group. In particular the recognition of the roles and skills of the individual fieldworkers involved in the project was observed. There was also an indication of trust/enthusiasm in the adoption of a multi-agency approach to an initiative focused on nutrition. For example, the commitment of graphics expertise was provided by the Health Promotion Service to produce the scheme materials and an exhibition to support the launch

of the scheme. This was provided free of charge and came about as a result of co-operation between the agencies. The key role and the expertise of the community dietitians was acknowledged by all the members of the Project Group. This was evident in both the development of the resource materials and leaflets for local shoppers and shop keepers and in the visits made to participating stores to explain the aims and objectives of the scheme.

Good working relationships across the members of the Healthy Shopping Group were also observed. There was an atmosphere of openness and trust at project group meetings. The visits undertaken to the stores by Project Group members also facilitated the development of a team approach and a practical approach to joint working.

As a counter-balance to the comments outlined above, a number of less positive features have been identified through unstructured observation. These have been identified below under two key themes: Practical Tasks and Scheme Implementation.

2.4 Practical Tasks

Observations were made concerning the practical tasks of chairing and minuting project group meetings. The responsibility rested with the Healthy Eastleigh Co-ordinator and this, it may be suggested, impacted on the true sense of inter-agency ownership of the project. It was clear that constraints on time and other work pressures prevented other members of the group taking on the responsibility. For example, the responsibility for both circulating the minutes of meetings and maintaining information about the progress of the scheme and data on those stores participating rested with the Health for All Co-ordinator.

2.5 Scheme Implementation

The responsibility for co-ordination of store visits and the compilation of resource materials rested initially, entirely with the Healthy Eastleigh Co-ordinator. As the scheme developed, however, members of the project group took on more responsibility in terms of undertaking visits and the Community Dietitians in particular began to assume a vital role in the scheme. However, in terms of long term monitoring of the food shops participating in the scheme, less clarity was observed in terms of how and who should best take on this responsibility. The problems of conflicting priorities in terms of the demands on time on the staff involved in the scheme was observed. The lack of clear contractual commitment to the project was apparent, a conflict and work overload on the part of those involved in the project could be identified. For example, discussions in the project Group meetings revealed that the Community Dietitians and the Health for All Co-ordinator were the only participants who could commit time to undertake store visits on a regular basis.

3. SMOKING PREVENTION PROGRAMME

The Smoking Prevention Programme represented an alliance between the local authority, N.H.S. Health promotion Units and the retail sector. Four key themes from the unstructured observations are identified below in terms of positive and negative features.

3.1 Multi-Agency Programme Development
3.2 Changing Work Practice
3.3 Contributions of Individual Agencies
3.4 Time Constraints

3.1 Multi-Agency Programme Development

A sense of a joint approach to identify both smoking as a problem and the need to develop a programme in Eastleigh was observed. There appeared to be a simultaneous recognition of the problem and the need to do something about it at a local level. This appeared to assist the development of joint ownership of the project aims and objectives. For example, the Public Health Departments in each of the health authorities had identified reduction of smoking prevalence as a key priority in improving the health of the local population. The importance of smoking policy development had also been identified by the teacher adviser on the group as a priority for schools.

In the development of the programme and in particular in designing the research tool for the establishment of baseline data, an enthusiasm to work towards shared objectives was observed. There was also a sense of embarking on a new way of working, a sense of adventure into the "unknown": and a shared commitment to undertaking and implementing the programme. The strong links with the local authority and the health promotion services in Winchester were particularly evident in developing the project. In terms of the links with Education, there was a clear commitment and willingness to integrate smoking prevention activity into life-skills teaching and onto the agenda of a "whole school" health policy.

3.2 Changing Work Practice

The direction of the work particularly in the context of workplace catering establishments and smoking policy development seemed to indicate a wish to integrate the issue of smoking into mainstream activity. An enthusiasm

to work in an innovative way was observed. For example, the potential role of the environmental health officers in raising smoking as an issue in the course of their visits to catering establishments was explored. The issue was discussed through the Environmental Health Management Team in the local authority and a willingness to change current work practice as a means of supporting the project objectives was observed.

3.3 Contributions of Individual Agencies

An "easiness" of working together was observed which allowed for the individual partners involved in the project to have their contribution valued and recognised. There was an openness and trust about what the individual participants could undertake. Good working relationships between those participating in the Programme were identified as a source of facilitating the development of ideas and a vision for the work. The strong links between the Health Promotion Service in Winchester and the Health for All Co-ordinator were a particular feature of this effective joint working. The establishment of a "shared vision" for the work and how and what the programme was aiming to achieve was observed. This was facilitated by the investment of a considerable amount of time in developing both the programme outline and in securing the commitment of the Steering Group and the Joint Committee.

3.4 Time Constraints

The key constraints to collaboration focus around observations linked to lack of time. The addition of this activity on to the packed agendas of those participating in the Programme, led to observations about pressures on time and resourcing. For example, the outcomes of the telephone survey identified a need to

support the development of smoking policy in local workplaces. The lack of committed health promotion specialist time to devote to health promotion at work was identified as a barrier for progressing this part of the project. The complexity of addressing smoking in schools also revealed a potential shortfall in terms of staff time. For example, it was suggested that to address both the integration of activity into the curriculum and the establishment of No Smoking policy in schools would require considerable input from both the teacher adviser and health promotion specialists.

4. HEALTH PROMOTION GROUP

Once again in line with the observations around the three projects above, positive and negative features linked to inter-sectoral collaboration have been observed by the Healthy Eastleigh Co-ordinator. These are identified below under six headings.

4.1 Multi-Agency Commitment
4.2 Community Awareness
4.3 Range of Health Issues
4.4 Time Constraints
4.5 Lack of Resources
4.6 Knowledge of Effective Interventions

4.1 Multi-Agency Commitment

Observations identified that in an incremental way attendance and participation in the Health Promotion group began to increase and levels of multi-agency participation and "ownership" began to improve. Attendance and participation in the meetings to plan group activities illustrated increased involvement and ownership by the fieldworkers involved. For example, the Information Exchange item on the agenda for Group

meetings was observed as a key opportunity to identify areas of common interest across the project participants and to agree issues for future joint working. In the implementation of group activities increased involvement across agencies was observed. For example, the information stalls held by the Group in the local shopping centre were increasingly co-ordinated by the agency with the most input to a particular health issue. The community dietitian co-ordinated those events with a healthy eating focus and the local drugs and alcohol advisory service took the lead where their expertise was appropriate.

4.2 Community Awareness

An agreement and consensus in terms of local needs was observed from the Group meetings. The fieldworkers shared a common understanding of local health problems and the appropriate interventions for the community. This was reached by the Group considering information drawn from across the agencies involved. For example, the Public Health Reports and the local Social services plans were consulted as a means of identifying local priorities. The fieldworkers participating in the Group also had the opportunity to identify issues they considered important from their experience working with the local community.

4.3 Range of Health Issues

The broad range of health issues discussed and addressed in terms of group activities illustrated high levels of inter-agency collaboration. A willingness to explore a broad range of issues, encompassing the interests and skills of all members of the Group was observed. A good level of interaction and exchange of expertise and

knowledge was observed. Increasingly, the activities of the Group utilised the rich range of skills available. For example, the process of identifying lead individuals for particular initiatives and health issues was particularly helpful. Examples around the promotion of healthy eating and health promotion with young people highlight the effectiveness of this approach. The youth service played a key role in any group activities aimed at promoting the health of young people. This ensured that the interventions were appropriate and built on the initiatives already underway for young people in the Eastleigh area.

Outlined below are some of the more negative features linked to collaboration gleaned from participant observation of the activities of the Health Promotion Group.

4.4 Time Constraints

The lack of time available to Group participants to allocate to Health Promotion Group activities represents a key problem. The need for time which has been officially agreed to allow the involvement of fieldwork staff in inter-agency health promotion activity has been identified from the analysis of documentary evidence and from the interviews with staff. This is reinforced by the observations of the researcher. For the majority of the participants in the Health Promotion Group their involvement is an "add on" to their mainstream role. The restrictions on time impacted on the activities of the Group, from both planning activities through to their final implementation. For example, for a number of the group members participation on the local health stalls proved difficult. Client caseloads of individual group members had not been reduced to take account of their involvement in the Group and this sometimes prohibited

the development of a truly inter-agency approach to the Group's activities.

4.5 Lack of Resources

Linked to the issue of time is the scarcity of resources for the successful implementation of the activities of the Group. Observations revealed that there was no budget allocated specifically to pump prime the activities of the Group. This meant that time was spent trying to innovatively accrue allocations from other sources. For example, in launching the Group's health stalls in the local shopping centre, a good deal of time and energy was invested in obtain sponsorship from local shops to buy materials and resources required. Equally, lack of financial resources impacted on the development of a cohesive identity for the group. The professional production of leaflets and promotional materials is costly. As a result the group relied on very limited promotional materials.

4.6 Knowledge of Effective Interventions

Lack of knowledge about effective interventions in health promotion practice was observed as an inhibitor of group activities. The development of the market stalls and the involvement of a multi-professional group in health promotion practice highlighted the need for a sound theoretical base to assist planning effective health promotion practice. For example, the skills and approaches required to engage the local public in discussion about health issues in community based settings was an area around which more direction was required. The appropriate skill mix required for multi-agency approaches to health promotion was another area around which there was little information. This would have been of particular assistance in the development of

a planned approach to the involvement of individual fieldworkers.

5. SHARED INFORMATION PROJECT

Unstructured observation of the Shared Information Project revealed, as it has done for the other areas of work, a range of positive and negative themes around inter-sectoral collaboration. These are outlined under key headings below. From a positive perspective, observations revealed themes of high levels of participation, a common interest in sharing information and a strategic vision to the issue of information sharing.

5.1 Enthusiastic Involvement

Observations revealed that there was an enthusiasm on the part of project participants to be involved in the initiative. There was a common understanding of the aims and benefits of information sharing and a willingness to be involved. Linked to this was the need for a strategic, long term vision of the benefits of this approach. This was observed as a key feature of group discussions and the initial rationale of the project. The levels of inter-agency participation at the project meetings were a key example of the enthusiasm and interest in the issue.

Negative observations in terms of inter-sectoral collaboration focused around two key themes:

5.2 Lack of Clear Objectives
5.3 Time Constraints and Lack of Resources

5.2 Lack of Clear Objectives

The need for clearer objectives with specific outcome measures and time scales was revealed from observations of the activities of the Group. The difficulties experienced in progressing the project were due to a great extent to the lack of clarity in terms of aims and objectives. The identification of an action plan which identified milestones for the project would have assisted considerably and facilitated more focused, dynamic discussion in the project group. The work around information linked to services for children, for example, would have been facilitated considerably by the development of an action plan which identified both outcomes and the agency participation required.

5.3 Time Constraints and Lack of Resources

The lack of allocated time for the project and for those participating was observed as a key factor in impeding progress. The staff involved in the Project were, in common with the observations of the other projects above, adding this area of work on to an already busy agenda. The need for a designated co-ordinator, with contracted time for the role would have assisted in this and perhaps ensured that a momentum for progressing the work was sustained.

A lack of resources in terms of financial pump priming for the project was observed as a constraint on progress. The development of the shared database was a key focus for the development of the project. This had been progressed "free of charge". The need for finances for both staff time and non-staff costs was observed as a key feature in assisting or impeding the further development of the project.

6. CONCLUSIONS

Outlined above are the positive and negative features linked to inter-sectoral collaboration identified through the observations of the researcher. The participation of the researcher in the Healthy Eastleigh initiative has yielded a number of observations as an "insider". The subjective comments identified above have been counter balanced by the research findings from both content analysis and interviews. It is proposed that the employment of a number of methods has allowed for a richer range of data to be studied. The findings from the observations outlined above and the way in which they supplement and expand the viable model of inter-sectoral collaboration proposed in Chapter One will be explored further in Chapter Twelve.

CHAPTER TWELVE

FINAL DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

In Chapters 6 - 11 the results of the research undertaken into inter-sectoral collaboration and the Healthy Eastleigh Initiative were outlined. This chapter will focus on two key areas to be studied in separate sections:

- Conclusions on how the projects performed against the model of inter-sectoral collaboration proposed in Chapter One.
- Recommendations to emerge from the research, which expand and identify additional features to the viable model for inter-sectoral collaboration proposed in Chapter One.

2. PERFORMANCE AGAINST THE MODEL IN CHAPTER ONE

In Chapter One a model comprising five key features was proposed for effective joint working. The review of findings and conclusions for each of the five features are set out below.

2.1 Official Sanction

Each of the projects had been sanctioned by the Healthy Eastleigh Steering Group and the Health for All Joint Committee. The membership and terms of reference of these two groups are outlined in Chapter Two. The process for sanctioning comprised the presentation of a brief report outlining the main parameters and objectives of the area of work. The research confirmed that for the five key areas of work, official sanction was sought and

obtained from the management committees for the initiative. On the positive side, therefore, the research across the projects has revealed a high level of expressed support from both the Healthy Eastleigh management structure and the partnership agencies. For example one of the respondents interviewed from the Community Participation Project suggested that:

"Knowing we had the support of the management group provided us with the confidence to work together and development a community development approach".

It emerged from the research that whilst the individual members of the committee's may have expressed support, it did not necessarily follow that the "host" agency of project participants would be fully supportive of or get to know in detail about the main elements of the individual project. For example, the development of the Shared Information Project was supported in principle by the Healthy Eastleigh partnership agencies. However, support in terms of resource commitment was less evident. Analysis of documentary evidence indicated a lack of resource investment in the project to facilitate the achievement of project objectives. Those interviewed also indicated a lack of resources as a real problem, with one respondent suggesting that she felt that:

"If services really wanted to make headway in this area money for both staff time and the required computer technology would need to be forthcoming".

The results of the research into the Health Promotion Group indicated that whilst on a superficial level "sanction" was forthcoming, for the fieldworkers the collaboration was as a result of "goodwill" and "commitment" rather than the commitment of additional staff time. For example, one of the group members

interviewed suggested that the good working relationships prevailing between group members had been of vital importance:
"The fact that we seemed to work together well made up for the lack of resources and also made you want to participate in whatever way you could".

The view was also expressed that group members were disinclined to "let each other down" and this added to the commitment of those participating.

The exception to this was the allocation of additional health visiting time to support the co-ordination of Group activities. However, across all five projects the prevailing theme of joint working as an "add on" to existing work was identified. The degree to which this was the case varied across the projects. For example, the Smoking Prevention Programme Project developed as a more,long term strategic area of work and as a result issues of resourcing were more meaningfully addressed. By contrast, however, the Healthy Shopping Scheme, Community Participation Project and the Health promotion Group operated at fieldworker level and as a result the influence individual participants could exert in the procurement of additional resources appeared to be more limited.

The themes of "sustainability" and "continuation" of the areas of work were linked tc research findings around official sanction. The explicit support for areas of work by the agencies through the Steering Group and Joint Committee ensured sanction at a strategic level. However, at operational/fieldwork level, and in particular for the three more operational projects, the Community Participation Project, the Healthy Shopping Scheme and the Health Promotion Group, the results of the interviews and content analysis revealed the key importance of

personalities, inter-personal skills, co-operation and flexibility. From this it would seem that unless the same set of "players" remained, the lack of "structural sanction" and the limited allocation of contracted time would threaten the sustainability of areas of work. For example, the research findings from the interviews with those involved in the Smoking Prevention Programme indicated that the fact that each of the participants had worked closely together previously had played a major role in the development of the project. Comments from interviews with participants drawn from across the projects indicated the importance of previous contact or experience of working together in the past. For example one of the respondents from the Healthy Shopping Scheme indicated:

"A couple of us had worked together previously, that always helps".

Doubts were also expressed around whether the work would continue if they moved on. One of the participants in the Community Participation Project suggested that:

"Not everyone in my role would see the importance of work like this.....if I moved on I'm not sure that they'd see it as important the service to be represented on the project".

By contrast the members of the Shared Information Project Group had, for the most part, no previous experience of working together and their involvement was in addition to their normal role. This impacted on the extent to which the momentum of the project was sustained.

2.2 Multi-Agency Programme Development

Each of the projects researched exhibited levels of

inter-agency approach to programme planning and implementation. It was clear from the investigation that for some projects there was the necessity for more agencies to be actively involved than for others. For example, the broad agency representation achieved on the Health Promotion group indicated high levels of collaboration. However, by contrast, the Smoking Prevention Programme required a small core group of individuals with the facility to draw on other agencies as appropriate.

In terms of agreeing plans, it is clear from the responses from those interviewed from the Health Promotion Group that a consensus approach was achieved. This was ensured through the multi-agency attendance at meetings and the levels of participation. One respondent suggested that:

"Agreeing both the issues we're going to address and how best to tackle them is not a particularly difficult process. Discussion takes place at the Group meetings and generally, those taking a lead role move the planning forward and link up with Group members as appropriate".

However, in terms of the development of the Healthy Shopping Scheme and the Shared Information Project, there was a sense that one agency took the lead and proposed the substance of the collaboration. This, it may be suggested reduced levels of inter-sectorality in the development and implementation of areas of work. Both the content analysis of documentation and the interviews undertaken with those participating, highlighted this problem in relation to the Shared Information Project. For example, one of the participants interviewed expressed the view that:

"We didn't play a leading role. I'm not sure that my

service contributed very much to moving the project forward. All the real work was done by the health authority and the I.T. services".

The research illustrated that in the context of project implementation, not all of those interviewed felt that a truly inter-sectoral approach had been achieved. For example, whilst the respondents participating in the Healthy Shopping Scheme felt that "everyone had played their part", the respondents from the Health Promotion Group indicated that not everyone had contributed the same amount of time to the business of the Group. For example, in maintaining the momentum for the health stalls it was suggested that one or two members of the Group played the lead role. One of the participants interviewed suggested:

"That if it weren't for the sustained effort from..... and ....., I'm not sure the stalls would happen every month".

In terms of the Community Participation Project it was also felt that a small group involved in the Project took the lead in terms of co-ordination. The issue of lack of time on the part of project participants was once again a theme influencing successful project implementation. Analysis of the documentary evidence confirmed that one or two project participants took the lead and did all the "donkey work", as one of the respondents suggested. The addition of an involvement in the Healthy Eastleigh Initiative to their contracted role was a recurring theme which emerged from the research into each of the projects. The willingness of individuals to participate in an inter-agency approach, as opposed to being funded to be involved was another recurring theme. This in turn influenced the levels of involvement in implementation. It also accounts for some of the negative responses expressed when participants were asked about levels of involvement overall.

The development of inter-agency objectives for the work emerged as an important issue linked to project development and implementation. The identification or lack of direction linked to areas of work and objective setting was raised as a theme which helped/hindered project implementation. For example, in both the Health Promotion group and Shared Information Project group, a lack of clarity in terms of aims and objectives was identified as impacting on the smooth implementation and sustained momentum for the work. For example one of the respondents interviewed suggested that the Shared Information Project lacked:

"Sufficient focus or direction. This makes you feel we're

going over the same ground every time we meet as a group."

By contrast the research into the Healthy shopping Scheme indicated that there had been clear objectives and that this had facilitated the implementation of the project and the achievement of successes early on. Analysis of the documentation for the project identified a clear set of aims and objectives which were defined in the early planning stages for the project. Those participating in the project also indicated that this was a positive feature of the work. One participant suggested that:

"We've known what we've been trying to achieve from the outset and this has helped us define what we need to do and what our individual roles should be".

2.3 Domain Consensus

The enquiry into levels of "domain consensus" and levels of understanding across the projects about the potential contributions of individuals/professionals to areas of

work revealed interesting contrasts. For example, in terms of the Healthy Shopping Scheme and Shared Information Group, both content analysis, interviews and participant observation indicated high levels of awareness of the skill mix within the project groups. Comments expressed by participants from each project indicated a high level of understanding of the roles of individual professional:

"Its essential to have the dietitians involved in the scheme. We couldn't undertake the store visits and advise on the healthy options without their expert advice".

"The I.T. experts from the County Council have a key role to play. We can identify the sorts of information we want to share, but shaping it into a database is beyond our expertise".

The clarity of the contribution and function of the community dietitians, identified in the first quotation above, exemplifies this in the research into the Healthy Shopping Scheme. This assisted in operational terms the speedy implementation of the project during its first phase. The expertise from the Information Technology Department assisted in the development of the Shared Information Project. However, in the case of the Health promotion group anxieties were expressed by those interviewed about the low levels of awareness about each others role and from this the potential contribution of individual participants to the work. For example one of the interview respondents participating in the Health Promotion Group suggested:

"I'm not sure we know exactly what our individual roles are. This could mean we're not using each other to the full!"

2.4 Shared Vision and Commitment

The development and maintenance of a shared vision across all five projects was another focus for the research. Once again this revealed it had been achieved to a greater degree in some areas of work than others. The clear objectives of the Healthy Shopping Scheme seemed to ensure that there was a shared vision across the agencies. For example, the content analysis revealed a clear set of objectives for the work and the interviews undertaken with project participants indicated a high level of clarity:

"We're clear about what we're trying to achieve and how we want to get there. This helps, particularly as we don't see each other every day".

By contrast the Shared Information Project and Health promotion group indicated that this was not a feature of the project. For example, the content analysis of the documentation relating to the Shared Information Project and the comments noted from respondents reinforced this:

"I don't think we've all got the bigger picture of what we're trying to achieve. This has definitely made progress a lot slower".

The participants in the Community Participation Project identified that the project supported the achievement of the objectives of their own agency, however, the long term commitment to this way of working was less clear. For example, one Project Group member suggested:

"I'm not sure that if I left the ..... Service would think it was a good idea for my successor to become involved in this sort of work, I don't think the time would be available".

2.5 Network Awareness

In terms of network awareness and the formalisation of collaboration, each of the five projects would seem to have achieved high levels. The project groups established for the Healthy shopping Scheme and the Shared Information Project, for example, reported back to the Healthy Eastleigh structure in the shape of the Steering Group and Joint Committee. Content analysis of the documentation relating to the projects indicated a high level of formalisation of the project group discussions in the shape of minutes of meetings and project proposals. There appeared to be a high level of awareness from project participants of the "networks" that they tap into and the reporting mechanisms for progress. For example, one of the participants in the Health Promotion Group suggested:

"As well as participating in the Group in my own right, I'm involved so that I can keep my service informed about what is going on. I try to share information about the Group's activities with the other professionals I work with".

Informal networking between project participants, however, varied across the projects. For example, the participants of the Smoking Prevention Programme identified a high level of informal networking between those involved. This facilitated the development of the work. However, in the case of the Shared Information Project contact between the formal meetings was limited and it was suggested this reduced both collaboration and project progress. Participant observation and the comments expressed by those interviewed reinforced this:

"One reason why progress is slow is perhaps because we all have busy workloads and the contact between meetings

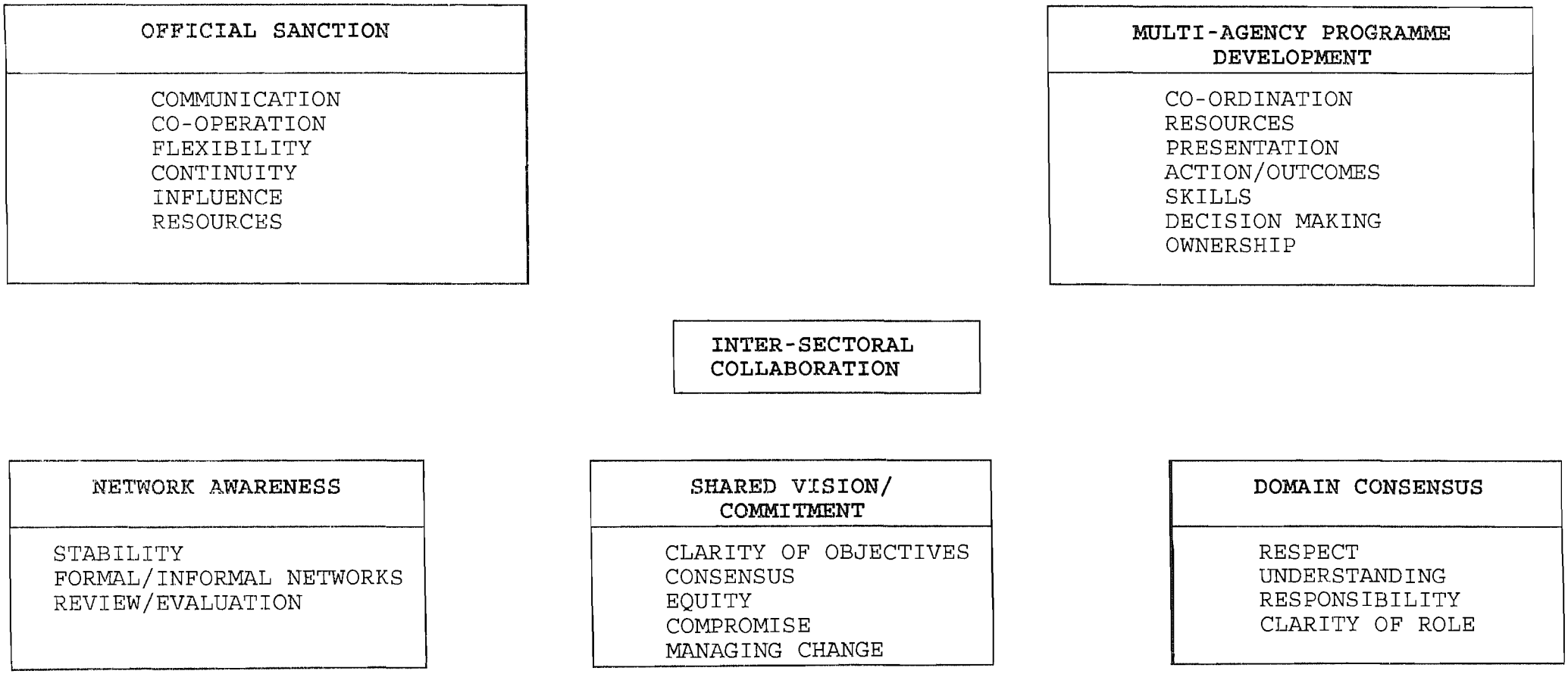
is limited. This can lead to a feeling that you're starting from scratch again when we meet as a group".

3. EXPANDED VIABLE MODEL OF INTER-SECTORAL COLLABORATION

Section 1 focused on an examination of the research related to the model proposed in Chapter 1, comprising five key features. The research undertaken into the five projects in terms of content analysis, interviews and observation has expanded this initial model proposed in a way that supplements and extends the five features proposed at the outset. The emergence of a viable model comprising a number of sub features concealed within each of the original features is proposed. The extended model is outlined below. An attempt will be made to propose/relate these additional features as a component part of the original model. A summary of the additional characteristics is outlined below. The rationale/ justification of these will be explained subsequently.

FIGURE 4

EXPANDED VIABLE MODEL FOR EFFECTIVE COLLABORATION



3.1 Official Sanction - Additional Features

Communication within and across participating agencies was identified as an important theme. For example, the recurring theme in response to the question on the key skills/factors for effective collaboration was communication, i.e. close and effective communication. This was a response identified across all five projects and emerged from both interview and from participant observation. On further enquiry it was found that this response was expanded to include both "good communication" across the partner agencies and within the individual organisations. One respondent suggested that:

"Communication both up and down services and between services is of vital importance if we're to be clear about if and how we can contribute to inter-agency work".

Flexibility and co-operation were other key factors to emerge which can be linked to official sanction. A need for a flexible approach within agencies to sanction the work was identified both from content analysis and the interviews undertaken. For example, the observations related to the Shared Information project indicated a need for the partners to be flexible about their support without necessarily knowing what the outcomes of the project would be. In the context of the Health Promotion group the need for managers to be flexible about providing their support to the initiative, without the project fitting neatly with their management objectives was identified. For example, one of the Group members suggested that:

"Although I can see the relevance of our service being involved in something like this, I'm not sure all my colleagues can. I'm lucky my manager can see the potential long term benefits".

Continuity of support was another factor to emerge from the research. This was linked specifically to the operation of the Health promotion group. The need to ensure that their host agency continued to support/sanction their involvement in the Group was expressed by two respondents. One expressed concerns:

"If I left I'm not absolutely certain they'd continue to send a representative to the Group. I'm sure it would depend on caseloads at the time".

In the context of the Shared Information project, it was suggested that long term support was needed if the initiative was to reach its full potential. Analysis of documentary evidence reinforced the view that the project would yield long term benefits to inter-agency planning rather than immediate returns. One of the Group members interviewed suggested:

"This sort of initiative takes time. I'm hope that the individual agencies stick with it so that it can yield its full potential".

Strategic planning, influence and resources were proposed as other important features which can be related to official sanction. The need for collaboration to be approved at the strategic planning level was identified as an important feature of collaboration. Joint areas of work needed to be sanctioned and the need to "bring on board" people who can "influence" and procure resources to support the collaborative activity were other identified features. For example, in the context of the Health promotion group there was a need to involve those who could allocate or secure pump priming of funds to support initiatives. The way in which the Group's activities were reported back to the Healthy Eastleigh management structure was also recognised by Group members. One of the group members interviewed suggested:

"We need to be sure what we're doing as a group fits in with the overall plan. We also need to keep senior managers aware so that they continue to allocate staff time and any resources which might be available".

3.2 Multi-Agency Programme Development - Additional Features

A number of additional themes emerged comprising a multi-agency approach to programme development. Co-ordination was expressed as an important consistent message across the five projects. It was identified as an essential means of ensuring equal input across agencies by respondents involved in the Healthy Shopping Scheme, the Health Promotion Group and the Community Participation Project. For example, one of the participants in the Community Participation Project suggested:

"Pulling together, co-ordinating what we can contribute both in individual agencies and with a multi-agency approach seems is of vital importance if we're to achieve our objectives".

Analysis of the documentary evidence also identified the co-ordination role of one or two participants in the projects as a consistent theme. For example, analysis of the documentation linked to the Healthy Shopping Scheme indicated the key, co-ordinating role played by both the Health for All Co-ordinator and the community dietitians. The need for dedicated co-ordination time was identified by two respondents involved in the Health Promotion Group. It was suggested that planning the monthly health stalls undertaken by the Group required a high level of networking and co-ordination across the agencies. One of the criticisms or reasons for the slow progress linked to the Shared Information Project was the lack of dedicated co-ordination support. Analysis of the documentary

evidence and themes identified from participant observation reinforced this view. One of the project participants suggested:

"the identification of time or a specific individual to pull all this together and co-ordinate the project would move things along a lot faster".

The allocation of sufficient resources in terms of staff time and funds for pump priming the business of individual projects was another key feature linked to programme development. Across all five projects the need for dedicated staff time and additional monies to assist in the development of projects was identified. For example, the responses linked to the Health promotion Group clearly proposed the need for staff to have their involvement in the inter-agency activities as part of their contract. One respondent suggested that:

" whilst managers have sanctioned our involvement in this work, there has been no reduction in our normal caseloads to take account of this".

The notion that goodwill and enthusiasm played a key part in their involvement was expressed by staff.

Dedicated resources in terms of additional monies to support initiatives to come out of the joint working were identified as important. This theme emerged in particular from the analysis and interview responses of those involved in the Community Participation Project. The need for additional resources to help with the community survey emerged from all three research methods, the interviews, analysis of documentation and participant observation. For example, one of the Project participants interviewed suggested that:

"the lack of a specific budget allocation for the work hinders planning. It means we approach the powers that be on an as and when basis".

The need for good levels of representation across the agencies is a common factor to have emerged from the research. The interviews for each of the projects revealed that there was a need for good levels of involvement from the agencies participating in each project. For example, the responses to the interviews around the Community Participation Project revealed that there was a need to have active involvement across a variety of agencies. This was also a theme identified from the interviews with participants in the Health Promotion Group. For example, one respondent commented:

"Not everyone attends the group meetings on a regular basis. This can limit both the range of discussion in the meetings and agency representation in the activities".

Difficulties emerged when time allocation became a problem. In the case of the Healthy shopping Scheme, it became apparent that the theme of appropriate representation across the agencies was an important theme. The crucial involvement of the community dietitians was a key feature contributing to the schemes effectiveness. For example, analysis of documentary evidence indicated their key role in sustaining the momentum of the project and the problems experienced by other group members in committing time to the Scheme.

Linked to the theme of representation is the notion of the need for an <u>appropriate skill mix</u> participating in the projects. The activities of the Health promotion Group were underpinned by the involvement of appropriate expertise for particular health issues. The involvement

of the local health visitors around accident prevention and preventing cot deaths exemplifies this theme. The key contribution of the Information Technology service to the Shared Information Project is another example of this. Comments made by those interviewed reinforced the need for the service's expertise.

Practical outcomes and tangible successes is another key theme linked to successful multi-agency programme development. The interviews undertaken with participants in the projects indicated that the sense that something was being achieved and contributing to the health of the local population was an important theme in inter-agency working. For example, respondents from the Community Participation Project indicated that there would be a need for some practical, demonstrable outcomes to the project, if momentum was to be maintained. One of the participants interviewed suggested that:

"If we're involving local people we need to be sure something practical comes out of the project".

The number of shops promoting healthy foods as part of the Healthy Shopping Scheme was a practical outcome identified from both participant observation and the analysis of the documentary evidence. One participant also identified this theme as being of prime importance if continuing resource commitment from the partnership agencies was to be forthcoming.

A clear, objective and shared approach to decision making and the development of ownership across the agencies for areas of work are other supplementary features to multi-agency programme development to emerge from the research. Participants involved in the Healthy Shopping Scheme identified the clarity of the Scheme objectives as a key feature contributing to successful implementation. The

documentation linked to the Scheme indicated a clear vision of the objectives and how they would be achieved and comment from those involved reinforced this view:

"It was easy to identify what we're trying to achieve from the outset. This helps in identifying what our individual contributions might be and makes you feel part of the project".

This contrasts with the expressed concern of participants involved in the Shared Information Project who felt that the lack of clear, focused decision making hindered the progress of the project. The observations linked to the Smoking Prevention Programme, on the other hand, support the strategic approach adopted to decision making and the clear definition of the proposed contributions of the participating agencies. Analysis of the documentary evidence linked to the Programme reinforces this view. The settings and potential activity targets are clearly defined and this facilitates the identification of lead agencies and professionals to progress the programme. Further evidence for this is provided from comments obtained from the interviews conducted with those participating:

"It all seems very systematic and well planned. This approach has helped us to be clear about out potential contributions to the work".

3.3 Shared Vision and Commitment - Additional Features

A number of additional characteristics were identified to expand the development of a shared vision and commitment linked to inter-sectoral collaboration. Clarity of objectives was a key feature identified across the five projects researched.

The features identified from participant observation of the Shared Information Project indicated that there was a lack of clarity and consensus about the key objectives in the short, medium and long term for the project. Respondents participating in the Health Promotion Group also identified a lack of direction in terms of aims and objectives, it was felt this hindered progress and commitment from the participants. Observations and comments relating to the Community Participation Project, by way of contrast, suggested that progress in terms of identifying local health needs had been achieved because key stages and objectives had been identified at the outset. One respondent suggested that:

"The staff workshop set the scene in terms of outlining what we were trying to achieve. This has helped in setting
some key objectives".

The themes of consensus and decision making are additional features to emerge from the research. Responses linked to the Community Participation Project and the Health Promotion Group indicated that a few members took the lead in identifying and steering action. It would seem that this impacted on the extent to which a consensus view of the way forward was achieved and a number of respondents indicated that they felt that the levels of inter-agency decision making and the equitable balance of power in terms of project management were disturbed. For example, one respondent participating in the Community Participation Project commented:

"The proposal for the project had been developed before I got involved. To a certain extent this meant we had little input into the decision making process".

The range of professionals involved in the Health Promotion Group increased difficulties in reaching a consensus view or a truly equitable approach to decision making. To focus the potential range of priorities which could be identified by individual agencies, the key areas linked to the Government's Health of the Nation strategy were proposed as core health issues to be addressed by the Group. Concerns were expressed by one of the participants interviewed:

"The issues the group addresses are very much "health" led. It would be good to broaden the agenda. Perhaps this will happen in time".

Compromise was identified as another key theme linked to shared vision and commitment. The responses to the interviews and the analysis of documentary evidence identified the range of agency commitment and representation achieved in projects such as the Health Promotion group and the Shared Information Project. The focus and areas of work agreed indicated that individual agencies were prepared to compromise or exercise a flexible approach to commitment to the project. This often meant that they were participating in areas of work which were outside their area of expertise and responsibility for the sake of inter-sectoral collaboration. For example, respondents participating in the Health Promotion Group, indicated that they were not necessarily focusing on areas of work that were of prime importance to their agency, but felt that it was important to be involved. One respondent suggested that:

"The aim is to improve the health of local people. We're all interested in that".

The focus of Children and Families and the Elderly adopted by the Shared Information Group did not, it was

suggested sit neatly with the focus of work/priorities of individual agencies, but nevertheless provided a means of progressing the issue of shared information across agency interests. Analysis of the documentary evidence indicated that even those agencies not working in care groups were able to identify their information priorities for these population groups.

The preparedness of agencies to become involved in new areas of work and to manage change as a result was another supplementary theme to emerge from the research. The willingness of individuals to participate in unfamiliar areas of activity was identified as an important theme form the analysis of the documentary evidence linked to the Smoking Prevention Programme. In particular the implementation of smoking prevention activity called on the adoption of new ways of working for the health promotion staff and the local authority. Two of the respondents involved in the project indicated that they felt they were in "unchartered territory". The development of the Shared Information Project represents another example of work where a flexible approach to change was required of individual agencies. The lack of clarity in terms of objectives exemplifies this. One respondent suggested that:

"it's good to be part of an innovative approach to sharing data and identifying health needs".

3.4 Domain Consensus - Additional Features

Issues of respect and understanding were identified as important additional themes for effective collaborative working. For example, responses to the interviews of those participating in the Health Promotion Group indicated that there was a need for members of the group to respect and understand the different skills and

interests different professionals brought to the Group. One of the participants interviewed suggested:

"The Group is a good way of getting to know what other services are doing and perhaps appreciating each other more!"

In the context of the Community Participation Project the need for understanding of the different "interest" areas of individual agencies emerged. In identifying health needs in a particular community a broad definition of "health" was adopted which embraced the interests of the local authority, social services, education, health and the voluntary sector. Participant observation identified both the broad range of health issues identified and the way in which representatives from individual agencies showed respect and understanding for the priorities of their colleagues from other services.

The outcomes of the Smoking Prevention Programme further highlighted the importance of understanding of the potential role and contribution of the participating agencies. The effective identification of baseline data to assist in the establishment of local activity targets was due in part to the understanding and close working relationship of those participating. The development of the programme to integrate smoking into the general work practice of environmental health officers in the local authority was identified as requiring levels of understanding and respect of the pressures and constraints under which they are working.

Responsibility emerged as an important theme across the research findings and further supplements the features of effective joint working. The roles of individual professionals in contributing action to the business of each project and taking on responsibility for

implementation were identified as key qualities by those interviewed across the five projects. For example, analysis of the documentary evidence linked to the Health Promotion Group indicated a high level of inter-agency collaboration in terms of participation at Group meetings. However, the data collected from the interviews revealed that a small core group of members took responsibility for progressing activity. One respondent suggested:

"It seemed to fall on two or three of us to ensure things happened on time and in a co-ordinated way".

This was also reflected in the outcomes of the research into the Community Participation Project. Interviews identified that it seemed to be one or two members of the project group who took on the responsibility for moving things on and it was felt that this reduced levels of inter-sectoral collaboration.

3.5 Network Awareness - Additional Features

Three key additional features comprising network awareness were identified from the research into the Healthy Eastleigh initiative. The need for levels of stability across both individual membership of project groups and in terms of support in terms of direction and official sanction was identified as an important feature. For example, analysis of the documentary evidence linked to the Health Promotion group revealed that potential difficulties were identified when it was revealed that the health visitor chairing the group would no longer be able to fulfil this role. This added some levels of uncertainty to the process for action planning of the group. The ongoing participation of the community dietitians in the Healthy Shopping Scheme and the stability this provided for the initiative assisted in

both the implementation and ongoing development of the project. This was reinforced by the data collected from both participant observation and the interviews conducted with Scheme participants. For example, one respondent suggested:

"The input from the community dietitians is absolutely vital. The credibility of the Scheme hangs on their involvement".

Consistency in terms of the managerial support for the direction and focus of the projects was identified as a key feature of effective collaboration. For example, the community involvement focus of the Community Participation Project and the commitment of the individual agencies to engage with the local community to identify health needs was a consistent feature of the project and gave stability to the project. One respondent suggested that:

"Engaging with the local community to identify what they want is a common theme across services".

The value of formal and informal networks represents another supplementary feature to effective collaboration. The development of formal project groups for each of the five areas of work was identified in earlier chapters. This was an important feature in the development of action and setting objectives for the individual projects and facilitated inter-sectoral collaboration. For example, the levels of informal networking between the project participants in the Smoking Prevention Programme were high and this in turn assisted in the implementation of the initiative to set baseline activity data and process targets. Contact between members of the project groups varied and this in turn impacted on the effectiveness of the joint working. For example, members

of the Healthy Shopping Scheme identified that there were high levels of informal contact between project group meetings. By contrast those interviewed from the Shared Information Project indicated less frequent informal contact outside the formal project group meetings. This, it was suggested, contributed to the slow progress of the project.

The need for regular review and evaluation are additional features to emerge from the research. Reports of progress were compiled on a regular basis. However, both analysis of documentary evidence and participant observation, indicated that some more in depth analysis of outcomes was required. This would considerably enhance the willingness of agencies to participate in effective interventions. For example, the activities of the Health Promotion Group were analysed in terms of the numbers of community health promotion activities and the number of community contacts achieved. However, those members of the group who were interviewed indicated the need for better evaluation of effective and ineffective interventions. One respondent suggested that:

"It's vital we know whether or not we're being effective so that we can improve what we do and increase our impact on the local community".

4. CONCLUDING COMMENTS

In conclusion, therefore, this research has described, analysed and reflected upon the development of an inter-sectoral approach to promoting the health of the local population in one local authority area. Furthermore, it has sought, by means of a multi-method research approach to identify the sorts of features at play if collaboration is to be effective. In Chapter One a limited model of features of effective collaboration was

proposed. This was utilised to assist in the development of the interview schedule, the areas of focus for content analysis and the observations of the researcher and full participant in the project, the Healthy Eastleigh Co-ordinator. A multi-method approach was employed to increase levels of both internal and external validity and to achieve a balance in the use of the subjective and objective data collected via interview and participant observation.

The results of the research have indicated that in the case of Healthy Eastleigh the levels of inter-sectoral collaboration vary across individual areas of work. For some projects the development of a sustained approach to joint working has proved easier than for others. Most significantly, the research indicated additional features underpinning collaboration, which have been identified and discussed in this chapter, as essential components of the model proposed at the outset of this research. The outcome of this research has, therefore, been an in-depth analysis of the development of one approach to Health for All at a locality level and the proposal of a model of "features of effective collaboration" to assist in the monitoring and deeper understanding of inter-sectoral approaches to health promotion activity.

Negotiation and Corporate Rational versus Partisan Mutual Adjustment Approaches

The sections outlined above illustrate the key features to emerge from the research undertaken in Eastleigh. Issues around negotiation and the theories of corporate rational and partisan mutual adjustment approaches identified by Harrison and Thether (1987) and Sanderson (1990) have not emerged from the research. However, their significance in terms of the theories underpinning joint working merits their identification at this stage.

Delaney, Cumming and Tilford (1993) suggest that a corporate rational approach to policy development comprises :

> "attempts to co-ordinate and control organisations through a bureaucratic hierarchy"

This assumes that decision making is rational, however it is proposed that the process of agreeing policy is :

> "fragmented and results from a balance between competing interests, ie. partisan mutual adjustment."

Implicit within this theory is the notion of negotiation and bargaining between organisations. The importance of models of inter-organisational co-ordination and bargaining between stakeholders is, therefore, proposed as being an important feature of inter-sectoral collaboration and health promotion. Furthermore, it is suggested that a "middle position" between corporate rational and partisan mutual adjustment approaches appears more useful and realistic (Delaney et al 1993).

CHAPTER THIRTEEN

CRITICAL REVIEW

The focus of this chapter is to take a critical look at the whole process and outcomes of the research into Healthy Eastleigh and inter-sectoral collaboration. It will provide the opportunity for the researcher to reflect on how effective the research has been in meeting the research objectives. The outcomes of the research and what they have indicated in terms of the need for future enquiry will also be explored. To facilitate the process of critical review issues are identified below under key headings to assist in the process of identifying positive and negative features.

1. PROJECT SELECTION

The Healthy Eastleigh initiative has spawned a wide variety of projects. These reflect a richness both in terms of the variety of issues being tackled and the focus in terms of operational and strategic. For example the Healthy Shopping Scheme and the Health Promotion Group provided good examples of collaborative approaches to community health promotion. The focus of the schemes closely links with the priorities of the Health of the Nation:

- Coronary Heart Disease and Stroke
- Cancers
- Accidents
- Mental Illness
- HIV and Sexual Health

They also draw on the participation of fieldworkers who are in close contact with the local community and can provide an operational focus for the work. The Community

Participation Project, on the other hand, provides a contrast with these projects, illustrating a community development approach to Health for All and health promotion. The project provided the opportunity to illustrate the involvement of local people in identifying health needs and the developing responses across service areas.

The Smoking Prevention Programme and the Shared Information Project, however, represent projects with a different focus both in terms of the issues being addressed and the way in which they are designed to meet strategic needs, by this it is suggested they aim to support the long term development of service plans and health promotion initiatives. The Smoking Prevention Programme aimed to develop a multi service, planned approach to reduce smoking prevalence throughout the Borough. A key focus was the involvement of a number of different sectors; community health, education, environmental health and the retail sector, and clearly identifying the interventions they could support relating to project aims. Similarly, the Shared Information Project aimed to support the identification of local health needs in the long term and to provide the strategic support to the development and targeting of health promotion interventions in the community.

The sample of projects comprising the focus of this research indicates a breadth of focus which in turn has increased the comprehensiveness of research outcomes and the generalisability of the research results.

2. DEVELOPMENT OF FRAMEWORK FOR ANALYSIS

In Chapter One the issues surrounding both Health for All and the current influences stimulating inter-sectoral collaboration are explored. From a review of the

theoretical literature around inter-agency working a model of key features comprising effective collaboration was proposed in Chapter One.
The application of the model through the development of a questionnaire, a framework for the analysis of documentary evidence and participant observation yielded a broad range of additional features which expanded on the initial framework.

This would seem to indicate that the research tools were sufficiently flexible to allow for the development of a more comprehensive picture of the features facilitating inter-sectoral collaboration. For example, the interviews undertaken with project participants identified additional issues around communication, sustained commitment and flexibility which expanded the five features initially proposed in the framework for analysis.

Enquiry around joint planning and implementation of projects revealed a whole range of additional features which are of importance if approaches are to be truly collaborative. For example issues around respect and understanding of the potential contributions of agencies were identified as being important if this is to be achieved. The investigations into official sanction also identified a range of sub features which are key facilitators to collaborative working, outlined in detail in the previous chapter.

In conclusion, therefore, it would seem that the framework for analysis proposed from a critical review of the theoretical literature around joint working in Chapter One, was sufficiently broad and flexible so as to allow a whole range of additional characteristics to be uncovered. This would seem to indicate that the research tools themselves were designed effectively to facilitate broad enquiry to take place.

3. RESEARCH DESIGN

The efforts made to triangulate the research methods and consequently to increase internal and external validity and the reliability of the research outcomes represents a key strength of the research. The application of interview, analysis of documentary evidence and participant observation allowed sufficient checks and balances for validation of the research findings. For example, the interviews undertaken with project participants facilitated the collection of qualitative data from those involved in the Healthy Eastleigh projects. This was further supplemented by the subjective comments of the researcher as full participant in the initiative. It may be suggested that by critically reviewing the research methods applied a number of strengths and weaknesses begin to emerge.

The interviews undertaken provided the opportunity for direct contact with those participating in the projects and for the range of professionals involved to comment on their perceptions of how effective the projects had been in achieving inter-sectoral collaboration. The range of participants interviewed allowed for a "cross agency" view on the effectiveness of the projects. This enabled comparisons to be drawn across agencies participating and for a wealth of comment to be collected. The co-operation and willingness of project participants to contribute to the research was a key feature of the research process. This further facilitated both the process of data collection and the breadth of comment contributing to the research findings.

The range of documentary evidence relating to each project provided another important approach to building up a comprehensive picture around inter-sectoral collaboration and the Healthy Eastleigh initiative. The variety of documentation examined was a key strength contributing to the research findings. Minutes, reports,

project proposals and strategy documents were utilised. The ease of access to documentation facilitated the research process and allowed for analysis of printed material relating to all five projects. The framework for analysing the documentation outlined in Chapter Five, provided a consistent approach for application to the data relating to each project. It also facilitated a wealth of data to be drawn from the evidence which further supplemented the research outcomes.

An attempt was made to apply both quantitative and qualitative measures to the research. A frequency count around words and sentences illustrating joint working was applied as an additional measure to the documentation for each project. This, on reflection, was the weakest element of the research methodology. Efforts were made by the researcher to apply consistent judgement in the identification of words and sentences reflecting joint working. However, by critically reviewing this approach, it could be construed as subjective and lacking in reliability. The triangulation of the research methods, on the other hand, and the structured approach to the qualitative approach to analysing the printed evidence would seem to provide sufficient counter balance to this weakness.

At the outset of this research the role of the researcher as full participant in the Healthy Eastleigh initiative was identified. An attempt has been made to utilise the observations gleaned by participant observation to further supplement the research findings. In Chapter Eleven the qualitative data gleaned from this approach was outlined and observations relating to the five projects were explored. Efforts were made to structure the comments both in relation to the elements of the model for inter-sectoral collaboration proposed in Chapter One and with reference to each of the five projects under scrutiny. This process allowed for the valid contribution of the researcher as full participant

in the initiative. On reflection, this element of the research methodology may be identified as comprising both positive and negative features. The possible intrusion of biased and subjective data may be identified as a weakness. However, in defining a framework around which these comments were structured efforts were made to maintain focus and to limit bias. The other research methods employed also provided sufficient checks and balances.

In conclusion, therefore, the application of a triangulated approach to the research design provided maximum opportunity to utilise all avenues of enquiry relating to the Healthy Eastleigh initiative. Access to project documentation, project participants and the observations of the researcher as full participant, facilitated a wealth of data to be collected and a comprehensive picture to emerge in terms of research outcomes.

4. FURTHER AREAS OF ENQUIRY

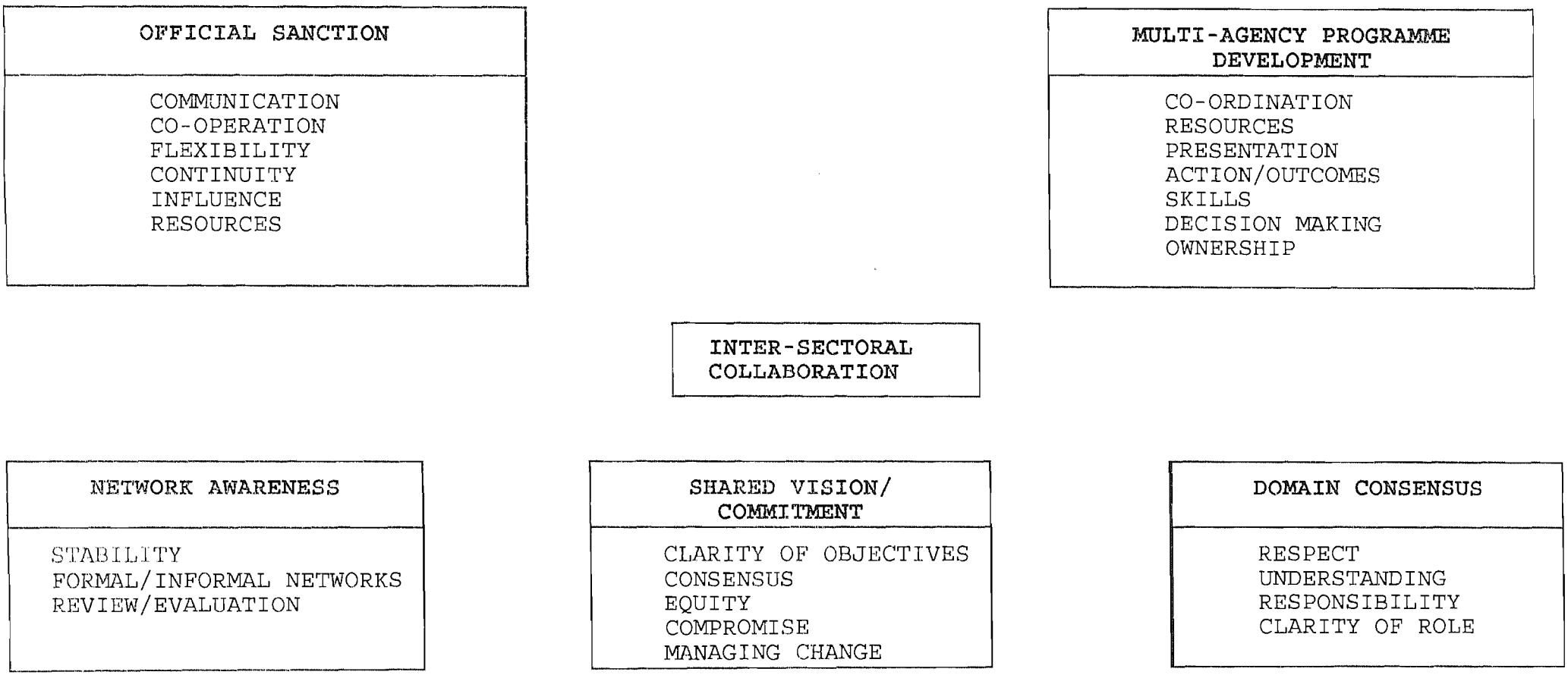
Critical review of the research process and outcomes has indicated two key areas requiring further enquiry. The research into Healthy Eastleigh has identified a range of features comprising effective inter-sectoral collaboration. However, the relative importance of these features was highlighted as an issue of importance from the data gleaned from participant observation. It was suggested in Chapter Eleven that there were issues around how important one feature may be as opposed to another. For example, the relative importance of ensuring official sanction for joint working as opposed to the creation of a shared vision and network awareness. Issues around the relative weighting of the features of effective collaboration have, therefore, emerged from this research. However, the key focus of this study comprised the identification of a viable model for effective collaboration. Whilst, issues of the significance of

individual features have emerged, this study has not been able to focus on these issues in detail. It would seem, therefore, that further enquiry in this area is required.

Issues linked to the application of the viable model to different kinds of projects follows on from the comments above. It would seem that the relative importance of each feature and the constituent sub features identified below from the research into Healthy Eastleigh will vary in importance and will depend upon a number of variables:

- The focus of the work in terms of health issues.
- The range of participation in terms of agency representation.
- The nature of the project, strategic versus operational activity.

EXPANDED VIABLE MODEL FOR EFFECTIVE COLLABORATION



It may be suggested that the application of the viable model outlined above will be dependent on the health issues being addressed. The national strategy for health, detailed in the Health of the Nation document promotes both the need for agencies to work together to improve the health of the population and the investment of effort around five key health issues:

- Coronary Heart Disease and Stroke
- Cancers
- Mental Illness
- Accidents
- HIV/AIDS and Sexual Health

Whilst the research into the Healthy Eastleigh initiative has revealed a model around effective working, it may be suggested that further enquiry is called for into the application of the model and the interplay of the features when applied to activity focusing on specific health issues.

The focus of projects in terms of strategic or operational activities was identified above as an area of potential further enquiry. Earlier in this chapter the mix of projects comprising the focus of this research into Healthy Eastleigh was identified as a key strength. The range of health issues it encompassed facilitated the identification of a wide range of features. Issues around the strategic versus operational focus of the projects were identified. Strategic approaches were defined as comprising areas of work which have as a key aim the facilitation of service/project planning, as opposed to the operational delivery of health promotion in the community. The Smoking Prevention Programme and the Shared Information Project were identified as comprising more of a strategic focus of the five projects investigated. It would seem that the relative importance

of features in securing joint approaches to these distinct levels of working requires further investigation.

5. GENERALISABILITY OF RESEARCH OUTCOME

The final key theme to emerge from this critical review of the research into Healthy Eastleigh focuses around the generalisability and the usefulness of the research outcomes to the field. It may be suggested that the initiative is representative of the approach adopted to Health for All by a number of health and local authorities around the country. The agencies represented from both the statutory and the voluntary sector reflect the models of good practice identified in Chapter Three and the approach adopted to Health for All across the United Kingdom. However, the participation of two health authorities, both of which provide services to the Borough's population is probably less common. However, overall agency representation reflects a common approach and therefore impacts on the generalisability of the research outcomes. The range of projects investigated also increases potential levels of generalisability of the research findings. The contrast across the projects investigated in terms of the health issues and the approaches adopted to health promotion in the community provides further scope for the relevance of the results to other projects.

In conclusion the critical review of the research has identified a range of themes around both the research process and outcomes. The viable model for effective collaboration proposed in Chapter Twelve provides an audit tool to assist in the development of inter-agency approaches to health promotion. It provides some prerequisites to joint working which may assist in the establishment of effective collaboration. An attempt has

been made to provide a balanced evaluation of the integrity of the research methods adopted and the outcomes. Overall, the range of data collated provides a valid contribution to the intelligence around inter-agency approaches to Health for All and health promotion and healthy alliance approaches to Health of the Nation.

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APPENDIX 1

WORLD HEALTH ORGANISATION

TARGETS FOR HEALTH

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Appendix One

The 38 Targets for the WHO European Region

1. By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25%, by improving the levels of health of disadvantaged nations and groups.
2. By the year 2000, people should have the basic opportunity to develop and use their health potential to live socially and economically fulfilling lives.
3. By the year 2000, disabled persons should have the physical, social and economic opportunities that allow at least for a socially and economically fulfilling and mentally creative life.
4. By the year 2000, the average number of years that people live free from major disease and disability should be increased by at least 10%.
5. By the year 2000, there should be no indigenous measles, poliomyelitis, neonatal tetanus, congenital rubella, diphtheria, congenital syphilis or indigenous malaria in the region.
6. By the year 2000, life expectancy at birth in the Region should be at least 75 years.
7. By the year 2000, infant mortality in the Region should be less than 20 per 1000 live births.
8. By the year 2000, maternal mortality in the Region should be less than 15 per 100,000 live births.
9. By the year 2000, mortality in the Region from diseases of the circulatory system in people under 65 should be reduced by at least 15%.
10. By the year 2000, mortality in the Region from cancer in people under 65 should be reduced by at least 15%.
11. By the year 2000, deaths from accidents in the Region should be reduced by at least 25% through an intensified effort to reduce traffic, home and occupational accidents.
12. By the year 2000, the current rising trends in suicides and attempted suicides in the Region should be reversed.
13. By 1990, national policies in all member states should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of policy-making.
14. By 1990, all member states should have specific programmes which enhance the major roles of the family and other social groups in developing and supporting healthy lifestyles.
15. By 1990, educational programmes in all member states should enhance the knowledge, motivation and skills of all people to acquire and maintain health.
16. By 1995, in all member states, there should be significant increases in positive healthy behaviour, such as balanced nutrition, non-smoking, appropriate physical activity and good stress management.
17. By 1995, in all member states, there should be significant decreases in health-damaging behaviour, such as overuse of alcohol and pharmaceutical products; use of illicit drugs, dangerous chemical substances; dangerous driving and violent social behaviour.
18. By 1990, member states should have multisectoral policies that effectively protect the human environment from health hazards, ensure community awareness and involvement, and effectively support international efforts to curb such hazards affecting more than one country.
19. By 1990, all member states should have adequate machinery for the monitoring, assessment and control of environmental hazards which pose a threat to human health, including potentially toxic chemicals, radiation, harmful consumer goods and biological agents.
20. By 1990, all people of the Region should have adequate supplies of safe drinking-water, and by the year 1995 pollution of rivers, lakes and seas should no longer pose a threat to human health.

21. By 1995, all people of the Region should be effectively protected against recognised health risks from air pollution.

22. By 1990, all member states should have significantly reduced health risks from food contamination and implemented measures to protect consumers from harmful additives.

23. By 1995, all member states should have eliminated major known health risks associated with the disposal of hazardous wastes.

24. By the year 2000, all people of the Region should have a better opportunity of living in housing and settlements which provide a healthy and safe environment.

25. By 1995, people of the Region should be effectively protected against work-related health risks.

26. By 1990, all member states, through effective community representation, should have developed health care systems that are based on primary health care and supported by secondary and tertiary care as outlined at the Alma-Ata conference.

27. By 1990, in all member states, the infrastructures of the delivery systems should be organised so that resources are distributed according to need, and that services ensure physical and economic accessibility and cultural acceptability to the population.

28. By 1990, the primary health care system of all member states should provide a wide range of health-promotive, curative, rehabilitative and supportive services to meet the basic health needs of the population and give special attention to high-risk vulnerable and underserved individuals and groups.

29. By 1990, in all member states, primary health care systems should be based on co-operation and teamwork between health care personnel, individuals, families and community groups.

30. By 1990, all member states should have mechanisms by which the services provided by all sectors relating to health are co-ordinated at the community level in the primary health care system.

31. By 1990, all member states should have built effective mechanisms for ensuring quality of patient care within their health care systems.

32. Before 1990, all member states should have formulated a research strategy to stimulate investigations which improve the application and expansion of knowledge needed to support their national 'Health For All' developments.

33. Before 1990 all member states should ensure that their health policies and strategies are in line with 'Health For All' principles and that national legislation and regulations make their implementation effective in all sectors of society.

34. Before 1990, member states should have a managerial process for health development geared to the attainment of 'Health For All' actively involving communities and all sectors relevant to health and accordingly, ensuring preferential allocation of resources to health development priorities.

35. Before 1990, member states should have health information systems capable of supporting their national strategies for 'Health For All'.

36. Before 1990, in all member states, the planning, training and use of health personnel should be in accordance with 'Health For All' policies, with emphasis on the primary health care approach.

37. Before 1990, in all member states, education should provide personnel in sectors related to health with adequate information on national 'Health For All' policies and programmes and their practical application to their own sectors.

38. Before 1990, all member states should have established a formal mechanism for the systematic assessment of the appropriate use of health technologies and of their effectiveness, efficiency, safety and acceptability, as well as reflecting national health policy and economic restraints.

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APPENDIX 2

DOCUMENTARY EVIDENCE

COMMUNITY PARTICIPATION PROJECT

HEALTH FOR ALL IN EASTLEIGH

COMMUNITY PARTICIPATION - PILOT PROJECT PROPOSAL

Introduction

A community participation working group was established in October 1990 to explore possible ways of involving local people in Health for All in Eastleigh. The proposal outlined below reflects the group's initial discussions and represents a first step in establishing community participation at a local level. Five key issues are addressed below:

1. Key Principles
2. Pilot Project Objective
3. Bishopstoke Pilot Project
4. Action Plan
5. Resources.

1. Key Principles

Nine key principles have been identified and it is proposed these underpin the pilot project and provide a framework for future activity.

(1) Resources

Activity during the current financial year will be undertaken from within existing resources. However, during the pilot project both staff time and other expenses will be identified and quantified. The project will provide information on the resource implications of extending the approach throughout the Borough and identify the level of additional resources required.

(2) Development of an Identity for Health for All

The provision of information which is both relevant and 'jargon free' will underpin all activity.

Work is currently underway to develop a logo for Health for All in Eastleigh and to identify existing communication channels which could be used to disseminate information.

(3) Statutory Agency Commitment and Responsibility

The statutory agencies will have equal commitment and responsibility for the planning and implementation of the pilot project and future activity.

(4) Contractual Nature of the Work

Activities involving both local residents and staff will be contractual in nature and both parties will be equal partners in initiatives.

(5) Staff Training and Development

It must be recognised that some fieldwork staff will be more accustomed to working in a community development style than others, and that some staff will have training needs both prior to and throughout the pilot project.

(6) Involvement of Community Groups and Leaders

Existing community groups and leaders represent key points of contact with the neighbourhood and will be involved in both the planning and implementation of the pilot project.

(7) Support for Groups/Community Health Forums

Emphasis will be placed on enabling local people to play a key role in the support of local groups/community health forums established under the auspices of the pilot project.

(8) Flexible Approach

The approach adopted for the pilot project will be flexible. Both staff and local residents must be made aware that the emergence of issues will be a dynamic process and thus subject to shifts in emphasis.

(9) Evaluation

All aspects of the pilot project will be monitored and evaluated. The responsibility for undertaking this role must be defined at an early stage in the project.

2. Pilot Project Objectives

Three key objectives have been identified for the pilot project in Bishopstoke:

- to inform local residents and field workers about Health for All in Eastleigh

- to enable and facilitate all population groups to express their health needs

- to identify ways of involving local residents in the planning and implementation of initiatives to meet expressed needs

3. Bishopstoke Pilot Project

It is proposed that a neighbourhood approach be adopted and a pilot project be undertaken in the Bishopstoke area (Appendix A).

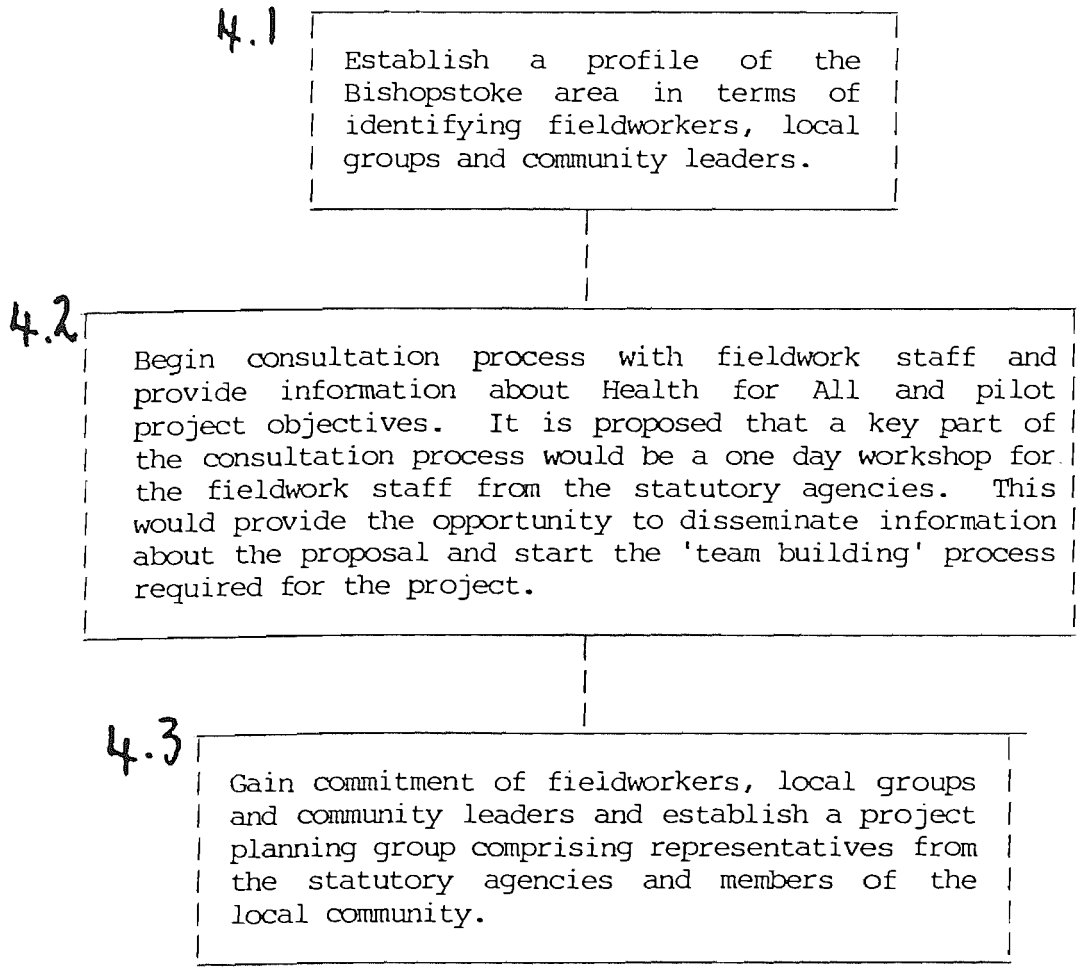
A neighbourhood approach would allow:

(d) A local health visitor has already undertaken a 'community profile' in the Bishopstoke area and this will provide useful reference information for the project.

(e) The Bishopstoke area represents a fairly discrete geographic patch which has a central focus in terms of shops and other facilities.

4. Action Plan

An action plan for the preliminary stages of the pilot project is proposed below:



5. Resources

At this stage it is not possible to fully quantify the resource implications for the pilot project. However, the workshop identified in 4.2 above would require resourcing both in terms of sundry expenses, eg. room hire, refreshments, and in terms of relieving fieldwork staff from their normal duties to attend.

NK/SJM
23/11/90
NK1AAP

HEALTH FOR ALL IN EASTLEIGH

COMMUNITY PARTICIPATION WORKING GROUP

NOTES FROM A MEETING HELD ON THURSDAY, 29 NOVEMBER 1990 AT 10.30 AM

Present

MEMBER A	- Community Health Worker, Winchester Health Authority
MEMBER B	- Community Development Worker, Eastleigh Borough Council
MEMBER C	- General Secretary, Eastleigh Council for Community Service
MEMBER D	- Eastleigh Health for All Co-ordinator

D explained that the purpose of the meeting was to agree a proposal for the pilot project in Bishopstoke.

Resource Implications

It was agreed that reference be made in the proposal to the need for resources to support the project. At this stage it would not be possible to quantify these. However, it was proposed that as an important part of the development of the project, a one day workshop be organised for the fieldwork staff working in Bishopstoke. It was suggested that this be identified in the Action Plan for the preliminary stages of the project and in the resource implications of the pilot.

Fieldwork Staff

The group discussed the range of fieldwork staff who would be approached to participate in the project. A schedule of the agencies and fieldworkers identified is attached.

Action Plan

The initital stages of the project were discussed. It was agreed that the preparatory stages of the project would underpin what was achieved. The involvement and commitment of fieldwork staff was identified as a pre-requisite to initiating contact with the community.

D agreed to include reference to resource implications in the proposal and to identify the workshop for fieldwork staff as an important part of the Action Plan for the preliminary stages of the pilot. Members of the group agreed to submit any other amendments to Noreen within the next week.

NK/SJM
3/12/90
NK1AAQ

HEALTH FOR ALL IN EASTLEIGH

COMMUNITY PARTICIPATION WORKING GROUP

Notes of a Meeting held on Monday, 18 February 1991 at 2.45 pm

Present

MEMBER A - General Secretary, Eastleigh Council for Community Service
MEMBER B - Community Development Worker, Eastleigh Borough Council
MEMBER C - Eastleigh Health for All Co-ordinator

Apologies

MEMBER D - Community Health Initiative Worker, Winchester Health Authority.

The Group considered some reservations D had now raised about starting the project in Bishopstoke. After a wide ranging discussion the Group felt that the positive factors identified for starting in Bishopstoke were stil valid. The Group agreed to pursue the Bishopstoke Proposal and Noreen agreed to inform D of the Group's decision.

The Group discussed the resources and staff commitment required to progress the project.

Action

1. C agreed to write a brief paper outlining the resources and staff commitment required to progress the project.

2. It was agreed C and D get together to devise an outline for the fieldworkers' Workshop.

Both 1 and 2 above would be considered at the Working Group's next meeting prior to submission to the Health for All Steering Group.

Date of Next Meeting

Monday 8th April 1991 at 2.00 pm in A's Office at E.C.C.S.

Noreen Kickham
HFA Co-ordinator
25/2/91

HEALTH FOR ALL IN EASTLEIGH

Bishopstoke Community Participation Project

The purpose of this paper is to identify the resource implications of the Bishopstoke Community Participation Project. Three key areas will be considered:

1. Staff commitment.

2. Staff workshop.

3. Administration and support costs.

1. Staff Commitment

The involvement of fieldworkers from the statutory agencies is a fundamental aspect of the project. At its meeting on 29 November 1990, the Working Group identified the range of staff they wished to involve (Appendix A). Some of the agencies identified will have fieldwork staff assigned specifically to the Bishopstoke area. For those agencies whose staff are not assigned to geographical patches, the local manager will be invited to nominate a fieldworker to participate.

- It is proposed that local managers of the agencies participating in Health For All be requested to commit approximately two hours per week of fieldworkers' time to the Bishopstoke project. It is important that those staff involved are flexible, enthusiastic and motivated to participate in the project.

2. Staff Workshop

A half day workshop for the fieldworkers participating in the project has been identified as a key stage of the project. A draft programme for the day is attached (Appendix B).

The resources required for the workshop are identified below:

(i) Staff time - it is proposed that the fieldworkers identified in Appendix A be given the time by their managers to attend the workshop.

(ii) Accommodation - a number of potential venues have been identified within health authority and local authority premises eg. Family Resource Centre, Social Services, Committee Room, Civic Offices/Day Room, Mount Hospital. It is anticipated that the accommodation would be available free of charge.

NK1ABK

(iii) Refreshments - it is proposed that a sandwich lunch be provided for those attending the workshop along with morning and afternoon refreshments.

Approx Cost: £40

3. Administrative Support

The Project Working Group has identified the need for an administrative base/support. Two options have been identified:

(i) One of the participating agencies undertake this role from within existing resources.

(ii) A separate administrative base be established for the project eg. within the community/voluntary sector.

At this stage of the project it is difficult to accurately identify the additional funds required to resource the project. An amount of £250 has been identified to provide initial pump priming. This would cover additional costs such as room hire, postage and publicity for the first 4 months of the project.

- It is proposed that:

(i) funds be sought from national bodies eg. Health Education Authority, Community Development Foundation, Community Education Centre.

(ii) the statutory agencies participating in Health For All be requested to allocate funds to the project for initial pump priming.

NK1ABK

Community Participation Working Group.

HEALTH FOR ALL IN EASTLEIGH

COMMUNITY PARTICIPATION WORKING GROUP

NOTES OF A MEETING HELD ON MONDAY, 8 APRIL 1991 AT 2.00 PM

Present: MEMBER A - General Secretary, ECCS
MEMBER B - Community Health Initiative Worker
MEMBER C - Health For All Co-ordinator

Apologies: MEMBER D - Community Development Worker, EBC

The group discussed C paper on the resources required for the project. The amended paper is attached (Appendix A).

There was discussion about the need to inform middle managers about the project.

Action - C agreed to contact the middle managers of the participating agencies to inform them about the project. This would be undertaken after the HFA Steering Group Meeting on Friday.

The middle to end of May was identified as a possible date for the fieldwork staff workshop.

Action - C agreed to book two rooms in the Family Resource Centre for the morning of Friday, 24 May 1991.

- C and B agreed to meet to firm up the contents for the workshop.

It was agreed that the Working Group did not need to meet again before the Staff Workshop in May.

NK/SJM
9/4/91
SS2BOC

HEALTHY EASTLEIGH 2000

BISHOPSTOKE COMMUNITY PARTICIPATION PROJECT

Community participation represents one of the key principles underpinning Health For All by the year 2000. The Bishopstoke pilot project is an important stage of involving local people in Healthy Eastleigh 2000. The first part of the project comprised the establishment of a committed network of fieldworkers drawn from all the statutory agencies. This culminated in a staff workshop held on 24 May 1991. The purpose of this paper is threefold:

- to provide a summary of the activities and groups going on in Bishopstoke identified by the fieldworkers at the workshop on 24 May 1991.

- to outline the key outcomes of the workshop and the membership of the Project Planning Group.

- to identify some options for action for the Bishopstoke project.

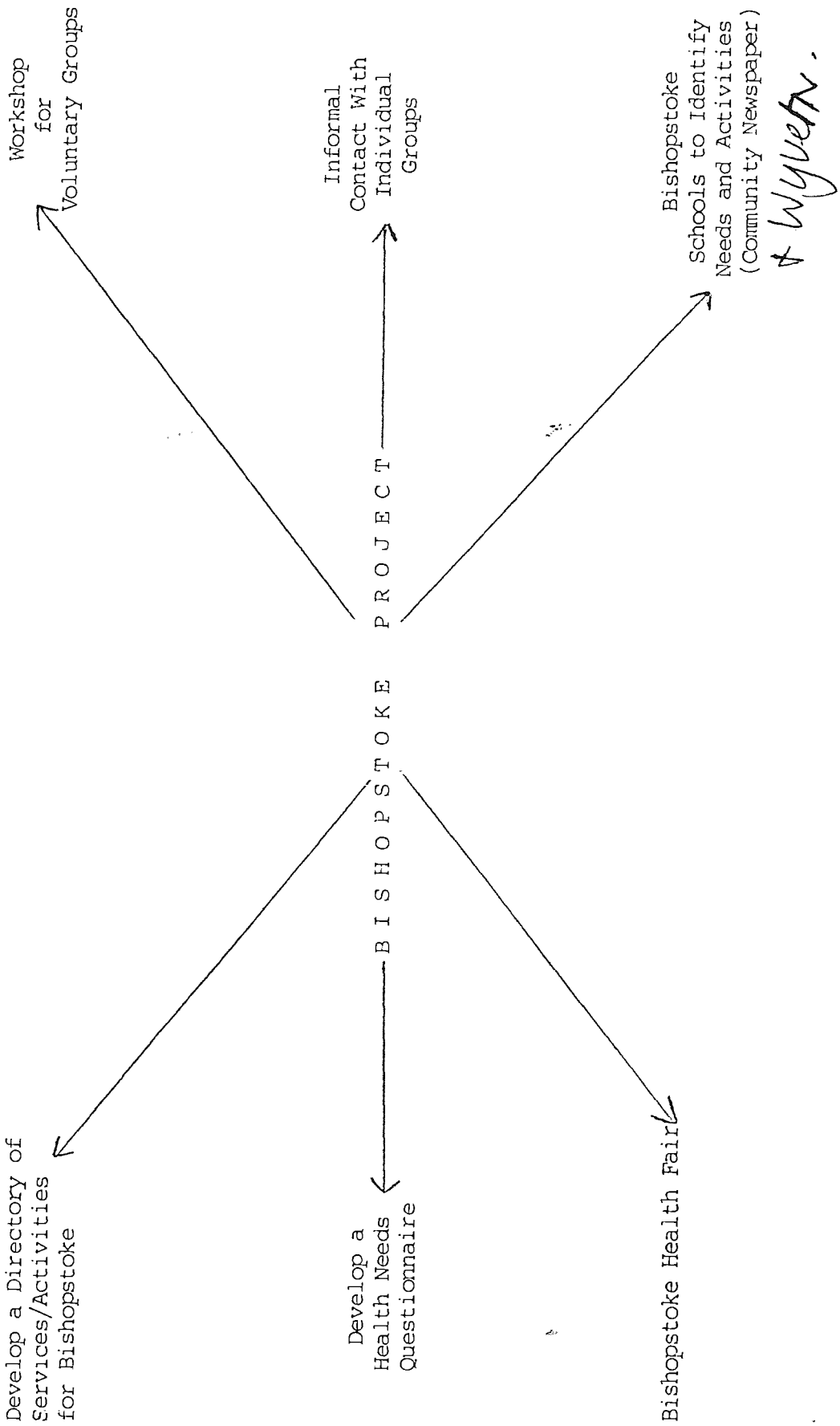
1. GROUPS AND ACTIVITIES IN BISHOPSTOKE

Presentations were provided at the workshop on Health For All principles and areas of work and the principles of community development in health. The main part of the morning was devoted to small group discussions to start the process of building up a community profile for the area.

The group discussions yielded a wide range of interests and issues. A summary is outlined below:

3. OPTIONS FOR ACTION

A number of possible options for action are identified below:



NK2AAR

CHILDREN AND YOUNG PEOPLE	ADULTS	SPECIFIC INTEREST GROUP
Eastleigh Boys' Club	Keep Fit (Memorial Hall)	Bishopstoke Good Neighbours
Scouts	Wyvern Day Centre: Frail & Elderly	Age Concern (Cpt Tennet)
Army Cadets	Luncheon Clubs (Wyvern & Methodist Church)	Parents' Support Group for Families of Children with Learning Difficulties
Play Groups	Silver Threads Club	Access Groups
Toddler Groups	Women's Institute	Bishopstoke Players
Meet a Mum Group	Bishopstoke Society	Sight Concern
Beavers, Brownies & Guides	Hostels for People with Hearing Difficulties: Itchen Mead	Church Groups
Gym Club	Bishopstoke House	League of Friends (Mount Hospital)
Boys Brigade	Mellor House	East Bishopstoke Residence Association
Church Youth Clubs		
Twins Club		
Wyvern Youth Club.		

NK2AAR

APPENDIX 3

DOCUMENTARY EVIDENCE

HEALTHY SHOPPING SCHEME

Healthy Shopping Basket Award

Working Group Meeting

Present : MEMBER A - HEALTH PROMOTION MANAGER
MEMBER B - HEALTH PROMOTION OFFICER
MEMBER C - COMMUNITY DIETITIAN
MEMBER D - HEALTH VISITOR MANAGER
MEMBER E - GRAPHIC ARTIST
MEMBER F - HEALTH FOR ALL CO-ORDINATOR

F and B reported the outcome of the meeting held with the Marketing and Promotions Manager, ... STORES Interest in participating in the scheme had been expressed and F and B had agreed to get back to the firm once draft materials were ready.

F had circulated the materials produced by Portsmouth. It was agreed that E produce drafts of the Eastleigh Healthy Shopping logo for considerattion at the next meeting.

C and F agreed to produce the core list of healthy foods for the scheme and to give consideration to the other printed information required for the scheme.

Issues for consideration at the next meeting:
- Agree Healthy Shopping Logo
- Agree printed materials for the scheme
- Consider launch date for the scheme

Date of next meeting : Friday, 1st May 1992 at 10.00 am in the Meeting Room, Southampton Health Promotion services

File 28/30
Healthy Shopping Basket

HEALTHY SHOPPING BASKET AWARD

WORKING GROUP MEETING

THURSDAY 16 JANUARY 1992

Present: MEMBER A - HEALTH PROMOTION MANAGER
MEMBER B - HEALTH PROMOTION OFFICER
MEMBER C - COMMUNITY DIETITIAN
MEMBER D - HEALTH VISITOR MANAGER
MEMBER E - HEALTH FOR ALL CO-ORDINATOR

. E circulated a task list to members of the group. The key elements of the scheme were outlined:

- Healthy staple foods to be highlighted on store shelves.

- Promotional materials (Healthy Shopping Award poster, leaflet and recipe cards) to be prominently displayed in participating stores.

- Criteria for the award, to advise participating stores on practical aspects of the scheme.

- A media plan would be developed to ensure maximum publicity and awareness raising.

There was discussion about the range of food retailers with whom the scheme could be piloted. The group agreed that starting with .... stores within the southern parishes would present considerable benefits:

- The shops tended to be sited near or in the middle of housing estates. This would present the opportunity to raise awareness among the key target group: shoppers on a low income and families with children.

- .. STORES has a chain of stores throughout the Southampton area. Thus, there would be the potential to extend the initiative throughout both Eastleigh Borough and beyond.

- Starting off with a small chain of stores would provide the opportunity to reinforce "healthy eating" and "healthy shopping" messages.

Action Agreed

- E agreed to draft some criteria for the award scheme.

- C agreed to draft a list of healthy shopping choices (using the Hull list as a starting point).

- E agreed to contact ... STORES and propose starting the scheme with their stores in the southern part of Eastleigh Borough.

- It was agreed that A and C would be involved with any preliminary meeting with ... STORES

- E agreed to obtain promotional materials from the Portsmouth scheme.

Date of Next Meeting

6 March 1992 at 9.15 am in Southampton Health Promotion Unit.

HEALTHY EASTLEIGH 2000

WORKING GROUP MEETING - 16TH JANUARY 1992

Tasks

1. A list of healthier staple foods must be drawn up which will at a later stage form part of the criteria upon which a store will be assessed.

2. Participating stores will be expected to concur with the broad aims and objectives of the campaign. There will be provision for negotiating with individual stores or chains.

3. Promotional materials must be produced:

- Initial promotional materials & displays.

- Shelf labels

- Recipe leaflets.

4. Criteria for the award scheme must be developed, i.e., practical aspects of what must happen in a store if an award is to be given.

5. Identify other officers/agencies to join the working group.

NK/PAW
13.1.92.

Circulated 6/3

3

Healthy Shopping Basket Award

Working Group Meeting

Friday 6 March 1992

Present : MEMBER A - HEALTH PROMOTION MANAGER
MEMBER B - HEALTH PROMOTION OFFICER
MEMBER C - COMMUNITY DIETITIAN
MEMBER D - HEALTH VISITOR MANAGER
MEMBER E - HEALTH FOR ALL CO-ORDINATOR

E circulated the Portsmouth Healthy Shopping Basket information. This included the scheme criteria, information leaflets and poster. E agreed to circulate copies of the pack. Members of the group agreed to come to the next meeting with comments/amendments.

C circulated a list of "healthy foods" for the scheme. This included the five main food groups. It was agreed that the list was comprehensive and provided a broad base from which to negotiate with food retailers.

E reported that a meeting had been set up with ... STORES for 20th March 1992. E and B would meet with the Marketing Manager and feed back to the rest of the group. E agreed to check with Portsmouth that they would be happy for their promotional/ information materials to be circulated for background information. It was also suggested that Trading Standards be involved and kept informed about the project.

As part of the Healthy Sheffield 2000 initiative, a food availability survey had been undertaken in a particular locality of the city. E agreed to copy the survey report to other members of the group.

Date of Next Meeting

Monday, 30th March 1992 at 1.30 pm in the Health Promotion Unit, Southampton.

HEALTHY EASTLEIGH 2000

HEALTHY SHOPPING BASKET

Notes of a Meeting held on 18th August 1992

Present: MEMBER A – HEALTH PROMOTION MANAGER
MEMBER B – HEALTH PROMOTION OFFICER
MEMBER C – COMMUNITY DIETITIAN
MEMBER D – HEALTH VISITOR MANAGER
MEMBER E – GRAPHIC ARTIST
MEMBER F – HEALTH FOR ALL CO-ORDINATOR

F and C reported that they had met with the marketing consultant for STORES. She had confirmed that the firm was keen to host the launch and would confirm the 'launch store' in due course.

Scheme Materials

E had produced final drafts and obtained quotes for printing of scheme materials. F agreed to place the order with the printers, with being identified as the key contact. E agreed to link up with B to agree the final wording and illustrations to be included in the materials.

Launch

Members of the group discussed the format of the launch. It was agreed that display boards could provide a backdrop to a display of the "healthy choices". B, C & E agreed to design the display. The Mayor would award a Scheme Certificate to a senior member of staff from STORES and both, along with a member of the Health Authority, would have the opportunity to say a few words about their organisation's involvement in the scheme. It was proposed that the following be invited to attend:

Health for All Steering Group
and Joint Committee Members

B agreed to visit one of the stores participating to provide direction with the Healthy Choices (F to confirm the date).

Date of Launch

The provisional date of the launch is 9th October 1992, not 25th September 1992. (The Mayor of Eastleigh was unable to attend on 25th September).

Date of Next Meeting

Friday, 18th September 1992 at 1.00pm.

NK/JHA 26/8/92

TUE 28/7/30

HEALTHY EASTLEIGH 2000

HEALTHY SHOPPING BASKET SCHEME

Notes of a meeting held on 20 July 1992

Present: MEMBER A - HEALTH FOR ALL CO-ORDINATOR
MEMBER B - COMMUNITY DIETITIAN
MEMBER C - HEALTH VISITOR MANAGER
MEMBER D - GRAPHIC ARTIST

Apologies: MEMBER E - HEALTH PROMOTION MANAGER
MEMBER F - HEALTH PROMOTION OFFICER

A reported that she had met with ... in Bursledon and the Swan Centre, Eastleigh and that both stores were keen to participate. There was discussion about the process and date for launching the scheme. It was suggested that a launch could be undertaken with ...STORES on 25 September 1992 representing the commitment of a large supermarket chain, and with ... on 9 October 1992 as a chain with community-based stores. A agreed to contact both stores with this proposal.

D provided drafts of the poster, leaflets and guidelines for the scheme. All members of the group agreed the graphics were excellent. A agreed to have the materials available for HFA Steering Group members to look at at their next meeting. D agreed to draft the outstanding items:

- the certificate for participating stores;

- the shelf label (same size as the Portsmouth label and an additional larger label to conform to ...STORES marketing materials.)

D -agreed to get costings for the printing costs (to include the cost of a wallet/cover for the scheme pack).

Date of Next Meeting

18 August 1992 at 2.00 pm in the Meeting Room at Health Promotion Services, Southampton. This meeting would focus on finalising the scheme pack and the format of the launch.

NK/SJM
E4/30NKmins

6

HEALTHY EASTLEIGH 2000

Eastleigh Healthy Shopping Basket

Background

Reducing levels of mortality and morbidity linked to coronary heart disease has been identified as a target area for the Healthy Eastleigh 2000 initiative. The "Healthy Shopping Basket" programme outlined below addresses one of the key risk factors linked to coronary heart disease - Diet and Nutrition. It represents a community based approach to the promotion of healthy eating which has collaboration with local food retailers as its focus. The programme also represents a practical way of addressing one of the key principles underpinning Health for All - Equity in Health. Availability of healthy foods at budget prices is currently inequitable so improving access to a healthy diet for all groups in the way of working towards "Health for All".

Programme Aim

The overall aim of the programme is to make healthier dietary choices easier for all people, regardless of social class or where they shop.

Programme Objectives

1. To highlight the healthy staple foods on supermarket/ grocery shelves.

2. To highlight low priced wholesome foods so healthy eating can be achieved when shopping on a budget.

3. To raise awareness of the basic principles of healthy eating and dispel the notion that it is extremely cranky.

4. To encourage food stores in the Borough of Eastleigh to stock a wider range of healthier foods.

5. In the long term to encourage competitive pricing of healthier foods between the supermarkets/stores participating in the programme.

6. To provide a programme which supports the Heartbeat Award Scheme.

CC1AAY

Implementation

Outlined below are some of the issues/activities underpinning the implementation of the programme.

1. A Working Group of officers committed to the development of the programme to be established.

2. A bid for finance to produce the promotional materials required for the programme to be submitted to the Look After Your Heart Community Projects Scheme.

3. Agreement on the area/wards in the Borough which are to be the focus for the first stage of the programme.

4. Agreement by the Working Group on the criteria underpinning the programme, to include:

   - the list of "healthy foods" which will form an important part of the criteria for the programme.

   - protocol for approaching stores to participate in the programme.

   - collaboration on the production of the promotional materials for the programme e.g.

     Shelf labels
     Posters
     Display materials
     "Healthy Shopping Basket" Awards

   - how best to secure media coverage.

CC1AAY

APPENDIX 4

DOCUMENTARY EVIDENCE

INTER-SECTORAL SMOKING PREVENTION PROGRAMME

EASTLEIGH SMOKING PREVENTION PROGRAMME

Introduction

Smoking reduction has been identified as a key area for action in Winchester Health Authority's District Plan 1992. The Health Authority identified the key ways in which it aims to reduce death and disease caused by smoking as being:

- Publicity : taking a public stand on the health costs of smoking
- reducing the number of people who start to smoke
- increasing the number of people who stop smoking

Winchester Health Authority
District Plan 1992/93

Initial activity to develop a smoking prevention programme has been focused on the Eastleigh sector. This has been progressed through Eastleigh's Health for All initiative in an effort to ensure that a comprehensive, inter-agency programme emerges. It is proposed that the Eastleigh programme will provide a model for implementation throughout the other sectors in Winchester Health Authority. This paper provides an interim report on the key areas of work beginning to develop and the activity currently being progressed. It is anticipated that the activities proposed below will facilitate the establishment of baseline data and enable the identification of appropriate local targets for smoking prevention activity by August 1992. A summary of the key areas of action is attached in Appendix A.

Eastleigh Smoking Prevention Programme

The key elements of the programme are outlined under three categories of prevention activity:

1. Prevention of uptake of smoking
2. Educationaland motivational approaches to encourage cesssation
3. Advice from health care workers

1.Prevention of Uptake of Smoking

Two key arenas of activity have been identified: Schools
Local Retailers

Schools
A. Background

The establishment of baseline data around four areas of activity has been proposed:

* Existence of smoking education in each year group from 7 and 8 year olds until 16 in all schools
* Evidence of active participation of pupils through peer led methods
* Involvement of parents in primary education about smoking

* Development of school policies on smoking control, applying to all school users

The identification of current levels of activity will facilitate the establishment of appropriate process targets.

B. Proposed Action

To develop a model for education based smoking activity, it is proposed that during 1992/93 work be undertaken with one of the 5 "clusters" of Eastleigh schools.

Cluster of Schools

Secondary School

Infant & Junior Primary Schools

School

Primary School

Infant and Junior Schools

The emphasis of activity will be on the development of a model focussing on health related skills. This will enable both the identification of current activity and facilitate the development of initiatives within the curriculum which has a broad lifeskills base. Discussions will be progressed with the schools during the Summer Term 1992 with a view to initiating development activity in September 1992. To facilitate the involvement of local teachers in the development of this model funds have been earmarked from Prevention/Health education training monies (GEST 12a).

Gathering intelligence about the existence of "smoking policies" in schools in the Eastleigh area and establishing a programme of activity to develop policies will be undertaken by the Smoking Prevention Co-ordinator. It is proposed that initial baseline data will be collated during June-August 1992 with the development of measurable outcome targets andimplementation increase policy development in schools commencing September 1992.

Retailers

A. Background

Increasing the number of shops who refuse cigarette sales to children and who give out an explanatory leaflet to children trying to purchase cigarettes represent the key targets for smoking prevention activity with local retailers.

B. Action

Information identifying local retailers by ward in Eastleigh Borough has been retrieved from the Environmental Health database. It is proposed that local retailers are surveyed to establish baseline data on current practice with a view to establishing measurable targets for increased smoking prevention activity by August 1992. A draft of the questionnaire proposed for use with local retailers is attached(Appendix B).

2. Educational and Motivational Approaches to Encourage Cessation

Three key arenas of activity have been identified:
National No Smoking Day
Workplaces
Eating Places

National No Smoking Day
A. Background

National No Smoking Day represents an important opportunity to raise public awareness about smoking. The Eastleigh Health Promotion Group is a key focus for community based health promotion activity. Activities ranging from health stalls to a monthly health promotion column in the weekly newspaper are among the activities currently being progressed.

B. Action

Baseline data around activity undertaken for National No Smoking Day 1992 is currently being collated. This will focus on the establishment of information around:

- Local activities during the day
- Poster sites displaying No Smoking Day information
- Column inches of media coverage about smoking and National No Smoking Day

It is proposed that targets for activity in 1993 will be established by August 1992.

Workplaces and Eating places
A. Background

The establishment of baseline data around four areas of activity has been proposed:

* number of workplaces known to have smoking control policies
* number of restaurants/cafes to have total or partial smoking bans
* number of workplaces signing up for Look After Your Heart
* number of retaurants/cafes receiving Heartbeat Awards

B. Action

Information on the numbers and location of workplaces, restaurants and cafes in the borough has been retrieved from the Environmental Health Database. It is proposed that these premises are surveyed to establish baseline levels of activity. A number of survey methods have been proposed including the possibility of conducting a "telephone" survey. A draft interview schedule for use with these premises is attached(Appendix C). It is proposed that measurable targets for increased activity under the four areas of activity outlined above will be established by August 1992.

Advice from Health Care Workers
A.Background

The establishment of baseline data around 3 areas of activity has been proposed :

* number of practices providing smoking cessation support groups in health promotion clinics
* number of smokers seen in well-person clinics followed up for smoking cessation counselling
* number of primary health care staff trained in motivational methods of smoking cessation

Preliminary work is underway in liaison with the Family Health Services Authority to establish current levels of activity. Work is underway to identify the number of practices routinely recording the smoking status of patients. A review of Health Promotion Clinics is also underway. It is anticipated that this will be completed by August and provide more detailed information to assist in further target setting.

Conclusions

The areas of work proposed in this report focus on the identification of current levels of smoking prevention activity in the Eastleigh area with a view to establishing appropriate local targets for future activity. The principles of inter-sectoral collaboration and the implementation of activity to achieve maximum health gain in the community underpin the development of the smoking prevention programme. It is anticipated that once baseline levels of activity have been established, detailed discussions will be initiated to ensure a multi-agency approach to monitoring and evaluation of future activity. A further report will be available in August 1992 outlining proposed smoking targets and proposed programmes of action.

Noreen Kickham - Health for All Co-ordinator, Eastleigh Borough Council

Appendix A

Eastleigh Smoking Prevention Programme
Summary of Key Areas of Action

Schools

- Develop a model for education based smoking prevention activity linked to health related skills with the Toynbee Secondary School Cluster

  Summer Term 1992

- Implement health related skills programme in the Toynbee Cluster

  September 1992

- Survey local schools to establish those with a smoking policy

  June - September 1992

- Implement programme to increase the number of schools in the Borough with a smoking policy

  September 1992

Retailers

- Establish current practice and concerns of retailers around cigarette sales to children

  June - August 1992

- Establish target for increased participation of local retailers in smoking prevention programme and implement programme of action

  August 1992

National No Smoking Day

- Collate baseline data around activities for National No Smoking Day (NNSD) 1992 to enable the identification of a target for activity for NNSD 1993

August 1992

Workplaces and Eating Places

- Establish baseline levels of activity around smoking prevention

June - August 1992

- Implement programme of action to increase levels of smoking prevention activity

August 1992

Primary Health Care

- Review recording procedures for smoking status and health promotion clinics being run by general practice. This will provide baseline information on the current levels of smoking prevention activity in primary care and facilitate the identification of appropriate targets.

June - August 1992

Appendix B

Local Retailers

1. Are you concerned about the numbers of children under 16 who attempt to but cigarettes in your shop ?

Please tick one box

Yes

No

2. Do you prominently display information about the prohibition of cigarette sales to children under the age of 16 ?

Yes

No

3. Would you be prepared to give an explanatory leaflet encouraging smoking prevention to those children under 16 who attempt to buy cigarettes ?

Yes

No

4. (For Food Retailers) The Eastleigh Healthy Shopping Award aims the purchase of healthy food choices in shops within the Borough. Participating retailers are given the award as a result of highlighting healthy food choices on their shelves.
Would you like more information about the scheme ?

Yes

No

5. Are there any other health issues you would like us to consider ?

Appendix C

Workplaces

1. Have you signed up with the Health Education Authority's Look After Your Heart campaign?

Yes

No

2. Do you provide information to staff about healthy living by distributing health promotion materials?

Yes

No

3. Do you publish advice on aspects of healthy living in the house newspaper or magazine?

Yes

No

4. Do you have a smoking policy ?

Yes

No

5. Do you provide smoke-free areas on the premises ?

Yes

No

6. Do you provide healthy choices of food and publicity about them in the staff canteen ?

Yes

No

7. Do you provide opportunities fro staff to take exercise ?

Yes

No

8. Do you provide health screening/fitness testing for staff ?

Yes

No

9. Do you have company wide policies on the following ?

	YES	NO
Smoking		
Healthy Eating		
Exercise		
Alcohol		
Stress Management		

Catering Establishments

1. Do you provide NO SMOKING areas for the public on your premises ?

Please tick one box

Yes

No

2. Do you regularly provide healthy food choices on your menu ?

Yes

No

3. Have you heard of the Heartbeat Award Scheme ?

Yes Go to question 4

No Go to question 5

4. Are you interested in participating in the scheme ?

Yes

No

5. The Heartbeat Award Scheme aims to promote the provision of "No Smoking" areas in eating premises, healthy food choices

and high hygiene standards.
Would you be unterested in hearing more about the scheme ?

Yes

No

APPENDIX 5

DOCUMENTARY EVIDENCE

HEALTH PROMOTION GROUP

Health Promotion Group.

MINUTES OF THE HEALTH PROMOTION MEETING

HELD ON FRIDAY 21ST JUNE 1991

AT EASTLEIGH HEALTH CENTRE

Present:
MEMBER A - HEALTH FOR ALL CO-ORDINATOR
MEMBER B - HEALTH VISITOR MANAGER
MEMBER C - LEISURE CENTRE ASSISTANT
MEMBER D - DENTAL THERAPIST
MEMBER E - FAMILY RESOURCE CENTRE MANAGER
MEMBER F - PHYSIOTHERAPIST
MEMBER G - HEALTH VISITOR
MEMBER H - HOSPITAL MANAGER

Apologies:
MEMBER I - COMMUNITY DEVELOPMENT WORKER
MEMBER J - SOCIAL WORKER
MEMBER K - HEALTH VISITOR
MEMBER L - ALCOHOL ADVICE WORKER

Minutes of the last meeting were agreed.

Healthier Communities Workshop

It is hoped that the report initiated as a result of the recent workshop, would soon be published. The Eastleigh group would then have a clearer idea of its standing and the way forward. The possibility of having a small budget for the group was raised, and this will be investigated. Funds could then be available for resources, such as balloons with logos on, badges for children, and items for kitting out future market stalls. C would find out from Fleming Park what methods they adopt in the way of promoting themselves. One suggestion was a £20 donation from each agency represented on the group, to this end.

The question of raising funds also arose. It was thought that probably we could not do this at Eastleigh Market, as the space there is offered to 'charitable' organisations only. However, it was agreed that finances do help support our intended aim, of reaching the public.

It was felt that we needed to build up the identity of the group, in order to 'sell' our group to the general public, who probably don't know (a) that we exist, or (b) why we exist. A reported that 'Healthy Eastleigh' would be publised soon by Eastleigh Borough Council for the 'Health For All' group. The aim of this publication is to raise consciousness amongst local people on health issues.

E reported on the Eastleigh College health promotion stall, which was recently held. This will probably become an annual event. She could provide more feedback, if this is required.

Eastleigh '91

A reported on the fitness testing stall at Eastleigh '91, on 15th and 16th June. This went well, with Health Visitors 'manning' the stall on Saturday, and A and G on Sunday. There had been much interest shown and appropriate leaflets had been distributed. K, the Health Visitor who organised the stall, would be asked what the key issues had been this year.

Drinkwise Day

K from Vol. Group had reported that their stall had also been successful: There had been a lot of information available, balloons for children and samples of free/low alcohol drinks for adults.

Healthy Lifestyles Market Stall

Despite a specific request for more help, there were still more volunteers required for the market stall on Thursday 27th June. 50% of these volunteers were Health Visitors. It was hoped that the stall could be 'manned' for the whole day - if not by representatives from the group, then by their colleagues.

Information Exchange

A reported on two current projects -

(a) Community School Peer Training Project

This is a core group of interested pupils, who aim to encourage their peer group, by identifying environmental issues. They are most enthusiastic and aim to produce their own logo. They are 'twinning' with a similar group in Kettering.

(b) Community Participation Project at Bishopstoke

Field workers from all agencies in Bishopstoke are endeavouring to produce a directory of local activities and information.

Also in this vicinity, Junior School have published a community newspaper for young people's needs.

Health Promotion Group.

MINUTES OF THE EASTLEIGH HEALTH PROMOTION MEETING

HELD ON MONDAY 11TH NOVEMBER 1991

AT EASTLEIGH HEALTH CENTRE

Present: MEMBER A – HEALTH FOR ALL CO-ORDINATOR
MEMBER B – SECRETARY, COUNCIL OF COMMUNITY SERVICE
MEMBER C – HEALTH VISITOR
MEMBER D – HEALTH VISITOR
MEMBER E – PHYSIOTHERAPIST

Apologies: MEMBER F – COMMUNITY WORKER
MEMBER G – HOSPITAL MANAGER
MEMBER H – DENTAL THERAPIST
MEMBER I – LECTURER F.E. COLLEGE

Minutes of the last meeting were read.

MATTERS ARISING

Information Exchange

B Redundancy - A group may be started for . . . . professional people who have been made redundant. . . . . , a personnel officer, has recently lost her job and finds there is a gap in support for people in her situation. An initial meeting is planned for 10-12.00 on 22nd November 1991 at the Family Resource Centre.

A : Funding for the 'Healthy Shopping Basket' (Look After Your Heart) has been approved.

E E attended a one-day conference recently 'Rehabilitation Targets to 20000'. One talk by Dr stressed the importance of the prevention of back injury. 40% of GP referrals are for back pain. 80% of the general public will suffer at least once in their lives. The group discussed writing to Dr to outline our aims and request his general support.

D : Winchester Health Authority have increased D working hours from 30 hours to full time until the end of March 1992 - in order for her to spend 7½ hours per week on Health Promotion work.

NEW BUSINESS

The launch of the Sector Health Promotion Group has been changed to Monday 9th December. All group members are invited and encouraged to attend. Please see invitation attached with reply slip, plus an invitation list - please inform us if you feel there are any omissions: (D – TEL: . . . . .)

The logo adopted by Health For All 2000 will also be used by our Group. A rota for the stall on the launch day was discussed. Please come and represent your area of work on the day; any help between 10-2.00 will be greatly appreciated.

DATE AND TIME OF NEXT MEETING

Monday 16th December 1991 at 10.00 in Room 102, Eastleigh Health Centre.

91/Mins/HPMeet11.11.91

INVITATION LIST TO HEALTH STALL - 9.12.91

All members of Eastleigh Health Promotion Group

ASSISTANT DIRECTOR - ENVIRONMENTAL HEALTH
Eastleigh Borough Council

AREA MANAGER
Social Services

GENERAL SECRETARY
Eastleigh Council of Community Service

PUBLIC HEALTH CONSULTANT
Winchester Health Authority

Health Promotion Manager

GENERAL MANAGER
Winchester Health Authority

HEALTH PROMOTION MANAGER
Southampton and South West Hants Health Authority

HEALTH VISITOR MANAGER
Winchester Health Authority

GENERAL MANAGER
Family Health Services Authority

Councillors at Eastleigh Borough Council

MEMBER - NON EXECUTIVE
Winchester Health Authority

MANAGER
.....General PLC

DEPUTY CHAIR
Southampton and South West Hants Health Authority

The Mayor of Eastleigh,

COMMUNITY MANAGER
Winchester Health Authority

COMMUNITY NURSING MANAGER
Winchester Health Authority

Manager, SHOPPING Centre

FILE: 28/17

MINUTES OF THE EASTLEIGH HEALTH PROMOTION GROUP MEETING

HELD ON MONDAY 16TH DECEMBER 1991

AT EASTLEIGH HEALTH CENTRE

(Meeting Time: 30 minutes)

Present:
MEMBER A – HEALTH FOR ALL CO-ORDINATOR
MEMBER B – GEN. SECRETARY COUNCIL OF COMMUNITY SERVICE
MEMBER C – HEALTH VISITOR MANAGER
MEMBER D – COMMUNITY HEALTH INITIATIVE WORKER
MEMBER E – DENTAL THERAPIST
MEMBER F – HEALTH VISITOR
MEMBER G – MIDWIFE

Apologies:
MEMBER H – F.E. LECTURER
MEMBER I – HEALTH PROMOTION MANAGER
MEMBER J – MENTAL HEALTH WORKER

The minutes of the last meeting were agreed by all present.

No matters arising.

A thanked all who attended and helped prepare the Healthy Eastleigh stall. The launch was a success and it was good to see so many members and representatives there.

The Group can continue to promote health issues through a small display in the Oxfam shop, which has been approved by the Manageress; Health Promotion will provide a printed title for the display.

Eastleigh Weekly have agreed to print a monthly article, to inform and promote the topic(s) of the next stall.

The next stalls are planned for Thursday 30th January and Thursday 27th February 1992. Three requests were made for use of the stall. Dental Health would like to book the date in May 1992. The Carers Association and Mind would also like to secure dates. A and F plan to negotiate further dates with The ... Centre Manager in the New Year and will offer these to the Group in due course.

Fundraising

I hasattended a fundraising workshop and would be prepared to act as a resource person to facilitate fundraising. When preparing the stall, it was agreed a central fund of money would have been beneficial.

Our future needs for equipment should be discussed. A will make enquiries into the cost of a mobile stall, such as the one the Southampton Health Visitors use. A will make

enquries about the possibility of appealing for money from the Mayor's Fund.

D suggested that we consider taking part in the Eastleigh Carnival as a means of raising money and promoting the work of the Group.

The topic of the next stall is to be Accident Prevention, in line with the TV series 'Play It Safe'. Health Visitors will specialise in temperature control in babies.

Suggestions of people to invite to contribute:-

*

* Housing Safety Advice Officer

* College students, who have recently taken part in an awareness-raising exercise about home safety in Eastleigh

Information Exchange

A : Crestwood project will be launched in January.

Health For All: have approved the Healthy Eating Basket. It will be implemented in conjunction with Southampton Health Authority initially, and will be in use across the borough in due course.

E Great need shown in the form of requests from interested groups for information on prevention of accidents and injuries. Her Department is not able to meet this need. The Group suggested other allied staff may be able to take on this role. In particular, LAY tutor may be well suited.

B : The Redundancy Group has fulfilled a need - 15-20 people attend each meeting. Aims and objectives of the group will be reassessed in the New Year.

DATE AND TIME OF NEXT MEETING

Monday 20th January 1992 at 10.00 in Room 102, Eastleigh Health Centre.

LTHY EASTLEIGH GROUP

tleigh Health Centre
town Road
tleigh
ts. SO5 4AG

ephone: 0703 610961

MEMBERS 17.

HEALTHY EASTLEIGH

HEALTHY EASTLEIGH GROUP

MINUTES OF MEETING HELD ON 17TH FEBRUARY 1992

Present: MEMBER A – HEALTH PROMOTION OFFICER
MEMBER B – HEALTH VISITOR
MEMBER C – DENTAL THERAPIST
MEMBER D – HEALTH VISITOR MANAGER
MEMBER E – SECRETARY, COUNCIL OF COMMUNITY SERVICE
MEMBER F – HEALTH FOR ALL CO-ORDINATOR

1. Minutes of the meeting held on 20th January 1992

These were agreed.

2. Swan Centre Stall - 30th January

B reported that the stall on Reducing the Risk of Cot Death and Child Safety made contact with 48 adults who had a total of 32 children, mostly between 0-5 years and 91 leaflets were handed out. All the room thermometers were sold. It was agreed that counting leaflets and contacts would be a useful way of evaluating the stall in future.

3. Publicity

Copies of newspaper articles about the activities of the group are being kept by – B : and a photograph album is being compiled. It was suggested that some of the photographs be mounted for future display at the stall. and Noreen would draft the next article for the stall on 27th February, again on Play It Safe.

4. Fundraising

– A will obtain application form from the Regional LAYH office for funding for the mobile stall. A offered to draft the application for funds from the Carnival Committee for consideration at the next meeting, stressing that the stall has a Borough wide approach, is community based and that the public is encouraged to contribute.

5. National No Smoking Day

B had contacted celebrities to participate but was waiting for confirmation. It was agreed the stall may be staffed for longer than the usual 4 hours from 10am - 2pm. A had been in contact with young people from Eastleigh College on the pre-nursing course who may attend. B has written to local stores for small prizes for competitions run from the stall on the day.
Media coverage was discussed. HEALTH VISITOR had asked B that her SmokeStop group be mentioned in the article in Eastleigh Weekly's Health Matters. A discussion took place about the display sites which are under review by MANAGER at HPD. A said that displays have been arranged at the Family Resource Centre and Eastleigh Health Centre Reception. Consideration needs to be given to the sites we feel are the most appropriate.

6. Information Exchange

F reported that the Borough Council had received leaflets from the Government on solvents and drug abuse for parents to link with media campaign. Possible collaboration was discussed with Interface on Drinkwise Day and agreed to check out leaflets for teenagers from , SHPO for Young People, HPD.

F described Eastleigh College's developing campaigns on stress reduction and exercise for people with special needs and referred to the pre-nursing course looking at BTec Health Studies.

B reported that were offering space between 2-8 March and a volvo car for safety demonstrations for our use, but it was agreed two weeks' notice is too short. will, however, contact the campaign organiser and express our interest in future opportunities for collaborative work.

D and B described the Accident Prevention Workshops being run by the Play It Safe organisers. B is keen to attend and pass on the information to others. E suggested she talk to F about this. E will follow up on figures on child accidents for Eastleigh which had not been available. agreed to look into training for community based health promotion staff working on stalls such as the Swan Centre in Eastleigh and the Brooks in Winchester.

7. Future Health Stall Dates and Topics

27th February 1992	Play It Safe
11th March	National No Smoking Day
26th March	Look After Yourself / physical activity
	World Health Day ???
30th April	
28th May	
9th June	Drinkwise Day
25th June	

B asked for help with the stall next week, 27 February. Unfortunately the fire brigade and police are unavailable. B was in touch with the pre-school playgroup association and midwives.

F will contact the Regional LAYH office to find out if the exhibition board will be available to promote LAY/physical activity on 26th March to link with World Health Day on 7th April.
A will be meeting with Riverpark Leisure Centre staff re. their activities at this time and will pass information to Noreen for possible links with Fleming Park. A will book fitness testing equipment on 7th April in case it is decided to hold an additional stall for World Health Day then.

FHC 28/17

OBJECTIVE SETTING AND LIAISON FOR HEALTH PROMOTION GROUPS

The circumstances in which health promotion is planned and carried out is changing and will change further. The Health Promotion Liaison Group should be able to assist the Health Promotion Groups in their work at local level as well as ensuring district-wide co-ordination of health promotion whenever this is appropriate.

Health Promotion Groups

Following the changes to the structure of the Community Unit these cannot strictly be called "Sector Groups" as they are more closely linked to the Health For All initiatives. However the link between the Health For All committees and the senior managers responsible for the groups is not strong.

Clear information about the objectives and actions planned by the HFA committee ought to be circulated directly to the managers responsible for the local groups. This information should be reviewed by the Health Promotion Group so that it can agree appropriate objectives for its work.

For consideration:

Some criteria for the identification of such objectives are:

1. What are the DHA priorities for health promotion?
   (HPLG to review District Plan and Public Health Report)

2. Within these, what are the local Health For All Group priorities?
   (Manager and HFA co-ordinator)

3. Which of these requires multi-agency action?

4. From these set measurable objectives for the group to facilitate or achieve during the year.

5. Identify action/development of existing activities that can contribute.

6. Identify how to ensure involvement appropriate staff/people in such development.

The local groups do not set health promotion priorities, they respond to those identified by the Winchester Health Authority (the purchasing organisation) that have been endorsed by the multi-agency HFA groups (which include provider representation).

Other local health promotion priority action should form part of the contracts agreed between the District Health Authority, the Community Unit and other provider units. This is not co-ordinated by the local health promotion group.

Health Promotion Liaison Group

The role of this group is primarily to assist liaison between the local groups so that experience can be exchanged. This provides the opportunity to identify common issues that need detailed attention.

The Liaison Group currently offers an opportunity for other professionals to be informed about local activities and issues. The Health Promotion Department uses it to liaise with other organisations with responsibility for health education and health promotion.
The current membership is:

Eastleigh Group

Health For All co-ordinator - Borough Council
Health Promotion Officer - Health Promotion Department
Family Services Manager - Community Unit

Winchester Group

Health For All co-ordinator - City Council
Health Promotion Officer - Health Promotion Department
Health Education Officer - City Council
(FSM - Community Unit)

Andover Group
Health For All Co-ordinator - Borough Council
Health Promotion Officer - Health Promotion Department
Family Services Manager - Community Unit

Royal Hampshire County Hospital
None

Administrative Officer - Hampshire FHSA
Dental Health Education Officer - Community Unit
Business Manager - Health Promotion Unit

For consideration:

a) agreement of general objectives for the group

b) involvement of R.H.C.H.

c) identification of objectives for next 18 months

d) review of membership of the group (n.b. effective size)

c) communication with other agencies - via local groups
membership of HPLG
minutes and papers

HEALTHY EASTLEIGH GROUP

MINUTES OF MEETING HELD ON

17TH MARCH 1992

Present:

MEMBER A — HEALTH VISITOR
MEMBER B — HEALTH PROMOTION OFFICER
MEMBER C — HEALTH VISITOR MANAGER
MEMBER D — HEALTH FOR ALL CO-ORDINATOR
MEMBER E — MIDWIFE
MEMBER F — HEALTH VISITOR
MEMBER G — ALCOHOL WORKER
MEMBER H — COMMUNITY PSYCHIATRIC NURSE
MEMBER I — DENTAL THERAPIST

Apologies:

MEMBER J — VOLUNTARY REP
MEMBER K — COMMUNITY HEALTH INITIATIVE WORKER
MEMBER L — HOSPITAL MANAGER
MEMBER M — PHYSIOTHERAPIST

1. Minutes of the meeting held on 17th February 1992 were agreed.

2. Matters Arising

Play It Safe - 27th February

A reported that the stall had made 292 contacts, and 167 leaflets had been distributed. It had been during half term and people were aware of the campaign, so interest was high. Staffing levels were also good.

A informed the Group of the 'Play It Safe' workshop which she will be attending on 6th April.

D reported that people were also giving ideas for future stalls, eg, cycling proficiency classes for children.

No Smoking Day Stall- 11th March

101 contacts of all ages had been made. The number of leaflets had not been counted but there had not been a good uptake. It was felt that the timing was poor, being a Wednesday and the day after the Budget. Staffing was also depleted. Ideas were sought to raise awareness. B will write to the Campaign HQ to suggest a more consumer-orientated title, eg, Smokewise Day.

3. Mobile Stall

D and A met Health Visitors at Bitterne and saw their mobile stall. D described stall and approximate cost - £300. This amount could possibly be obtained from the Carnival Committee but she felt that the stall needed to be more collapsible. F explained it could easily be taken apart. D and A have been invited to group 'chat' at Bitterne Health Centre on 7th April.

4. Future of Health Visitor Input

C described the process of re-structuring of Health Visitor Management. One Manager will cover Eastleigh and Winchester.

A is coming to the end of her allocation to the Group, on 31st March. After that she will be working only four days a week, so will be less available for the Group. C felt there was a need for a Co-ordinator for the Group.

B suggested everybody in the Group wrote to ... Sector Manager, to endorse this point.

5. Application for Tender from Carnival Committee

A and D described their bid for £300 via letter explaining the Group and identifying its activities, future plans and the mobile stall. Also asked for money for a Smokerlyser. The bid had to be in by the end of March. D explained about possibility of source of funds at Wessex Region 'Look After Your Heart'. The bid must be in by 7th April.

B reported that a neighbour was in PR publicity and would be willing to talk to the Group about publicity.

Various ideas for badges, sweatshirts, balloons, etc, for Healthy Eastleigh were discussed around the table, with ideas for funds obtainable from various sources.

6. Future Stalls

A asked for ideas for 26th March stall. C brought forward Child Protection with information combined with various other ideas - child abuse, The Children Act, Childline, etc. The Group felt that there was not enough time to bring all this together. D underlined that the Group needed to plan much further ahead. This was agreed for next meeting. H suggested a Drug campaign - solvent abuse for parents, etc. Similar leaflets could be obtained in line with the current 'Smiley' campaign against drugs. This was agreed and staffing arranged. The local Mind group had expressed an interest in the stall and D could contact them for the date at the end of June.

World Health Day - 7th April

D reported that Images Fitness Centre at Fleming Park will link up to provide tester sessions in the foyer. Coronary care leaflets would be available. This would be a good resource to have for the future.

Drinkwise

H will be feeding back more information at the next meeting after linking up with Oasis.

7. Any Other Business

F informed the Group of a 'Swim and Slim' group which had been set up by Salisbury Health Visitors.

J is having a Healthy Dental Care at Pirelli's on 29th April.

D asked for ideas for the stall to be held at the Eastleigh Show on 18th/19th July.

A reported that only two people had enrolled for the next Smokestop group, commencing on 22nd March - more people obviously needed.

8. Date of Next Meeting

2nd June at 11.00 at Eastleigh Health Centre.

STOP PRESS

The meeting on 28th April is cancelled. Instead there is a day workshop to be held in Andover, title: 'Community Participation in Health'. You will be receiving further details. Please do your very best to come. We hope to have a good attendance.

92/Reports/HP 17.3.92

MINUTES OF THE EASTLEIGH HEALTH PROMOTION GROUP

HELD ON TUESDAY 28TH JULY 1992

Present:
MEMBER A — HEALTH VISITOR
MEMBER B — HEALTH FOR ALL CO-ORDINATOR
MEMBER C — MENTAL HEALTH WORKER
MEMBER D — HEALTH PROMOTION OFFICER
MEMBER E — HEALTH VISITOR

Apologies:
MEMBER F — PHYSIOTHERAPIST
MEMBER G — F.E. LECTURER

Due to staff changes within the Health Visiting Service, _ has had to relinquish her special role in Health Promotion. The Group would like to thank for her enthusiasm and hard work, and wish her well.

MINUTES OF THE LAST MEETING

1. Eastleigh Show (18th and 19th July)

B reported that the ADT Health Quest trailer, staffed by two ADT members, B and local Health Visitors, attracted much interest at the Show, and was a useful health awareness-raising exercise. The trailer offered the chance to cycle ½ mile, with the option of a full health profile (charge £3). Health information was available. A noted that the Health Visitors felt there was a lack of facilities and opportunity for individual counselling on health matters, and also noted that health data was not able to be collected (as in previously used fitness test data).

The Group considered staff implications for these events, as full fitness testing requires a large staff commitment.

The Group agreed to consider which events should be targeted in the future to maximise available staff input.

2. Stalls Update

July 30th - Home/Garden/Water Safety
The stall is well staffed and a representative from the Ambulance Service will also attend.

August 28th - . . . . has the 'Youth Stand' fully organised.

September 24th - 'Enjoy Healthy Eating'
The new Community Dietician (who takes post in August) will be happy to support this stall.

ANY OTHER BUSINESS

1. Healthy Shopping Basket Scheme

This is to be launched at the end of September linked with [illegible] and [illegible] shops - to highlight healthy choices on shop shelves. Long-term aim to work with small local shops. Community workers useful in identifying possible shops for scheme.

2. Future Events

(a) [illegible] suggested a 'Fun Run' to involve community in active participation. This would be considered at a future meeting.

(b) Young MIND are doing a sponsored walk to raise funds for their holiday on 18th August - more information from [illegible].

DATE AND TIME OF NEXT MEETING

Tuesday 15th September at 10.00 in Room 102, Eastleigh Health Centre.

92/Reports/HealthyEast

APPENDIX 6

DOCUMENTARY EVIDENCE

SHARED INFORMATION PROJECT

5 September 1991

GIS JOINT INITIATIVE PROJECT TEAM

NOTES FROM MEETING AUGUST 23RD

Attendees

CONSULTANT (WHA) WINCHESTR HEALTH AUTHORITY
MANAGER (HCC Social Services)
PLANNER (HCC Social Services)
LECTURER (GeoData) UNIVERSITY
INFORMATION (SHA) OFFICER SOUTHAMPTON HEALTH AUTHORITY
HEALTH FOR ALL CO-ORD.(EBC) EASTLEIGH BOROUGH COUNCIL

INFORMATION OFFICER(HCC Social Services)
CONSULTANT (SHA) SOUTHAMPTON HEALTH AUTHORITY
POLICY OFFICER (EBC) EASTLEIGH BOROUGH COUNCIL

The objective of the meeting was to review the progress towards completing the 'User' and 'Facilitator' planning tasks identified at the planning workshop on July 23rd.

User Tasks

The 'user' group presented the outcome from their planning meeting.

Their progress was documented (and has been circulated) the following comments/suggestions were made:

1. Some further work was identified for the definition of users:

   a. What is the population of each of the primary and secondary user communities? (broken down by sub-communities)

   b. Which of the subcommunities will be the focus of the initial pilot applications?

   c. What will be the size of the 'pilot' user communities?

2. In defining the 'Needs' of the users the general areas were identified but not prioritised. Thus whilst, for example, Community

Care planning is a shared need there must be a prioritised list of applications within the general subject of 'Community Care Planning'. Also what is the priority amongst the general subject areas ie is Community Care Planning a higher priority than, say, Special Needs planning?

3. A list current projects by HA has been documented, similar lists need to be drawn up for each 'agency' so that:

   a. Current projects that fit into the 'Joint Initiative' project can be identified.

   b. 'Re-inventing the wheel' can be avoided.

   c. An overall view of resource commitment (and impact of any new projects) can be assessed.

4. Initial application areas were proposed but need further refining. A 10 line 'specification' describing what the application will do, what data it will use, who will use it etc is required for each initial application.

5. The need for adequate management focus was re-emphasised. In particular it is essential that a project sponsor be identified as soon as possible.

6. The impact of the changes in working practice that might be by these new applications was discussed. It was agreed that:

   a. Anticipating and managing these changes could be the greatest challenge of the project. The possibility of a preliminary research project to assess the management impact of 'joint planning' was reviewed.

   b. A significant change could be that decision making will be based on 'new' types of information (including statistical analyses).There is a need to ensure that this is acceptable to the decision makers.

   c. The major impact of new systems is not so much the effect of what is new but what is taken away. In this project the 'thing' that is taken away is 'independence' ie agencies will be committed to joint, not independent planning.

7. The need for Education, at three levels, was discussed:

   a. Education on GIS for the project team. To ensure all members have the same concept of what can be achieved.

   b. Education for the user groups to 'set the scene'.

      The GeoData Institute has funding to develop 'general awareness education' about GIS. Collaboration between the HAs, HCC, EBC and GeoData was discussed. From the collaboration GeoData would get an insight into what education was required and the project team would have access to education material and facilities.

c. Education for decision makers regarding the use of new sources of information/analysis as the basis for decision making.

Facilitator Tasks

The sub projects for the technical reviews were identified as:

1. Current Status
   - o Data
   - o Systems
   - o Network
2. Technical Options
3. Database
   - o Ownership
   - o Management
   - o Update
   - o Formats
4. Application Development
5. Review/Evaluation
6. R&D
   - o Modelling
   - o Analysis
   - o Spatial Statistics
   - o Error/Data Quality
   - o Geographical Areas
   - o Indicators
   - o Interface
   - o Census
7. Customization
8. Implementation
9. 'Distribution'

- o Hantsnet
- o Schools
- o Other communities

Presentation

Training

10. Generic Structures

It was agreed that work on these areas could only begin when the context had been more clearly defined ie by defining (and specifying) the initial applications and requirements.

The need to:

1. Include Systems Management as a sub project was agreed ie who will be responsible for the 'system', data integrity, performance, change and problem management, service levels (availability etc). Where will the 'system' reside? ie on what processors, network etc.

2. Review existing DoH DIS and GIS projects is essential if we are to present a 'new' initiative to the DoH. IBM will co-ordinate, where possible with other DoH DIS projects in which it is involved.

Miscellaneous.

1. Further interest in this project has been expressed by the NHS IT Directorate.) has asked to be kept informed (and has been sent minutes of the meetings so far).

2. A 'core' project team was agreed. The team will consist of

   - o A 'user' representative
   - o A 'facilitator' representative
   - o A representative from each agency.

3. The core team will meet on Friday 6th September to begin the preparation of a draft project plan.

   Attendees on the 6th will be

   (user and Winchester HA representative)

   (facilitator and Winchester HA representative)

   (EBC representative)

   (SOuthampton HA representative)

(HCC SOcial Services representative)

(FHSA representative)

(GeoData, project advisor)

The meeting will be held in Winchester, 09:00 -13:00.

20 September 1991 2

GIS JOINT INITIATIVE PROJECT TEAM MEETING 6/9/91

ATTENDEES:

MEMBER A	(Winchester HA) HEALTH AUTHORITY
MEMBER B	(HCC Social Services)
MEMBER C	(Winchester HA)
MEMBER D	(IBM Health Services)
MEMBER E	(Southampton HA)
MEMBER F	(Eastleigh Borough Council)

APOLOGIES:

MEMBER G (Winchester HA)

It was hoped that , , , , , of the FHSA would be able to attend.

OBJECTIVE

It was agreed that the key areas for discussion at the meeting were:

1) To begin preparation of the Project Plan. This could only be done once the pilot applications had been agreed.
2) To identify an executive Project Sponsor.
3) To identify a potential Project Manager.
4) To identify an 'owner' for the presentation to Ray Rogers on 8th October and start planning for this.

TOPICS DISCUSSED / ACTIONS

1) A handed out notes from the meeting held on 23rd August with apologies for the fact that, due to holidays, and the short gap between meetings, A had not been able to send them out prior to this meeting.

Copies to the remaining interested parties will be sent by post.

2) SPONSOR

The major part of the meeting was taken with discussing the need for executive sponsorship and how this might be achieved.

The sponsor is typically the executive with the most to benefit from the success of the project and is fully committed to ensuring its success; has the power to influence policy decisions, to ensure that there is adequate funding and resourcing of the project and is typically the executive to whom issues are escalated in the event that they cannot be resolved elsewhere.

In a multiple agency collaboration of this type, there is no common reporting structure or single reporting point. The meeting felt that a single sponsor could not be identified.

It was agreed that there should be multiple sponsors representing each of the agencies involved, and any entities that could influence the success of the project.

No additional layers of bureaucracy should be introduced. It was proposed that the Joint Planning Group for Winchester should be used with representatives of Eastleigh, Southampton and the Regional Health Authority joining the existing group when the GIS/Collaboration Project is on the agenda.

A to look at the composition of the group.

It was agreed that the following members of the Joint Planning Group should be approached by a member of the Project Team to gain their sponsorship, their commitment to the project and their agreement that the Joint Planning Group could be used as the sponsorship forum.

AGENCY / REPRESENTATIVE	PROJECT TEAM CONTACT
Hampshire Social Services - Director (resp for Eastleigh)	
Winchester DHA - Director of Purchasing	
Community Unit Gen Mgr - (Andover, Winchester & Eastleigh)	
Eastleigh Borough Council - Dir Housing & Health	
Education - not involved in this Project.	
Hampshire FHSA - Asst Mgr Strategy Planning	

Additionally, the following agency representatives should be contacted to seek their sponsorship as before and their agreement to join the Joint Planning group as appropriate:

AGENCY / REPRESENTATIVE	PROJECT TEAM CONTACT
Southampton HA - Director of Planning	
Wessex RHA Snr Planner/Community Care-	
Wessex RHA Corporate Business Dir -	

E suggested that she would check Southampton HA's agreement to using the Winchester Joint Planning Group for sponsorship in this way and that the next meeting for Inter Agency Collaboration on 17th September would be an appropriate place to seek this.

3) PROJECT PLAN

Work had been done on identifying and prioritising a manageable number of prototype applications:

* The Elderly
* Child Accidents and Children with Special Needs
* Mental Health
* Coronary Heart Disease

All have clear issues for inter agency collaboration, although Coronary Heart Disease calls for less main stream agency interaction.

There is considerable information available for Community Planning for the Elderly and Children. There is little information for Mental Health, although a pressing need for collaboration.

After discussion, it was proposed that the following applications should be selected for prototype development:

* The Elderly
* Child Accidents and Children with Special Needs

The Group discussed how each of these applications could be defined in terms of the scope of the project:

THE ELDERLY

Whilst Community Care Planning for the Elderly has issues for all agencies, it brings in the acute services far more than Community Care Planning for Children, so there would be a balance of agency involvement and interest across these two areas.

The Project would cover Community Care Planning for Eastleigh Borough which spans part of the population of Winchester and Southampton.

It was proposed that the project should cover:

- the population of all those people over 75
- current provision for all people aged 75+
- required and planned provision for all aged 70+
- all services provided by all agencies, the private sector and voluntary agencies
- a resource inventory
- indicators of need
- use of resources

to support Community Care Planning to match resources to needs for the Elderly.

It was agreed that B would report back the size of the over 75 poplulation for Eastleigh Social Services District.

CHILDREN

It was proposed that the project should cover:

- services for children with disabilities/special needs and should include Child Accidents
- school age children (up to and including 16 year olds)
- current provision
- required and planned provision
- all services provided by all agencies, the private sector and voluntary agencies
- a resource inventory
- indicators of need
- use of resources

It was agreed that B would report back the size of the child poplulation to age 16 for Eastleigh Social Services District.

4) IMPACT ON EACH AGENCY

Each project team representative agreed to find out:

- who in their agency is involved
- the size of the user community who will be involved
- what are the implications on that community in terms of working practise
- the priority of this (Community Care Planning for the Elderly and Services for Children)

5) SYSTEMS IMPLICATIONS

Each agency representative agreed to start to document what systems they do already have in their agency that are relevant to the selected application areas - e.g. PAS system that will provide discharge information on the elderly.

6) PRESENTATION OWNER

It was agreed that a presentation 'owner' should be identified for the 8th October meeting with [illegible] and that detailed planning for this meeting should begin. A was proposed.
B will arrange a meeting with A to discuss.

7) PROJECT MANAGER

A would be prepared to take on this role assuming that due recognition of the time needed is given.

B would be prepared to project manage a sub-project.

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TUESDAY 8TH OCTOBER 1991 26/5

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MEETING ON

INTER AGENCY COLLABORATION

AND

INFORMATION SYSTEMS DEVELOPMENT

IN HAMPSHIRE

INTER AGENCY COLLABORATION IN HAMPSHIRE

09:45	COFFEE	
10:00	INTRODUCTION & WELCOME	CHAIRMAN WINCHESTER HA
10:10	INTER AGENCY COLLABORATION	DIRECTOR OF PUBLIC, HEALTH WINCHESTER HA
10:40	SOCIAL SERVICES PERSPECTIVE	AREA MANAGER, EASTLEIGH SOCIAL SERVICES
10:55	EBC HEALTH FOR ALL PROJECT	HEALTH FOR ALL CO–ORD EASTLEIGH BC
11:10	COFFEE	
11:25	HAMPSHIRE CC – HANTSNET	IT MGR CARE & COMMUNITY HAMPSHIRE CC
11:40	GEO DATA INSTITUTE'S ROLE	DEPUTY DIRECTOR GEO DATA INSTITUTE
11:55	CO–ORDINATING LARGE PROJECTS	MARKET DEVELOPMENT MGR IBM HEALTH SERVICES
12:10	HAMPSHIRE JOINT INITIATIVE PROJECT	
12:10	SUMMARY	
12:25	QUESTIONS / DISCUSSION	
12:45	LUNCH	

SEMINAR ON COLLABORATION

AND INFORMATION SYSTEMS DEVELOPMENT

HEALTH FOR ALL PROJECT - EASTLEIGH BOROUGH COUNCIL

Interagency Collaboration

The Health For All initiative in Eastleigh represents interagency collaboration at both a planning and operational level (Appendix A). The need for local information to assist in the identification of local health needs and planning appropriate responses has been identified as a key priority. The development of a shared information base would enable the development of projects/activities and the re-focussing of current services towards areas of local health need.

Current Developments

Outlined below are some of the projects already underway which would be facilitated by the development of a shared information base.

Local Health Targets - work is currently underway in Eastleigh to identify local Health Targets. The key areas identified in the Government's Green Paper on health, 'The Health of the Nation', are being used as a focus for local discussion. This process has illustrated the need for access to information from all the participating agencies if challenging achievable targets are to be identified. The monitoring of health gain at a local level can only be undertaken effectively if access to local health data across the whole Borough is possible.

Bishopstoke Community Participation Project - the identification of health needs in the community represents a key part of Health For All. The project in Bishopstoke represents collaboration between local people and staff drawn from all of the participating agencies. Access to a shared information base would assist in the identification of local health needs and local resources to respond to identified need.

Crestwood Community School Project - this project has as its key objective the identification of health needs in the school and its surrounding community. Once again, access to the shared information base would facilitate the identification of needs and the planning, implementation and evaluation of appropriate responses.

NOREEN KICKHAM
Health For All Co-ordinator

NK/SJM
1/10/91
E4/seminar

Hampshire County Council - IT SERVICES.

Seminar: Inter Agency Collaboration and Information Systems Development.

Date: 8th October 1991

Topic: Hampshire County Council - HANTSNET

Brief Synopsis.

The brief presentation will cover the following:-

1. What HANTSNET is.
   HCC's computerised, rapidly growing Information Network. An IT Infrastructure, a framework that crosses boundaries and enables cross agency communication and information sharing.

2. HANTSNET the vehicle for communication.
   Who uses it? 7,500 + Public Service staff at 300 + locations throughout Hampshire from a wide range of organisations. Using facilities such as Electronic Mail, Diaries, Electronic Forms etc.

3. HANTSNET - the vehicle for information sharing.
   A vast store of information (text and graphics) contributed by Hantsnet users. Including minutes, circulars, procedures, addresses, directories of people, GP'S, hospital consultants, waiting lists, politics, plans, key indicators - the list goes on and on and on.

4. HANTSNET and Inter Agency Collaboration.
   Clearly a framework that supports inter-agency collaboration. Hantsnet's role - to act as a central filing cabinet for information from a wide range of sources and formats, to act as a vehicle for wide public service access to this information in a simple, standard way, and to enable rapid communication between public service professionals.

5. HANTSNET Demonstration.
   The best way to get the feel for it, is to see it and use it, therefore it is hoped that we can have a HANTSNET screen available in the Thames Room, so that those who have not seen it before can see it and use it during coffee and after the formal presentation.This will need to be confirmed

1/10/91.

5

INTERAGENCY COLLABORATION AND INFORMATION SHARING

REPORT OF THE CHILDREN'S TASK GROUP

The Children's Task Group has met on three occasions. Its work has been in the following areas.

1. Information that we want

The participating agencies have put forward a list of the information about indicators of need relating to children that they want. These are now being combined into a single paper which will show the areas of overlap and those areas that are particular to a single agency.

2. Information that we have

The agencies have circulated information about the data that they collect routinely. When the paper that pulls together the information about indicators of need that the different want has been completed, a technical exercise will be undertaken to find ways of matching what people want with what is available.

3. How we will store the information and make it available

This will become more apparent from the technical exercise that has just be described. A prototype of a relational database has been demonstrated as a way of making most effective use of existing information. Access to this would be through Hantsnet. This has been agreed as being an appropriate way forward as it would be equally applicable to other care groups. To develop this properly, however, will require more investment of time and the cost of taking this step is being calculated.

4. Demonstration model

A model to show potential users what they would expect to see is being put together using Hantsnet. This will include indicators of measures of use, resources that are available and policies and procedures used by the different agencies. This is to be demonstrated at the next meeting.

5. SPANS

The full potential of SPANS is yet to be explored and this will be done at a later stage. However, maps derived from it will be used as part of the demonstration model.

6. Common Records

It has become apparent that some of the information that is being collected by the Education Department on children with special needs is also collected by the Social Services Department on the same children or is wanted by the Health Service for these children. Also, both the Social Services and the Education Department use the same technology to store and retrieve this information. A working group is being set up involving the

Social Services, the Education Department and representatives from both Health Authorities to explore whether there are better ways of collecting this information - perhaps through the use of a common record for some children.

7. Steps to avoid duplication

a) Review by Social Services of Children with Disability

The Social Services Department is about to undertake a wide ranging review of this subject. The issues of a common record is something that the review group might wish to consider. Two members of the Task Group are members of the review group and, in order to prevent duplication, they will inform the review group of the work being undertaken by the Task Group on a common record.

b) At Risk Register

An initiative has been taken quite separately from the activity of the Task Group to make the At Risk Register more accessible to people working in Accident and Emergency Departments. However, two members of the Task Group have been involved in these discussions and, in view of relationship that these have to the objectives of the Task Group, they will be keeping the group informed.

c) FHSA initiative in Southampton

Quite separately from the work of the Task Group an initiative is being undertaken in Southampton by the FHSA to look at services for children. Although the FHSA has done its best, consistent representation on the information sharing project between the Local Authorities and the two Health Authorities has been difficult to achieve because of the prolonged organisational changes that have been taking place within the FHSA. The representatives from the Southampton Health Authority have agreed to raise the issue of possible duplication of the two peices of work with the FHSA.

8. Barriers to making progress

Developing shared information between agencies is a very difficult piece of work. One aspect of this has been identified as an item for further discussion at the next meeting. This is around the issue of the way in which organisations feed and use their electronic information systemsas part of their normal work.

9. Future meetings

There is a programme of work to be undertaken and the group will need to continue to meet. Its next meeting is on 9th April, 1992.

14th February, 1992
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6

Shared Information Project - Children

Some information that is wanted by the Health Service

1. Number of live births per year by electoral ward.

Users : Planners and Health visitors and immunisation service.

? Hantsnet and SPANS

2. Number of children (m.f.p) by electoral ward by single year age bands to age of 15.

: Useful also to band 0 - 4, 5 - 9, 10 - 14 and 15

Users : "Planners"

? Hantsnet and SPANS

3. Number of children by school year group by school (m,f,p)

Users : School health service
Immunisation service

? Hantsnet

4. Number of families with children under 16 which are in receipt of Social Services by electoral ward

Users : Managers and planners (? by individual family).

? Hantsnet, SPANS and case records

5. Number of single parent families with children under 5 and under 16 by electoral ward.

Users : Fieldwork staff, managers and planners

? Hantsnet, SPANS, case records

6. Proportion of population in social class 5 by electoral ward.

Users : Managers and planners

?Hantsnet and SPANS

7. Number of families with children under 5 and under 16 in temporary accommodation by electoral ward and by individual family.

Users : Fieldwork staff, managers and planners

?Hantsnet, SPANS, case records

8. Number of families on low incomes receiving social security benefits by electoral ward (and by individual family).

Users : Fieldwork staff, managers and planners.

?Hantsnet, SPANS and case records

9. Number of pre-school children by age on waiting list or receiving speech therapy, physiotherapy, occupational therapy and other types of therapy by electoral ward.

Users : Managers and planners

? Hantsnet ?SPANS

10. Number of statemented children by age, sex, type of disability and electoral ward of home address and also by school.

Users : Managers and planners

?Hantsnet and SPANS

11. Measures of time required by statemented children for speech therapy, physiotherapy, occupational therapy and any other health service staff by school.

Users : Managers

?

12. Names, addresses, responsibilities and contact arrangements for Health Authority staff working with children.

Users : All

? Hantsnet

13. Names, addresses and telephone numbers of Social Services staff involved with children (including registered child minders) together with responsibilities and protocol for contact.

Users : All

? Hantsnet

14. Names, addresses and telephone numbers of Education Staff together with responsibilities and protocol for contact.

Users : All

? Hantsnet

15. Names, addresses, telephone numbers and functions of voluntary organisations for children.

Users : All

? Hantsnet

16. Names, addresses and contact arrangements of playgroups, nurseries and other voluntary preschool provision - point locations, number of places they offer and any catchment areas associated.

Users : All

?Hantsnet and SPANS for point data

17. Names, addresses and contact arrangements of services provided by Health Authority for children including clinics, immunisation, crying baby arrangements etc..

Users : All,

? Hantsnet, SPANS for point data

18. Names, addresses and contact arrangements for mainstream schools together with catchment areas.

Users : All

? Hantsnet, SPANS for point data

19. Names, addresses and contact arrangements of special schools and special provision in mainstream schools with type of disability catered for, capacity, catchment area and point reference.

Users : All

? Hantsnet, SPANS for point data

20. Names, addresses and contact arrangements of assessment "units", point locations and catchment areas.

Users : All

? Hantsnet, SPANS for point data

21. Number (w.t.e.) by different agency with responsibility for children of given age in defined area.

Users : Managers and planners

? Hantsnet and SPANS

22. Policies and protocols relating to child care that are used by the different agencies.

Users : All

? Hantsnet

23. Number of children on the Child Abuse Register by electoral ward and by individual family.

Users : Managers, planners and fieldwork staff

? Hantsnet, SPANS and case records

24. Immunisation uptake by electoral ward and General Practice.

Users : Managers, planners

? Hantsnet, SPANS

25. Attendances at A&E Department for children 0 - 4, 5 - 9 and 10 - 14 by electoral ward of home address, by school, and by type of accident.

Users : Health Visitors and other involved in accident prevention

? Hantsnet and SPANS

26. Number, location, type and time of day of child road accidents.

Users : People involved in road accident prevention

? Hantsnet and SPANS

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EASTLEIGH SHARED INFORMATION PROJECT

CHILDREN'S TASK GROUP

Information Needs

- Population Data by Ward

- Road Accidents, by Ward

- Immunisation and Vaccination Data

- Mortality and Morbidity Data

- Social Indicators of Need, eg one parent families

- Levels of Homeless Families with Children

- Information on Leisure Facilities/Activities for Children throughout the Borough

- Child Accident Information from A & E Departments by Cause and Ward

- Policies Relating to Children - Leisure Strategies for Children EBC

NK/SJM
30/1/92
E4/InfoNeed