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**Public Health Training in Kent –
understanding the needs of
non-NHS staff with responsibility
for health improvement**

**Prepared for the Kent NHS Education and
Training Consortium**

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April 2002

**PUBLIC HEALTH TRAINING IN KENT
- UNDERSTANDING THE NEEDS OF NON-NHS STAFF WITH
RESPONSIBILITY FOR HEALTH IMPROVEMENT**

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EXECUTIVE SUMMARY

The survey reported here was commissioned by Kent NHS Education and Training Consortium and was carried out by the Centre for Health Services Studies (CHSS), which is part of the University of Kent at Canterbury. The fieldwork was carried out between October 2000 and February 2001, and its aim was to investigate the level of public health knowledge and skills among those involved in inter-agency working to improve health.

While staff in NHS posts with a responsibility for improving health will have public health qualifications or access to public health training and advice, this is less likely to be the case for non-NHS staff. For this reason the survey targeted **non-NHS** staff working in public sector and voluntary organisations across Kent whose responsibility for health improvement would benefit from a reasonable understanding of population health.

Membership lists were used for Partnership Boards, Joint Planning Boards, Health Action Teams and Health Improvement Plan (HImP) Policy Boards. After excluding names of staff based in health authorities and other NHS organisations, all the remaining names were sent a self-complete questionnaire by post. A similar survey was commissioned and carried out by CHSS to assess the training needs of Practice Nurses. This has been reported separately.

The survey questions asked about people's perception of public health, and about their relevant knowledge and skills. The questionnaire was developed from a template provided by the Kent NHS Education and Training Consortium's Public Health Education Co-ordinator (Sylvia Beacham), and a survey of practice nurses in Hampshire. While aiming to identify public health training needs, the survey was additionally expected to perform an educational role in raising awareness of the function of public health and the range of techniques used.

Relatively senior staff from a range of local authority departments and voluntary organisations responded to the survey, and said the time they spent on population health varied enormously from 0% to 100% of their time. Although non-NHS staff were the focus, and staff in NHS public health policy and strategy roles had been deliberately excluded, one in seven respondents were in fact based in NHS PCTs and other NHS Trusts (although not necessarily in roles that required medical qualifications). Response rates were between 33 and 55% for HImP boards. Two thirds of the responses were from Local Authority departments such as Social Services, Community Development Services and Housing. Responses from the voluntary sector included sports clubs and charities. Respondents were working with several other agencies, and these almost always included parts of the NHS.

Respondents' definitions and understanding of public health in their own words were often quite limited – nine out of ten definitions of public health were rated as poor or limited. However, when prompted, most went on to say that all the key responsibilities within public health that the survey asked about were important. With regard to skills, respondents had greatest confidence in their skills of leadership, communication and working in partnership. They were least confident in the use of statistics and presenting data. A small but significant proportion (20%) did not feel at all confident in half of the public health skill areas the survey asked about, even though the majority thought they were all highly relevant to their jobs. With regard to knowledge, about half had none or basic knowledge in the areas the survey asked about.

Although self-reported knowledge and skill levels were not high, a significant proportion of respondents did not identify any training needs. This may be because just under a third rated their opportunities for personal development no better than fair, and time was a barrier for virtually all respondents. The next largest barrier to developing skills and knowledge was funding, mentioned by half the respondents.

The survey gives a snap shot of the perceptions and needs of senior staff, a group not often surveyed (and an area in which there is little existing research of this type). Most studies have focused on practitioners' needs.

The survey has identified some public health training needs. For example, two out of three respondents identified specific areas in which they wanted to develop their knowledge and skills, and a similar proportion felt they have good opportunities for personal development. The limited breadth of understanding of what public health covers indicates the need for some education among staff involved in health improvement plans. Inter-agency or shared training opportunities may be helpful here. Clearly time was a barrier for everyone, which indicates that training budgets will need to be identified and access to these clarified.

The survey found support for training that gives greater emphasis to economic, social and physical influences on health. There also seems to be a need to clarify roles and responsibilities of this group as well as helping them define the 'new public health' agenda.

The difficulty respondents had in giving a definition of public health needs to be taken into account when interpreting the results, and may itself suggest the need for general training. It seems likely that those involved in health improvement programmes would benefit from a broad education that would raise awareness of the methods and terminology of public health. An example supporting this statement is that when asked to rate the importance of topics, health impact assessment was at the top of people's list for not knowing whether it was important or not. Generally respondents were less confident with their technical skills, such as handling and presenting statistical material, and use of specific public health methods. Again this agrees with skills the CMO's report identifies are in short supply, and poses a challenge to educators.

If public health training for this group of people is to be successful, it will have to be designed to overcome the major obstacles of lack of time and money. It will also have to be seen to be sufficiently relevant to their role to rise above competing priorities. Although the survey respondents thought public health skills were important, they were actually not very good at defining what the subject covers. This may have led to difficulty relating to the topics that we asked about (hardly surprising as by definition we were surveying people outside NHS public health departments). This lack of familiarity with the terminology would also account for the relatively low levels of demand we found for developing the knowledge and skills associated with mainstream public health responsibilities. Facing such a broad subject, it may be that the first training objective should be to encourage shared thinking through shared training, then to raise awareness about public health issues and how to access expertise in them. To provide skills that people can use with confidence may be a considerable way down this road.

Recommendations from this survey are as follows:

- The main priority must be in raising awareness of the role of all the Local Authority departments that are involved in Health Improvement Programmes in the broad public health agenda both within Local Authorities and within the NHS.
- More opportunities are needed for joint appointments, joint training and education through existing routes but maybe more importantly through shadowing, learning sets, mentoring and good partnerships working.
- There is clearly a need to provide training/learning opportunities for senior staff to increase their skills and knowledge around public health issues particularly, health needs assessment, using statistical programmes to interpret data, presenting data and undertaking research using different methodologies.
- Learning opportunities could be integrated into existing provision to address the problem of time pressures.
- Inter-professional training and working on Health Impact Assessment would move the agenda forward as this is seen as a need both from NHS staff and from those respondents within this study.

1. BACKGROUND

This work was commissioned by Kent NHS Education and Training Consortium and carried out by the Centre for Health Services Studies at Tunbridge Wells. CHSS is part of the University of Kent at Canterbury.

Nationally, the Chief Medical Officer's Project has worked to strengthen the Public Health Function (DOH, 1997 and 2001), and regionally the NHS Executive South East has produced a strategic approach to developing capacity and capability of the Public Health Function. In commissioning the survey reported here, the Kent Education Consortium has raised the importance of public health knowledge and skills existing in the wider arena of local authority and other staff involved in inter-agency working to improve health. The focus of this study is therefore staff outside the main public health functions in the NHS, such as those on Partnership Boards and involved in Health Improvement Plans.

2. AIMS

The study was carried out between October 2000 and February 2001 and aimed to:

- identify those working in local authorities across Kent who had responsibilities for health or health improvement,
- examine their perception of public health,
- identify their training needs.

Given the target population consisted of people who were not working in NHS public health posts, it was envisaged that knowledge of what public health consists of was likely to be very uneven. As those being surveyed could not necessarily be expected to be familiar with the range of public health activities and skills, the survey was also required to perform an educational role in raising awareness of these.

A similar survey was requested and carried out by CHSS to assess the training needs of Practice Nurses. The second survey covered all nurses in general practice in West Kent, and is reported separately.

3. METHOD

The first task was to describe the target population for our survey more clearly, ie the wider client catchment population for public health training, and decide on an appropriate means of collecting information from them.

3.1 Target population

We decided to include people who were involved in improving health for those living in Kent, but who were not in NHS public health posts. They were likely to have 'improving population health' as part of their jobs or responsibilities. We expected to find them particularly in local authorities – for example housing or social service departments – but also in community groups, voluntary organisations, charities and primary care organisations (PCG/PCTs).

3.2 *Survey instrument*

To get reasonably widespread coverage of such a disparate group and enable comparison of the responses, it was decided to use a fixed set of questions in a self-completed questionnaire. This method had been used before in a survey of practice nurses elsewhere, and the Public Health Education Co-ordinator (Sylvia Beacham) made available some preliminary work drafting appropriate questions. Use of questionnaires enabled a broad coverage at relatively low cost, and this coverage helped to meet our secondary objective of raising awareness more widely.

3.3 *Questionnaire development*

A questionnaire was designed for the Kent wide non-NHS staff. The starting point was to review concepts in a pre-existing practice nurse survey used in Hampshire, and a template provided by the client in relation to the survey aims.

This resulted in an expanded list of skills and knowledge areas to cover the public health function in broad terms as would apply to those working in local authorities. These two areas were separated further so that respondents could rate their skills by how confident they were, and their knowledge by how good it was.

To gauge the potential demand for development and training, we asked which areas respondents would like to develop their knowledge and skills, and what barriers they saw to achieving this. Additional questions were included about whether staff had regular appraisals, and for an overall assessment of the opportunities for personal development.

A fundamental problem was uncertainty about respondents' understanding of public health. It was therefore decided first to ask an open question about this, in order to rate the depth and breadth of their concept of public health. In subsequent questions we used explicit lists, for example rating the importance of a list of responsibilities relating to public health. By giving these functions explicitly, plus the skills and knowledge areas listed in following questions, it was expected that respondents would come to a similar understanding about the topics that are included in public health and be able to give a more consistent view about their training needs.

The questionnaire was designed for self-completion and to take about five minutes to do. It was to be sent out under a covering letter saying how the person had been chosen and who had commissioned it.

There was little time for formal piloting of the questionnaires, and we decided this was not necessary as the format of the questions had worked well when used with practice nurses. However, a small number of copies were sent to personal contacts working in local authority positions in other counties, but no replies were received.

An example of the questionnaire is given in Annex A.

3.4 *Questionnaire distribution*

Copies of East Kent's and West Kent's Health Improvement Plans (HIMPs) were obtained and were studied in order to find the partner organisations signed up to them and the key multi-agency groups set up to own and drive the HIMPs. Local authority human resources departments were contacted and asked which staff had a public health role in their job descriptions.

The client catchment within East Kent was based primarily on members of partnership boards with Social Services called Joint Planning Boards. These focused on learning disabilities, housing, transport, and so on. The names of board members for seven of these were obtained. The client catchment within the West Kent area focused on the members who are part of Health Action Teams, HIMP policy boards and partnership boards.

Getting complete and up to date lists of people on multi-agency groups was problematic. The published HIMPs did not always reflect the current situation and, as board membership was somewhat fluid, the names and addresses we did manage to get from health authority staff were not always current. Details of this process are given in Annex B.

3.5 *Distribution timetable*

The questionnaires sent to East Kent were distributed prior to Christmas 2000. The West Kent questionnaires were sent out in the first week of January 2001. This staggered approach was used to ensure that as few questionnaires as possible would get mislaid in the Christmas post period, but that we would get as many questionnaires back as possible within the timeframe. The questionnaires were distributed to councils in the second week of January 2001.

Reminder questionnaires were distributed to those members who had not replied by the deadline of 26th January 2001.

4. **RESULTS**

4.1 *Response rates*

In East Kent there were 29 responses, including three who felt the questionnaire was not applicable to them and therefore did not complete them. Valid response rate $26/68 = 38\%$

In West Kent there were 45 responses, of which 4 people felt that the questionnaire was not appropriate for them to complete (either because they were 100% NHS based or because they were voluntary) and a further respondent stated that they did not have enough time. Valid response rate $40/84 = 48\%$.

Eight additional questionnaires were received from distributions carried out for us by ten local councils. As we do not know how many were distributed, it is not possible to calculate a response rate for these, but it would appear to be lower than the other approaches.

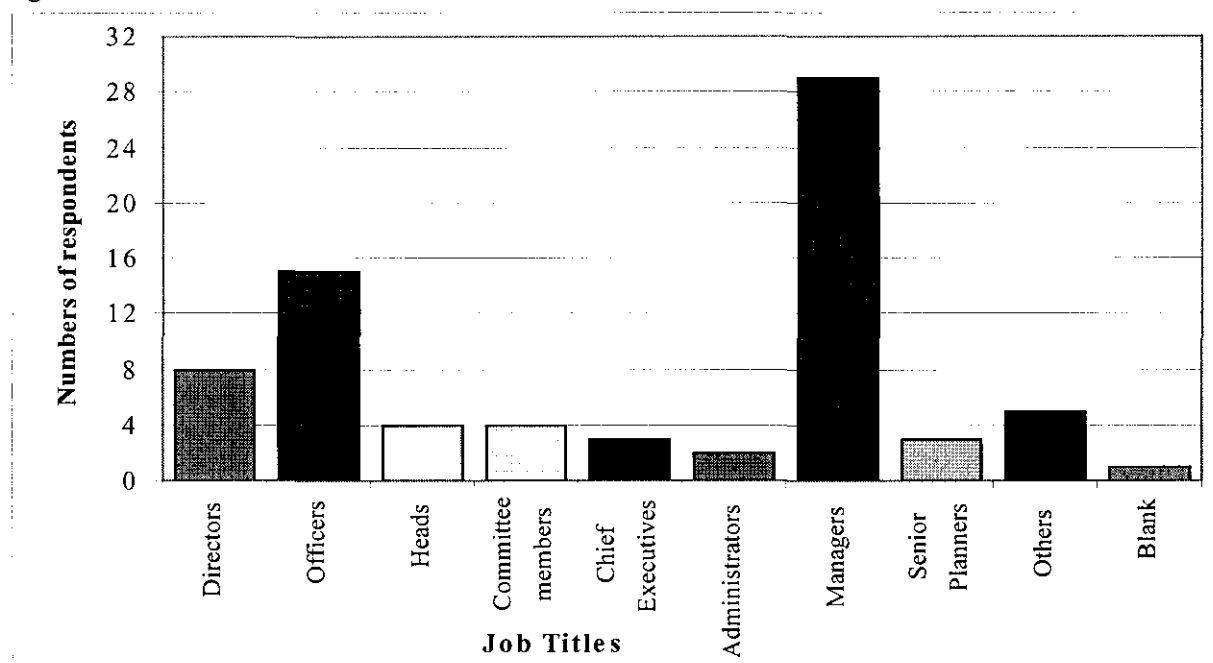
In total there were 74 responses that could be used in the analysis. The results from the survey are given in the following sections.

4.2 Respondents' Job Titles

A variety of job titles were described by the participants. Many of these job titles appeared to be senior posts. A total of 29 participants included the wording of 'Manager' in the title. One person left this part of the questionnaire blank.

Figure 1 below shows the distribution of the range of job categories.

Fig 1. Job titles



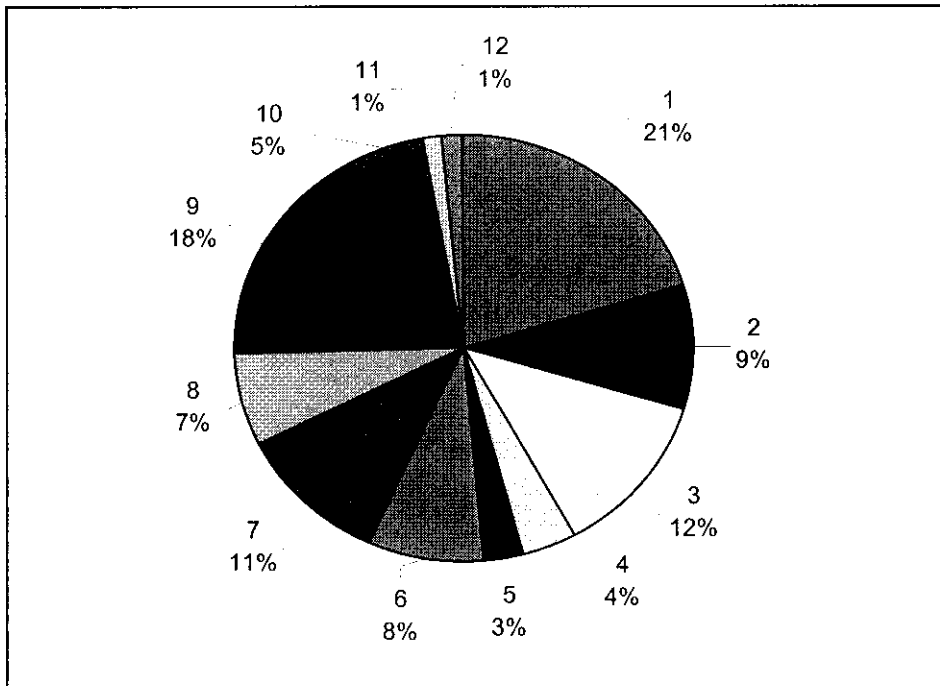
4.3 Organisations where respondents worked

The organisations respondents worked for were coded into 12 separate categories. These categories are as follows, with Fig 2 showing how frequently they occurred:

1. District Council, Chief Executive's office, service development, policy/planning development
2. Housing
3. Community development services (including family support, youth)
4. Leisure
5. Environment (including transport, highways)
6. NHS, CHC
7. Voluntary organisations, Equal Opportunities, Racial Equality
8. PCG/PCT
9. Social Services
10. Education, Community Colleges
11. Chemists, retailer, commerce
12. Police, justice services.

About two-thirds of those responding to our survey worked in Local Authorities, mainly social services, community development services, housing, policy development and planning departments. 15% were from primary care organisations (PCG/PCTs), Community Health Councils or other parts of the health service. 11% worked in the voluntary sector.

Fig. 2. Organisations where respondents worked



4.4 Public Health workload

When asked what proportion of their work was concerned with the health of the local population, 43% reported that over 70% of their work is related to this issue. Twenty one people (28%) stated that 100% of their work is concerned with the health of the local population. See Figure 3.

Fig. 3. Percentage of the respondent's work relating to health of the local population.

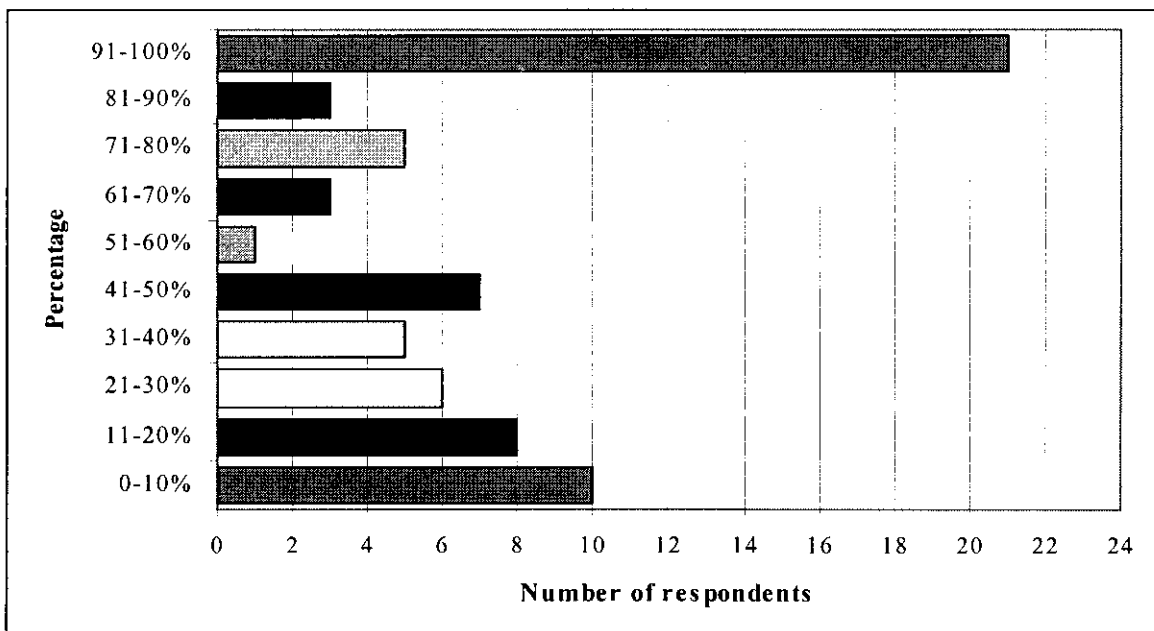


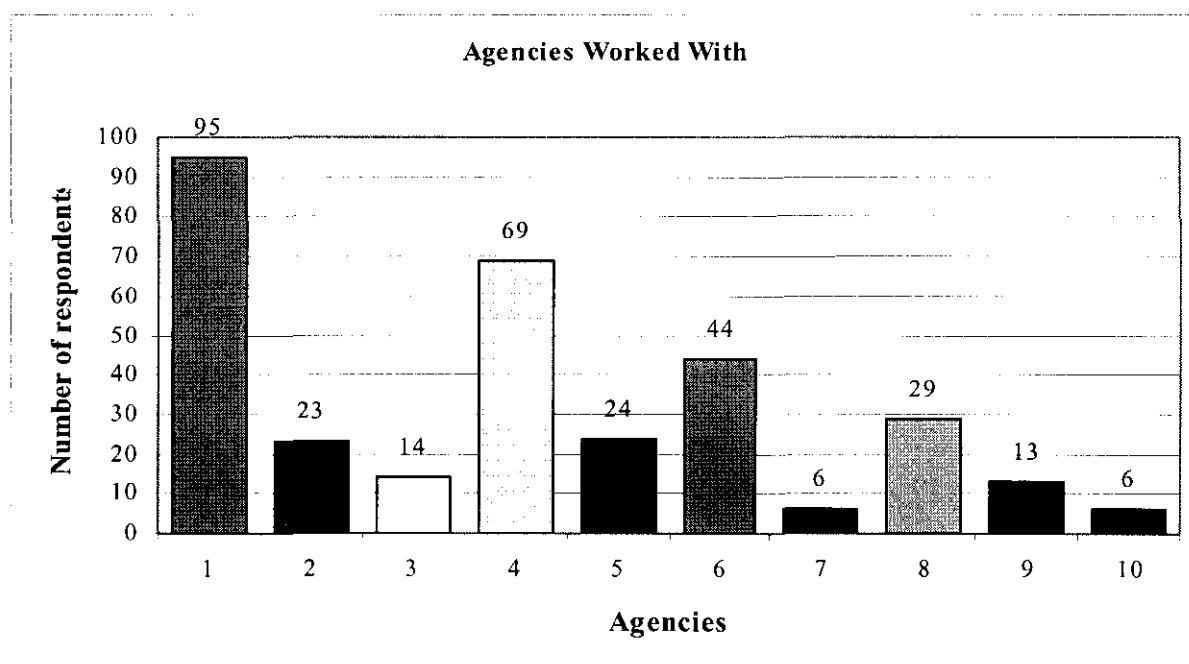
Figure 3 included some people who worked in the NHS even though we had tried to exclude them from the survey. Despite the fact that the NHS respondents' workloads were mainly related to health issues, when they were removed from Figure 3 the pattern of workload was relatively unaltered.

4.5 Agencies that respondents work with

The survey asked what other agencies people were working with and whether these working arrangements were formal or informal. Various agencies were indicated, and these were categorised into 10 groups as follows (These represent the key for figure 4):

- 1) Health Authorities, Health promotion, NHS Trusts, Community Health Councils, health visitors
- 2) Social services – including youth services, drug initiatives
- 3) Education – schools and adult education
- 4) Local Authority, Kent County Council (includes: highways, water, energy centre, fire service, environmental agency, sport, leisure and housing)
- 5) Police, probation, prison, youth offending team, transport police, crime prevention, victim support, domestic violence.
- 6) Voluntary and community groups and organisations – including YMCA, sports clubs, MIND, charities, national governing bodies of sport, private sector, transport operators
- 7) Multi-agency group
- 8) PCG/PCT
- 9) Others (such as Kent Registration, WHO, BTCV)
- 10) Nursing home, Independent sector, retail sector.

Fig.4 Other agencies with whom respondents were working



Although on average respondents were working with four or five other agencies, this masked two main patterns of working, which were either to work with three to five other agencies or

at least nine. A quarter (19) of the respondents identified 9 or more agencies that they were working with. Of the 323 agencies mentioned, the most frequently cited were health services, including Health Authorities, health promotion, NHS Trusts, Community Health Councils, Health Visitors, and PCG/PCTs (124).

The distribution of these showed that most respondents are working with staff in health services. The next most frequent other agency to be working with was national government, local authority/Kent County Council (69), followed by voluntary groups (44).

Sixty six respondents identified that they were members of inter-agency group/groups (this is not surprising as the mailout was based on those involved in Health Improvement Plans). Three respondents did not comment on this question.

The majority of respondents identified that work with these other agencies occurs on a formal basis (54%), although an additional 35% stated the work was conducted both formally and informally.

When the NHS respondents were removed from Figure 4, the pattern was relatively unchanged.

4.6 Understanding of Public Health

The survey asked what respondents understood by the term 'public health'. The question is relatively complex due to its multi-faceted nature and the way in which it incorporates a wide range of disciplines, professions, skills and knowledge with a broad focus on community /population health as opposed to treatment of individuals. The responses ranged from 'the health of the whole population' to rather more detailed answers. A simple scoring system was developed to assess the replies. The system enables one mark to be allocated for each of the five dimensions highlighted below. A further two discretionary marks were awarded for those answers which contained greater detail. The five aspects of public health we looked for were:

- public health goals – improving health, preventing disease, etc
- organisational and policy framework – eg strategic and multi-sectoral approach
- public health skills – research, monitoring, needs assessment, etc
- range of public health professionals/ workforce
- disciplines involved in public health.

The scoring of these results then fell into the following categories 0,1=poor, 2,3=limited/basic, 4,5=quite good, 6,7=excellent understanding of public health. According to this scoring system 51% (38) had a limited/basic understanding of public health, 39% had a poor understanding and 10% appeared to have quite a good understanding of public health. No answers received a score of excellent.

The results of the scoring appear to identify a lack of understanding with regards to a public health definition. It is evident that further work in this area is needed to establish a common understanding and shared definition of public health.

The next question asked the importance of various activities to anyone with a responsibility for public health. Three main areas were identified as being of particular importance within

public health. These were: health promotion, the reduction of inequalities and disease prevention. Environmental health hazards and studying patterns of disease came fourth going by the same criteria.

The percentages and numbers of responses to each area can be seen in table 1. 90% or more thought most of the topics we listed were at least ‘fairly important’. The two areas with the highest percentages in the ‘not very important’ category were: housing stock and conditions and health and safety standards. The percentages can be seen in figure 5. The area where most respondents said ‘don’t know’ was health impact assessment. However one must bear in mind that this is a relatively new area for most people.

Table 1. How important are the following areas within public health.

	Very Important	Fairly Important	Not very Important	Don't know
Disease prevention	82% (61)	15% (11)	0% (0)	1% (1)
Health promotion	80% (59)	19% (14)	0% (0)	1% (1)
Reducing health inequalities	84% (62)	14% (10)	0% (0)	3% (2)
Environmental health hazards	64% (47)	30% (22)	1% (1)	3% (2)
Disease screening programmes	58% (43)	32% (24)	4% (3)	3% (2)
Disease immunisation programmes	68% (50)	24% (18)	4% (3)	1% (1)
Clinical effectiveness of health care	57% (42)	34% (25)	4% (3)	3% (2)
Health needs assessment	58% (43)	31% (23)	4% (3)	5% (4)
Health impact assessment	49% (36)	38% (28)	4% (3)	8% (6)
Population health monitoring	54% (40)	39% (29)	4% (3)	3% (2)
Housing stock and conditions	45% (33)	41% (30)	12% (9)	3% (2)
Health and safety standards	45% (33)	38% (28)	9% (7)	5% (4)
Hygiene	55% (41)	34% (25)	5% (4)	4% (3)
Studying of patterns of disease	53% (39)	41% (30)	4% (3)	3% (2)

4.7 Confidence in skills

Respondents rated themselves on their confidence in particular skill areas. The main three skills in which they felt ‘confident’ were: working in partnership (75%), using leadership skills (53%) and communication skills (61%). When those who are ‘fairly confident’ are added, the percentage rises to around 100% feeling they had some degree of confidence in these skills.

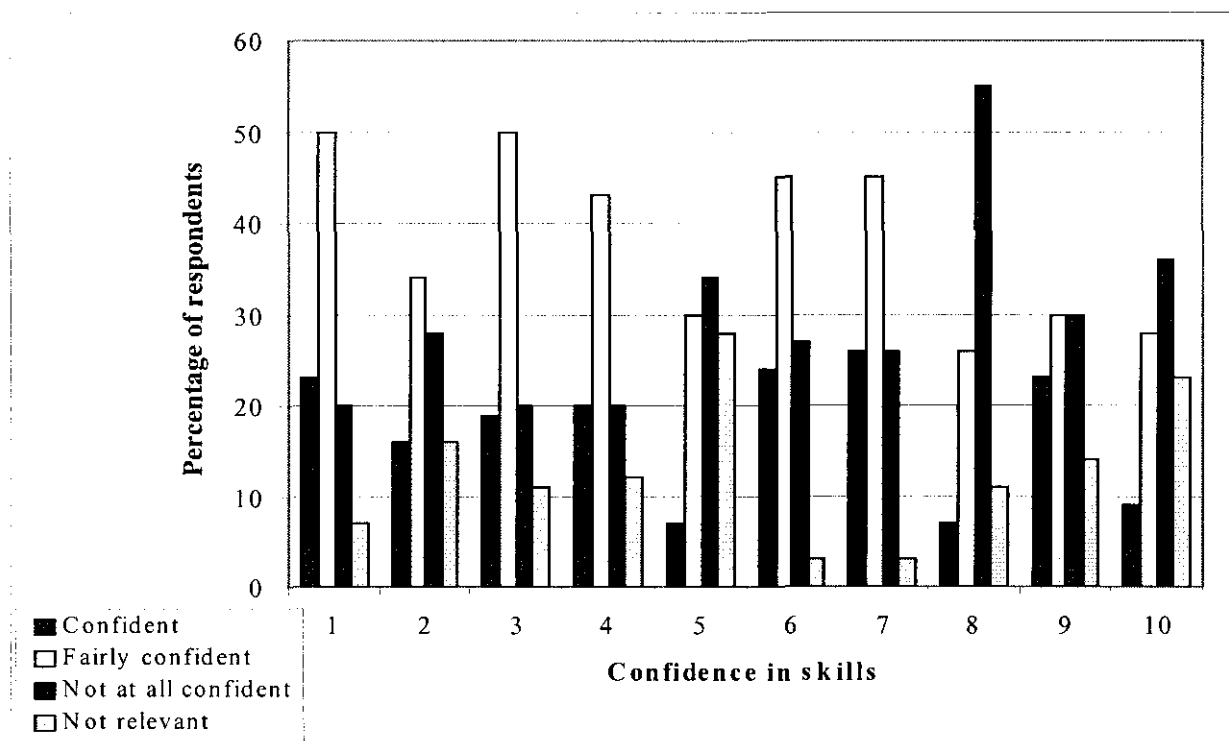
At the other extreme, there are some areas where relatively small numbers felt ‘confident’ and these were outweighed by the number who rated themselves as ‘not at all confident’ – both indicating potential training needs. These weaker areas were: using statistical programmes to interpret data, presenting data, health impact assessment skills, conducting a health needs assessments and undertaking research using different methodologies. Skill level ratings are in Table 2, which also shows the percentages of those replying who considered the skill irrelevant to their job. The data is shown graphically in Figure 5, picking out skill areas with the greatest percentages saying they were ‘not at all confident’ (20% or more).

The great majority of respondents rated the skills as relevant to their jobs. Around half felt only 'fairly confident' in each skill area. Respondents were much more confident in leadership and communication roles and much less so in technical and methodological aspects of data handling.

Table 2. Skill levels.

	Confident	Fairly confident	Not at all confident	Not relevant to my job
Knowing how and where to obtain information on population characteristics	45% (33)	48% (35)	7% (5)	1% (1)
Interpreting population data	25% (17)	54% (37)	22% (15)	7% (5)
Comparing information with other populations	19% (12)	63% (40)	17% (11)	15% (11)
Undertaking research using different methodologies	21% (12)	44% (25)	37% (21)	16% (12)
Developing interventions for local situations	28% (17)	59% (36)	13% (8)	14% (10)
Identifying methods to monitor progress against project objectives	32% (22)	54% (37)	13% (9)	7% (5)
Evaluate research projects	21% (14)	56% (37)	23% (15)	11% (8)
Using project management skills	49% (36)	40% (29)	11% (8)	1% (1)
Policy development	42% (30)	46% (33)	11% (8)	4% (3)
Critically appraising research	24% (15)	52% (32)	24% (15)	12% (9)
Working in partnerships	75% (53)	25% (18)	0% (0)	1% (1)
Using leadership skills	53% (37)	44% (31)	3% (2)	3% (2)
Conducting a health care needs assessment	10% (5)	42% (22)	48% (25)	28% (21)
Engaging and involving the public	39% (28)	49% (35)	11% (8)	3% (2)
Use of the internet to obtain data	25% (18)	46% (33)	28% (20)	3% (2)
Use of the internet to obtain literature	27% (19)	46% (33)	27% (19)	3% (2)
Statistical programme to interpret data	8% (5)	29% (19)	63% (41)	11% (8)
Presenting data	14% (7)	43% (22)	43% (22)	14% (10)
Facilitating group work	46% (33)	45% (32)	10% (6)	3% (2)
Communication skills	61% (44)	39% (28)	0% (0)	1% (1)
Health impact assessment	13% (7)	38% (21)	49% (27)	23% (17)
Accessing qualitative information	28% (19)	54% (37)	18% (12)	5% (4)
Accessing quantitative information	28% (19)	52% (35)	19% (13)	5% (4)

Fig. 5 Levels of confidence in specific skill areas



Key:

1. Interpreting population data
2. Undertaking research using different methodologies
3. Evaluate research projects
4. Critically appraising research
5. Conducting a health needs assessment
6. Use of the internet to obtain data
7. Use of the internet to obtain literature
8. Statistical programme to interpret data
9. Presenting data
10. Health impact assessment

4.8 Confidence in knowledge areas

As shown in table 3, there are a number of areas in which individuals feel they have no or only basic knowledge. For all knowledge areas we asked about, substantial proportions (over 40%) fell in the 'none' and 'basic' categories of knowledge. The five weakest areas (over 60% with 'none' or 'basic' knowledge) are: population health status, screening and immunisation programmes, systems for responding to environmental hazards, communicable disease control and clinical governance. Table 3 also shows that, apart from health status, over 20% felt the knowledge areas they were weakest on were not relevant to their job.

Table 3. Knowledge Areas

	None	Basic	Good	Very good	Not relevant
Population health status	11% (7)	50% (33)	33% (22)	6% (4)	9% (7)
Health Inequalities	8% (5)	37% (24)	42% (27)	14% (9)	11% (8)
Barriers to better health	4% (3)	38% (26)	41% (28)	16% (11)	7% (5)
Use of health and related services	4% (3)	37% (25)	43% (29)	15% (10)	9% (7)
Health promotion interventions	8% (5)	47% (31)	33% (22)	12% (8)	11% (8)
Health education interventions	9% (6)	45% (29)	35% (23)	11% (7)	12% (9)
Health improvement	7% (5)	34% (24)	37% (26)	21% (15)	5% (4)
Screening and immunisation programmes	21% (12)	57% (33)	19% (11)	3% (2)	22% (16)
Systems for responding to environmental hazards	32% (18)	54% (31)	7% (4)	7% (4)	23% (17)
Communicable disease control	26% (15)	53% (30)	12% (7)	9% (5)	23% (17)
Clinical Governance	27% (14)	45% (23)	24% (12)	4% (2)	28% (21)
Local Agenda 21	13% (9)	41% (29)	31% (22)	15% (11)	4% (3)
Saving lives: Our Healthier Nation	8% (5)	42% (27)	31% (20)	19% (12)	9% (7)

Other areas in which individuals felt knowledge would be beneficial are:

CHD/Stroke prevention	1
Community safety	4
Neighbourhood	3
Mental health	1
Health at work	1
Health impact of crime	1
Housing	1
National Plan	6
Various NSF's	6
Urban regeneration	1

4.9 Development of Knowledge and Skills

The survey asked about the areas in which individuals would like to develop their knowledge and skills. Relatively few answers were given and these were spread as shown in table 4. A total of 23 respondents identified that they would like to develop both skills and knowledge in public health. A further 20 respondents stated they wanted to develop their knowledge of public health and a surprising 23 (31%) respondents left this question blank, stated it was not applicable to them or that they did not wish to develop either their skills or knowledge in public health.

Table 4. Areas for development

Knowledge Areas		Skill Areas	
Population health status	2	Knowing how and where to obtain information on population characteristics	1
Health Inequalities	4	Interpreting population data	1
Barriers to better health	1	Undertaking research using different methodologies	3
Use of health and related services	2	Developing interventions for local situations	2
Health promotion interventions	6	Using project management skills	1
Health education interventions	1	Critically appraising research	1
Health improvement	5	Working in partnerships	4
Screening and immunisation programmes	3	Using leadership skills	2
Systems for responding to environmental hazards	1	Conducting a health care needs assessment	2
Government policies	4	Engaging and involving the public	2
Clinical Governance	1	Use of internet to obtain literature	1
Local Agenda 21	1	Statistical programme to interpret data	5
Other specific knowledge areas	14	Health impact assessment	1
General training areas	6	Accessing quantitative information	1
Strategic planning	1	Other specific skills	7
Saving Lives: Our Healthier Nation	1	General need for PH skills	1

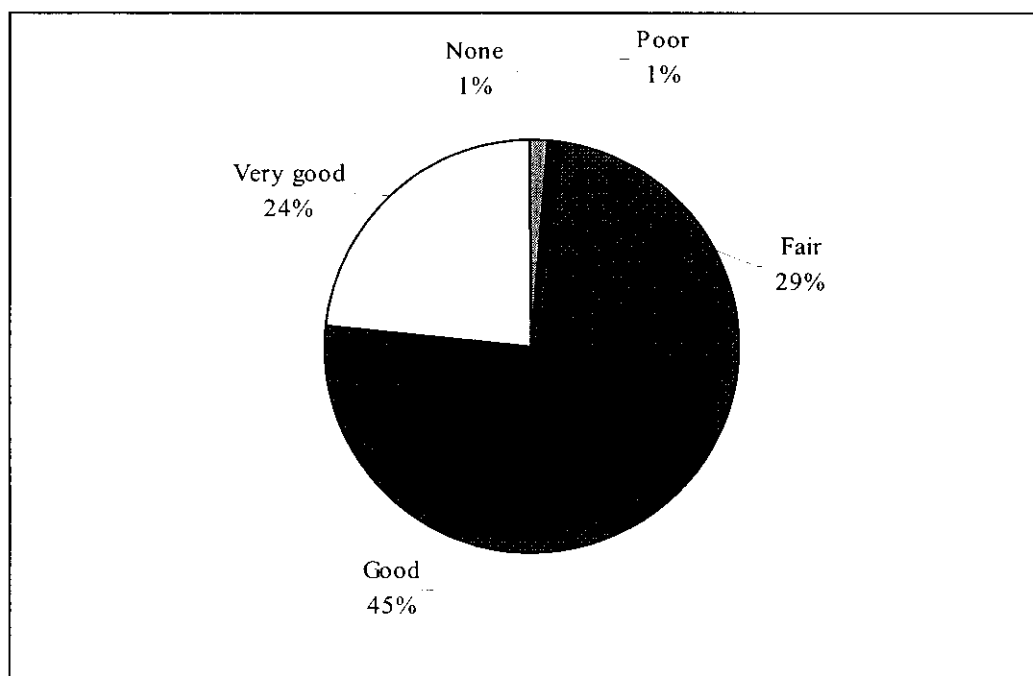
4.10 Appraisals and personal development opportunities

The majority of survey participants stated that they do have regular appraisals by their line managers. Only three people said they did not and six people commented they had not had an appraisal recently.

Opportunities for personal development appear to be good on the whole. Figure 6 identifies the percentages of those participants responding to the question of: what are the opportunities for your own personal development?

The results relating to staff appraisals and development opportunities were similar if the NHS respondents were excluded.

Fig. 6. Opportunities for personal development



4.11 Barriers to skills/knowledge

Respondents were asked to outline any barriers to developing skills and/or knowledge. The replies were free text, and have been categorised as shown below. Clearly time was the greatest barrier for everyone, and around half also mentioned funding as a problem:

No or limited time	73
No or limited funding	38
Not a priority/other priorities	11
No guidance, support or help	8
There are no barriers	1
Training is not a need at the moment	2
On training already	2
No suitable courses	1
Other	8

4.12 Further comments

At the end of the questionnaire, any other comments were invited. These have been arranged into the themes that emerged, as follows:

The importance of joint or inter-agency training.

“Multi-disciplinary training is excellent. Modular training – practical approach. Training/awareness raising of health and well being issues for council members is essential”.

“More inter-agency training”.

“Mandatory joint training/induction for HP/PH/social care medical trainees and social services trainees. Tried to set this up locally eg. through 2 year project called Medical And Public Health Inter Agency group (MAPHIA) with 4 local GP’s/CHC/social services/education/pharmacy/primary care/Kent University. No funding. Hope to progress this in postgraduate education in 2001-2”.

“There seems to be a need for more opportunities for joint training and development initiatives to engage senior managers/practitioners in other sectors”.

“Joint health and SSD training (not one off seminars), opportunities for secondment across agencies”.

“I am not involved with public health agencies as recognised, although I believe that adult education contributes to public health. We need joined up funding to go with joined up thinking”.

“Need to keep looking at health in its broadest sense (Joined up thinking). Not just in terms of disease or disease prevention”.

“The idea of inter-professional/inter-agency courses are very appealing to me. Its part of the new government agenda so why don’t we get together and start training together – excellent opportunity to network”.

Sharing of knowledge and skills

“Training needs to explore the wealth of experience and roles of agencies working to address causes of ill health, whether it be specific disease or general inequalities, deprivation factors etc. In both statutory and voluntary there is the need to explore links, the government agendas and mechanisms to make the impacts of interventions more effective and innovative”.

“The key area is for me to know how to access the knowledge of others rather than for me to have a more direct knowledge of the health agenda”.

“There is scope for sharing knowledge and skills within the public and voluntary sector and developing programmes particularly in the areas of working with and involving the public”.

“Need to use partnership working to share skills ie help some health professionals improve their community development knowledge/skills so that people most at risk of deprivation/inequality actually get improved access to services/opportunities and that they can begin to make supported life choices to improve their long-term health”.

Feeling that the questionnaire was inappropriate for some respondents.

“I don’t feel that this questionnaire is relevant to the work we do at our local volunteer bureau”.

“As a volunteer with the Community Health Council I’m not sure that this form should apply to me”.

“My work remit only skims health promotion. It is mainly dealt with by our health development officer”.

“My work as a planning policy officer does not have many direct health related issues involved in it – but there are many indirect consequences eg. location of development, need to travel, types of development, facility provision and planning etc”.

Other comments

“Needs and needs assessment is an area combined with ethics which are very important in health promotion and could be addressed by looking at best practice”.

“Too much emphasis on health care and cancer with less attention normally allocated to the economic, social and physical interventions.”

“Important need to strengthen epidemiological research into new governmental directions in National Neighbourhood Renewal Strategy”.

“I feel more work in the education field in schools and community centres would be beneficial. This could include living skills programmes etc. Also Healthy Living Centres”.

“Its essential to link environment and health issues they are diverging and spreading limited resources”.

“I have a great confidence in the development and opportunities to be gained by public health practices. The problem lies in reaching other people who should be involved but do not see it as their duty to become involved or ownership of identified problems”.

“There are an enormous range of interventions available to health workers if they had more time and training to be equipped to do this”.

“I think training in public health is very important and should be widely available”.

“Recently attended course at Public Health Resource Unit – Oxford – ‘Putting Evidence into Practice’ – excellent and practical. Would be a valuable resource to have a local programme of training for professionals”.

5. SUMMARY OF FINDINGS

- A survey instrument was developed and sent to staff involved in partnership and joint boards associated with improving health in Kent and distributed within local authorities.
- Replies were received from relatively senior staff in local authority and other positions beyond the usual boundaries of NHS public health.
- Response rates were not high (between 38% and 48% for members of HImP boards, and lower when distributed within local authorities).
- Respondents came mainly from social services, community, housing and policy/planning departments, although a quarter were from Community Health Councils, PCG/PCTs or voluntary organisations.

- There was a wide spread of people's time spent on population health, from 0-100%.
- Most respondents had formal working relationships with several other agencies.
- Respondents' definitions and understanding of public health were mostly quite limited.
- Most attached importance to all the key responsibilities within public health.
- Greatest confidence was expressed in skills of leadership, communication and working in partnership.
- Least confidence was expressed in use of statistics and presenting data.
- Around one in five did not feel at all confident in half of the skill areas.
- Half the respondents mentioned at least one skill area in which they wanted training.
- The majority thought the public health skills were relevant to their jobs.
- About half had none or basic knowledge in the areas contained in the survey.
- Over half the respondents identified a knowledge area in which they wanted training.
- Just under a third rated their opportunities for personal development no greater than fair.
- Time is a barrier to developing skills and knowledge for virtually all respondents.
- Funding is a barrier to 50%.
- Training needs will have to be assessed in the light of the relevance to jobs, availability of time and attitudes to personal development.

6. DISCUSSION

6.1 Limitations

The survey has been designed to and appears to have broadly achieved its aims, but it is worth noting, as in any design, there are a number of potential limitations which should be taken into account when interpreting the results.

First, the target population was hard to find: health authority and local authority staff were not always able to respond to our requests for contact names; partnership boards were emerging and had changing memberships with no clear responsibility for maintaining up to date lists. As a result we cannot be sure how well the survey has covered people with a responsibility for public health.

Secondly, we used more than one method of finding and contacting the target population and these methods are likely to lead to a bias in favour of senior people on partnership boards set up to implement Health Improvement Plans.

Thirdly, response rates were less than 50% and in some cases impossible to calculate, creating some uncertainties about the representativeness of the response. For example, non-responders might be staff with little interest in public health or developing their skills. We also know several people working in voluntary organisations did not believe the survey was relevant to them.

A self-completed survey containing questions, with a fixed range of responses, will inevitably limit the responses. In addition, respondents may not have shared our understanding when answering questions or may have given us the replies they think we would want to see. Since similar questions and format had been used before and performed well, we have no reason to believe these would present significant problems for the survey.

6.2 Benefits

The survey approach was chosen because of the coverage that could be achieved at reasonable cost. By using a number of open-ended questions it was possible to pick up additional views and comments. The survey approach ensured respondents were presented with a consistent and comprehensive list of topics relating to public health.

By choosing wide coverage and the questionnaire format involving explicit lists, it is anticipated that a second objective of the survey will have been met – to increase awareness of the responsibilities, skills and knowledge areas within the broader public health function.

6.3 Issues

The survey gives a snap shot of the perceptions and needs of senior staff, a group not often surveyed (and an area in which there is little existing research of this type). Most studies have focused on practitioner's needs. Some individuals did not answer the questionnaire feeling that it was not relevant to them. Methods of addressing this should be explored.

In several ways the survey stimulated a positive response to training opportunities in public health. For example, many thought the responsibilities that public health covers were very important, two out of three respondents identified specific areas in which they wanted to develop their knowledge and skills, and a similar proportion felt they have good opportunities for personal development. However, lack of time was a barrier for everyone, and meeting the cost of training a problem for at least half. This indicates that appropriate budgets need to be identified and access to these clarified.

Individual comments can be used to shape training programmes. For example, there was some consensus on the value of inter-agency or joint training with staff involved in improving health in partner organisations. This would help develop the public health 'mindset' across health and local authorities that is recommended by the CMO's report to strengthen the public health function. Induction courses were suggested for council members and social services trainees. There was also support for training that gives greater emphasis to economic, social and physical influences on health. One suggested the networking opportunities of training would allow access to skills without the need to learn them themselves. Another said they would like training to be modular and practical. Some specific skills were wanted such as needs assessment and putting evidence into practice.

Whilst respondents are not clear on the overall concept of public health' they know what needs to be done under the banner of public health but maybe not by whom . There is a need to clarify roles and responsibilities of this group as well as defining the 'new public health' agenda.

The difficulty respondents had in giving a definition of public health needs to be taken into account when interpreting the results, and may itself suggest the need for general training. It seems likely that those involved in health improvement programmes would benefit from a broad education that would raise awareness of the methods and terminology of public health. An example supporting this statement is that when asked to rate the importance of topics, health impact assessment was at the top of people's list for not knowing whether it was important or not.

It is interesting that over half felt that 'housing stock and conditions' were only 'fairly important' or 'not important' areas of public health. Almost as many felt the same about 'health and safety'. Traditionally only environmental health has been seen to have a connection with public health whereas public health is much broader than that and should encompass many other departments.

Although many did not feel confident in some of the skills listed they were not asking for training even though the majority felt that public health skills were relevant to their roles. This could be due to a feeling that they had no time for more personal development or that competing demands took priority?

Respondents felt confident in a number of key skills that have been identified in the CMOs' report on strengthening the public health function – these were working in partnership, communication and using leadership skills. For this group, there appears little need for training in these skills. The areas people were less confident were technical skills, such as handling and presenting statistical material, and specific public health methods. Again this agrees with skills the CMO's report identifies are in short supply, and poses a challenge to educators.

In many areas knowledge levels were described as basic, suggesting a widespread need for training. While there is clearly a benefit in gaining a detailed understanding of public health methods, training in these areas will need to take account of occasions when people feel the knowledge is not relevant to their job.

Most respondents felt that they had satisfactory opportunities for development but indicated that pressure of work and lack of funding stopped these from taking place. This may indicate either a need for more staff or a need to examine and redefine roles? The priority given to funding non statutory development needs to be explored.

This survey report will be disseminated to those agencies taking part in order to gain feedback as to the way forward. A conference to explore defining public health roles has recently taken place and a report is being produced with recommendations for action. The two reports will complement each other in supporting further action.

If public health training for this group of people is to be successful, it will have to be designed to overcome the major obstacles of lack of time and money. It will also have to be seen to be sufficiently relevant to their role to rise above competing priorities. Although the survey respondents thought public health skills were important, they were actually not very good at defining what the subject covers. This may have led to difficulty relating to the topics that we asked about (hardly surprising as by definition we were surveying people outside NHS public health departments). This lack of familiarity with the terminology would also account for the relatively low levels of demand we found for developing the knowledge and skills associated with mainstream public health responsibilities. Facing such a broad subject, it may be that the first training objective should be to encourage shared thinking through shared training, then to raise awareness about public health issues and how to access expertise in them. To provide skills that people can use with confidence may be a considerable way down this road.

7. RECOMMENDATIONS

- The main priority must be in raising awareness of the role of all the Local Authority departments that are involved in Health Improvement Programmes in the broad public health agenda both within Local Authorities and within the NHS.
- More opportunities are needed for joint appointments, joint training and education through existing routes but maybe more importantly through shadowing, learning sets, mentoring and good partnerships working.
- There is clearly a need to provide training/learning opportunities for senior staff to increase their skills and knowledge around public health issues particularly, health needs assessment, using statistical programmes to interpret data, presenting data and undertaking research using different methodologies.
- Learning opportunities could be integrated into existing provision to address the problem of time pressures.
- Inter-professional training and working on Health Impact Assessment would move the agenda forward as this is seen as a need both from NHS staff and from those respondents within this study.

REFERENCES

Chief Medical Officer's project to strengthen the public health function: report of emerging findings. Department of Health, 1997.

The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function. Department of Health, February. 2001.

Developing public health in the South East region: a framework for action. Cornish Y, Christmas P, et al. NHS Executive South East, May 2000.

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Survey of Staff Involved in Health Improvement.

This survey is being conducted by the Centre for Health Service Studies at Tunbridge Wells, part of the University of Kent at Canterbury on behalf of the Kent Education Consortium. Answers will be treated in confidence.

Job title:
Organisation:
Department:
Telephone Number:

1. What proportion of your work is concerned with the health of the local population?
 _____%

2. What other agencies do you work with:

Agency	Formally	Informally
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

3. Are you a member of any inter-agency group? Yes No
 (If yes please specify)

PUBLIC HEALTH DEFINITION

4. Please describe what you understand by the term 'public health'

5. In your opinion does a responsibility for public health include any of the following? (please tick the appropriate box)

	Very Important	Fairly Important	Not very Important	Don't Know
a. Disease prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Health promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Reducing health inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Environmental health hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Disease screening programmes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Disease immunisation programmes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Clinical effectiveness of health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Health needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Health impact assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Population health monitoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Housing stock and conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Health and safety standards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Studying of patterns of disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SKILLS AREA

6. Please indicate how skilled you feel you are in the following areas

	Confident	Fairly confident	Not at all confident	Not relevant to my job.
a. Knowing how and where to obtain information on population characteristics Eg. Age profile, ethnic mix.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Interpreting population data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Comparing information with other populations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Undertaking research using different methodologies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Developing interventions for local situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Identifying methods to monitor progress against project objectives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Evaluate research projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Using project management skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Policy development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Confident	Fairly confident	Not at all confident	Not relevant to my job.
J. Critically appraising research	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Working in partnerships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. <u>Using leadership skills</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Conducting a health care needs assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Engaging and involving the public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Use of the internet to obtain data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. <u>Use of the internet to obtain literature</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Statistical programmes to interpret data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. <u>Presenting data – eg graphs</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Facilitating group work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Communication skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. <u>Health impact assessment</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Accessing qualitative information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. Accessing quantitative information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

KNOWLEDGE AREAS

7. Please indicate the level of knowledge you have in the following areas

	None	Basic	Good	Very Good	Not relevant to my job
a. Population health status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Health inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Barriers to better health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. <u>Use of health and related services</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Health promotion interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Health education interventions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. <u>Health improvement programmes</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Screening and immunisation Programmes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Communicable disease control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Systems for responding to environmental hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	None	Basic	Good	Very Good	Not relevant to my job
j. Clinical Governance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Local Agenda 21	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Saving Lives: Our Healthier Nation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Other policies: (please detail below)					
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DEVELOPING KNOWLEDGE AND SKILLS

8. In relation to public health and health improvement, please indicate below the areas in which you would like to develop your knowledge and skills.

Knowledge Areas

Skill Areas

9. Do you have regular appraisals by your line manager?

Yes No Haven't had an appraisal recently

10. What are the opportunities for your own personal development?

None Poor Fair Good Very Good

BARRIERS TO SKILL/KNOWLEDGE DEVELOPMENT

11. Please outline below any barriers to developing your skills and/or knowledge. Eg. Lack of time, no funding available for courses etc.

FURTHER COMMENTS

12. If you have any other comments regarding knowledge and skill training within public health please write them in below.

Please return the questionnaire by the 7th February 2001 to: Miss F.E. Meade, Research Assistant, CHSS at Tunbridge Wells, Oak Lodge, David Salomon's Estate, Broomhill Road, Tunbridge Wells Kent. TN3 OTG.

ANNEX B. Establishing a sampling frame

Identifying and mailing out the questionnaire to the target population was not a simple process, and details of the approach that evolved are given below.

Methods

Lead staff in East and West Kent health authorities responsible for HImPs were telephoned and asked for contacts for all the key multi-agency boards or groups involved in the HImP.

Within East Kent six key contacts were identified, although ten planning groups were in the HImP dated April 2000. On follow-up of these key contacts, four names were no longer correct and we were given alternative names. The six key contacts were then sent letters requesting the board members names and contact addresses. All the key contacts replied, generating a mailing list of 76 names.

In West Kent nine key contacts were identified and contacted. Four did not respond. Members for the specified Health Action Teams and Partnership Boards were obtained from the remaining five key contacts. This led to a total of 84 named people to whom a questionnaire was sent.

All lists were checked to ensure there were no duplicates, which would result in a person receiving two or more questionnaires. Any duplicate names were omitted. Names of staff in NHS health authorities and trusts (apart from PCG/PCTs) were also omitted. All the names and addresses were then put into a database for mailing purposes.

As an alternative approach, all fourteen local authority councils in Kent were contacted by writing to heads of Human Resources or Personnel departments and asking for names and numbers of staff with a public health remit in their job descriptions. Two councils declined the invitation to participate in the survey. About 100 questionnaires were sent to the remaining twelve councils, who agreed to pass them on to relevant staff. At the outset, we believed this might be the best way to identify staff with public health training needs. However, the response from HR departments was patchy and so the approach was used to supplement the survey's coverage in local authorities. A disadvantage of using HR departments was that the questionnaires might have reached the same people twice. However, a possible advantage is that it extended our coverage to less senior staff (than those who were members of multi-agency boards).

We aimed to send a questionnaire to all named and unnamed contacts derived from the above process.

Questionnaire distribution

East Kent - The questionnaire was distributed to named persons. Forty two named people associated with the Joint Partnership Boards in East Kent were identified. The last two names were key people who wished to distribute the questionnaires to members of Children's Services Board and the Mental Health Board. The members of the Children's Services Board were identified by the key contact after the questionnaires had been distributed. The total number of people on this board to which the questionnaires were sent was 13. Fifteen questionnaires were sent to the key contact for the Mental Health Joint Partnership Board (the

actual number of people on this board was not confirmed). This suggests an approximate total of 70 questionnaires were sent out.

West Kent - Again the questionnaire was distributed to named persons identified through the key contacts. Four key contacts were unresponsive and therefore could not be included in the study. The total number of named persons in West Kent to whom the questionnaire was sent was 84.

Councils in Kent - These were sent questionnaires as an alternative approach to finding local authority staff with a responsibility for public health, but who had not been sent a questionnaire as a named person in the East and West Kent mailings. Questionnaires were sent to 12 councils. Previously two councils had declined the invitation to participate in the survey.

Comments on sample

Finding staff in local authorities with a public health component in their job description was not easy. In addition, health authority and local authority staff were not always able to respond to our requests for contact names. Partnership boards were emerging and had changing memberships with no clear responsibility for maintaining up to date lists.

People working in voluntary organisations and charities sometimes returned the questionnaire thinking that it did not apply to them.

It is therefore recognised that there could be serious biases or omissions in the contact names we were able to obtain.