Leadership in public health: a view from a large English PCT co-terminous with a local authority

Hugh Annett
Public Health, NHS Bristol, South Plaza, Marlborough Street, Bristol, UK
Address correspondence to Hugh Annett, E-mail: hugh.annett@bristolpct.nhs.uk

Keywords public health

It is just under 2.5 years since I took up my appointment as the Joint Director of Public Health for Bristol and this has proved to be a professionally rewarding time to be practising public health in the city. It has been intellectually stimulating to work with others to think through the implications of this role, particularly for local authorities some of whom felt—though not in Bristol—that this was an appointment foisted upon them without adequate consideration of its implications or appropriate consultation. But the implications are almost as significant for the NHS, especially as Primary Care Trusts embark upon the World Class Commissioning voyage—a journey that poses questions regarding the distinctive contribution of the contemporary public health function and how it can be best discharged both within the NHS and more widely. The solutions to these emergent issues regarding the role and responsibilities of public health in today’s complex environment of continuous organizational change, evolving inter-organizational arrangements and the coming-of-age of working in multi-agency partnerships are not straightforward, which is precisely why committed and effective leadership in public health remains an important and rewarding professional role.

Working with the local authority is a common experience for public health professionals, but when I started working for the City Council, I was surprised how much I had to learn—about local authority values and culture and methods of working—in order to be an effective member of the Strategic Leadership Team. It is a very considerable privilege to have the opportunity to fulfil this role, for this team, working for and with the political administration (the cabinet) of the Authority has the responsibility and opportunity to significantly influence the future shape and nature of the city; to a considerable degree the cabinet supported by the Strategic Leadership Team can determine the sort of place the city is and will be for its residents, including the richness or paucity of the opportunities citizens will have to make choices that are both healthy for them and for the planet. How can this opportunity of bringing a public health perspective to all the work of the council add real value to that work? This is the question that has and continues to challenge me on a daily basis.1

An important part of the answer is having public health directorate staff work closely on shared priorities with council staff in all of the major directorates of the council, especially as most people in the council, both members and officers, do not know what public health specialists and practitioners do.2 Our Health Our Care Our Say can be read to imply that the Joint Director of Public Health role is only or primarily about joint working with Directors of Adult Social Care and Children and Young Peoples Services; thus, the responsibility for the Joint Strategic Needs Assessment is given to these two directors and the Director of Public Health.3 These are indeed very important relationships, but spatial planning, economic, transport and housing policy, and environmental, culture and leisure services are major determinants of population health and health inequalities. I found that it was taken for granted that I would work closely with the Children and Young Peoples Directorate and the Health and Adult Social Care Directorate—though no great clarity about what my role would be or the added value I would bring even in these areas of work—but initially some surprise that I thought

Hugh Annett, Director of Public Health
that public health probably had at least as much to offer in terms of shaping policy in most of the other domains of the council’s work. But in all directorates, this was welcomed and initially small collaborations in most areas are maturing into shared programmes of work, none of which is led by public health, but in all of which public health is a valued contributor.

My time in local authority has been marked with a growing appreciation of the critical importance of understanding the political context and the complementary roles of officer and politician; respecting and valuing the political role and becoming skilful at working in the particular political context of local government is critical to successful leadership in a local authority. Fortunately, for most public health concerns a cross-party political consensus can be anticipated and most council members have an interest in such issues, at least insofar as it affects their ward. In my experience, the health scrutiny commission is also an important ally for public health. But the public health function does create some particular challenges for political leaders. In terms of gaining attention, having a political champion and obtaining resources, it is important to have an executive member who holds a cabinet portfolio for public health (or health and well-being). But the public health portfolio does not bring with it responsibility for functional areas with large council budgets, nor often require decisions that must go to cabinet or full council for debate and approval. These are important political roles that unfortunately responsibility for public health does not readily satisfy. Finding satisfactory resolutions to dilemmas such as these that give the public health portfolio holder a strong base in cabinet will be essential to achieve a sustained high profile for public health concerns in local authorities.

Although it is not possible to simultaneously give all of one’s time to two voracious organizations, it is possible and not unusual to simultaneously provide leadership, especially transformational leadership, in and for more than one organization, for leadership seems to share attributes with love, in that the more you give, the more there is to give. I am fortunate that NHS Bristol regards my leadership role in two organizations and providing leadership to partnerships working across many organizations in the city as the most important of my responsibilities. Still, leadership does take time, and again I am fortunate in having a relatively well-resourced public health directorate with dedicated and experienced staff who are leaders in their fields of expertise and responsibility. For example, although I participate fully in the PCTs Board and Senior Management Team, I am not a member of the PCTs professional executive committee where public health leadership is provided by my deputy. And so it has become normal and accepted within NHS Bristol that responsibilities that would formerly have been personally carried out by the Director of Public Health are now delegated to others. I do not find that my overall leadership of the public health function in the city is in any way diminished by such delegation of leadership responsibilities. Indeed, public health leadership as a whole, including my own is enhanced by a broadening and deepening of leadership responsibilities and abilities within the public health workforce—and this I think is critically important for the future credibility of public health as a discipline and profession.

My non-public health colleagues within NHS Bristol are supportive of the public health agenda and our Board committed to effectively tackling health inequalities. Yet there remains a measure of uncertainty about what public health does and how it does it—where is the dividing line between the delivery of public health interventions and the contribution to the PCTs commissioning agenda? How does the public health contribution to commissioning complement the role of commissioning managers? What can the PCTs strategic planning directorate expect from the public health directorate? These questions are familiar for “public health” is a contested concept and its structure and form is difficult to pin down. But the need to articulate a clearer response is particularly pressing with the economic recession biting and NHS funding already beginning to tighten. Once again public health leadership will need to be as attentive to its ‘social conscience as to scientific intent’.

There are now good examples, including Bristol, where Joint Director of Public Health appointments have been catalytic in accelerating innovation and effectiveness in partnership working between local government and the NHS. This provides a good base for public health leadership to help bring more reality to partnerships with the police, Children’s Trusts, Fire and Rescue, the voluntary and community sector, including pooling resources and aligning interventions. Our leadership challenge is to shape a future that effectively focuses our combined resources on the major public health challenges confronting our society.

References

2 Dalziel M. Leadership for health. How can we ensure that the values and principles of public health become central to health and social policy? *J Epidemiol Community Health* 2000;54:703–4.


7 Ryle J. Social medicine. *BMJ* 1942;i:801.