Collaborative Practice for Public Health

Dawne Gurbutt

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About the author

**Dawne Gurbutt** has a background in Nursing and Midwifery, but spent the majority of her practice career working as a Health Visitor (Public Health Nurse), initially in the mining villages of the Dearne Valley and later in Central Lancashire. Her work in areas of social deprivation led to a keen interest in the importance of collaborative working and community engagement. After more than a decade in this work she moved into education, initially in Further Education and then in Higher Education, leading programmes in Early Years and Social Work before moving to St Martins College to lead the division of Public Health and Primary Care. Following a reorganisation she became the Director of Studies for Public Health and Clinical Science whilst concurrently engaging in doctoral research around Sudden Infant Death Syndrome. She moved to UCLAN to lead and develop the Masters provision in Public Health. Since then she has led teams in Public Health, Health and Social Care and Allied Health. She worked for two years at the Higher Education Academy (UK) as Discipline Lead for Health working at a strategic level across the UK, providing support and development for the pursuit of excellence in teaching and learning, developing national and international materials and liaising with professional bodies on curriculum. She has a key interest in pedagogy and has contributed to the editorial board of two pedagogic journals. She has published and presented pedagogic research around: service user engagement, using coaching to empower students, simulation and interprofessional learning. Her current work involves exploring innovations in learning modes and she is leading on Interprofessional Education across Health and Medical Programmes within the university.
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Founded in 1987, CAIPE is a charity and company limited by guarantee which promotes and develops interprofessional education with and through its members.

It works with like-minded organisations in the UK and overseas to improve collaborative practice, patient safety and quality of care by professions learning and working together. CAIPE’s contributions to IPE include publications, development workshops, consultancy, commissioned studies and international partnerships, projects and networks.

CAIPE not only offers expertise and experience, but also provides an independent perspective which can facilitate collaboration across the boundaries between education and health, health and social care, and beyond.

Membership of CAIPE is open to individuals, students and organisations such as academic institutions, independent and public service providers in the UK and overseas.

For further information about CAIPE and other benefits of membership go to www.caipe.org.uk
A Paolo, Teresa e Totò, La cui amicizia mi ha insegnato che non è mai troppo tardi per imparare qualcosa di nuovo.

(For Paolo, Teresa and Totò, whose friendship has taught me it is never too late to learn something new.)
CHAPTER 1

Introduction: threads, challenges and the context of working collaboratively in public health

Dawne Gurbutt

CHAPTER SUMMARY

This chapter will introduce ‘public health’ and offer some definitions for key terms including ‘health’, ‘wellbeing’ and collaborative practice in public health. There is an overview of the book and a rationale which provides some insight into the context in which practitioners work; discussion of the diversity and differences which are encompassed by the term ‘public health’; some comparative examples, e.g. www.guardian.co.uk/news/datablog/2012/jun/30/healthcare-spending-world-country; and identifying how students and practitioners can approach interprofessional practice through case studies and opportunities for reflection.

In working through the chapter the reader will:

- consider definitions of ‘public health’ and ‘wellbeing’ and the context in which these operate.
- consider the importance of reflection in relation to working collaboratively in public health
- recognise the complexities involved in defining and working in public health.

Occasionally I am asked what I do for a living and my response is generally that I work in public health. This is not wrong; I hold a qualification in public health nursing and have written curriculum and taught public health for many years as well as working in community practice. However, there are those who would argue that this type of community work is not public health at all, although work with populations
and groups underpins the wider work of community engagement. This brings to the fore some of the complexities and contradictions of working in this field. If there is no consensus on what constitutes ‘public health’ both nationally and internationally, it becomes difficult for practitioners to clearly identify opportunities for collaborative working and their contribution to this endeavour.

Public health is a multiple rather than singular concept in that it has many definitions, some of which overlap and some of which are very different. There are underpinning models of public health which come from different historical traditions and which sometimes do not always sit easily with each other. There are distinctions between groups of people and practitioners which sometimes act against collaborative working. Yet all of those who recognise that they work within this field, and some who work in the general area of community health and wellbeing but would not readily construct their work as directly ‘public health’ or have this term in their job title, do have similar aims. These include, first, contributing to the health of identified populations and measuring the impact of initiatives, and, second, working together to bring about social change and improvements in health. Hence there are those who work in defined areas of ‘health’ – medical staff, nurses, allied health professionals – who would recognise elements of public health work within their role and those who work in other areas such as ‘transport’, ‘environment’ or ‘food policy’ to name but a few, all of whom make some contribution to the wider work of public health.

It is important to think about the relationships between public health and personal lifestyle or health choices. The part played by individual choice might be viewed very differently in a private healthcare system such as the US, where insurance is needed for healthcare and where behaviours identified as risky may affect premiums and healthcare cover, as opposed to a publicly funded system such as the NHS in the UK, in which such considerations have not impacted access to healthcare, up until now. There are difficulties in comparing countries, systems and policies. (See Hans Rosling’s bubble diagrams of the wealth and health of nations: www.gapminder.org.) But it is important to note the differences between systems, approaches and models and the ways in which these may impact on the opportunities for working collaboratively and understanding how public health functions and how the mechanisms within specific systems facilitate or hinder public health work.

So this complexity is, in a way, the rationale for this book. You might see yourself as someone who clearly works in public health, or you may be someone who works in an organisation which has a direct impact on the health of the population but not consider yourself as working in ‘health’ at all. Or you may spend just a proportion of your time working in ‘public health’ without it being part of your defining role or your job title. Whichever group you belong to, this book is for you.

Each chapter will include text exercises for the reader and reflection points. These are intended to help those using the book to gain the most from it, through making connections with their own experiences and practice and between different sections.
of the book, and will indicate opportunities for effective collaboration to improve services and care. Exercises may relate to a paragraph topic or, as in Chapter 3, to a larger case study; some include further references, including web-based material. The aim of this book, along with others in the series, is to help readers to develop as collaborative and interagency practitioners working beyond traditional professional boundaries.

This book, through case studies, examples and definitions, seeks to illustrate the different ways in which public health permeates health and social care, not only in the UK, but also further afield. It promotes reflection to encourage individuals to consider not only the opportunities and impacts of working in public health, but also the gains which can be made by working collaboratively. With a clear focus we can achieve much in terms of public health and improvements to health, but with a joined-up approach we can achieve far more; we are, indeed, stronger together in terms of impact.

**PUBLIC HEALTH DEFINITIONS**

The Faculty of Public Health (UK), the standard setting body for specialists in public health in the United Kingdom, defines public health as: ‘The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.’ (FPH, 2013)

The Faculty of Public Health takes the approach that public health is population-based and places emphasis on the collective responsibility for health. This includes responsibility for health protection and prevention of disease. This position recognises the key role of the state in acknowledging the impact of the underlying socioeconomic factors which contribute to ill health and the wider determinants of health. There is also an emphasis on partnership working to contribute to positive health outcomes.

The World Health Organization, the directing and coordinating authority for health within the United Nations System, defines public health as referring to:

all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease. (WHO, 2015)

The WHO describes three main areas of public health function and takes into account the social determinants of health. The first of these is concerned with the assessment and monitoring of the health of populations or communities who are at risk and the identification of health needs and priorities. This is accompanied by the formulation
of public policies which are designed to address the local and national problems and health priorities which have been identified. The third area is concerned with ensuring that all populations and communities have access to appropriate and cost-effective care which includes disease prevention and health promotion activities. ([www.who.int/trade/glossary/story076/en/](http://www.who.int/trade/glossary/story076/en/))

Public health operates at global, international, national and regional levels. It is currently defined by the UK Government as: ‘Helping people to stay healthy and protecting them from threats to their health.’ The government further explains that it ‘wants everyone to be able to make healthier choices regardless of their circumstances and to minimise the risk and impact of illness.’ ([www.gov.uk/government/topics/public-health](http://www.gov.uk/government/topics/public-health))

**EXERCISE**

How would *you* define public health?

Look back over the three definitions from the Faculty of Public Health, the WHO and the UK Government – are they all fundamentally the same? Is the focus and emphasis the same in each one?

This book is not just concerned with working in public health, but specifically with ‘working collaboratively’ in public health. The Centre for Advancement of Interprofessional Education (CAIPE) has sought to define interprofessional education.

[It] occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care. ([CAIPE, 2002](http://www.gov.uk/government/topics/public-health))

This is a good point at which to read Appendix 4 and the CAIPE position on interprofessional and collaborative learning, which has been widely adopted by many organisations.

It is important to recognise here that learning takes many forms and occurs in many places. It is not limited to learning prior to qualification and is not confined to classrooms or even occasions when practitioners might recognise that learning is taking place. But reflecting on learning and considering practices and case studies critically helps to identify what is being learned, how we are learning it and what we could do to enhance this process and work collaboratively to improve outcomes in public health.

Thinking about collaborative practice in public health, it is important to recognise that we are simultaneously part of the ‘populations’ and ‘communities’ which are at the heart of public health practice. We are ‘consumers’ as well as contributors, navigating our way through the complex web of circumstances, experiences and locations which
influence health, enmeshed in the socioeconomic factors, relationships and partnerships that influence and impact health, and which include education.

**EXERCISE**

- When you think about practitioners whose work encompasses aspects of health who do you include? Try to list them.
- Where did your list begin? What practitioners did you list? Were they ‘health’? ‘Social care’? Did you include geographers, built environment, economists, and informaticians? What about those working in the third sector or the private sector? Would this be different for other countries, for example in developing countries such as Malawi, which will be discussed in Chapter 4?

It is clear that there are implications for identity and role in terms of public health work. Some roles are very clear, whilst others are more difficult to transcribe in terms of where their involvement in public health begins, or even where it would begin if they were to be enrolled more fully in public health and the potential for the involvement of these roles in public health was fully realised.

There are groups of professionals whose work within the UK is clearly identified as being public health focused, such as public health specialists, epidemiologists, members of public health teams; then there are those involved directly in health improvement work, for example public health nurses and community engagement practitioners. The work of other groups in the third sector impinges directly on the socioeconomic and environmental factors which underpin, influence and impact the health of the public such as policy-makers and local government officials.

It is important to recognise that within the UK practice is also embedded within European and global public health practice.

The European Public Health alliance (www.epha.org/) works together on health improvement, children's health and towards achieving healthy diets as well as improving health and wellbeing and harm reduction in relation to substance misuse and addiction.

The EPHA believes:

that the conditions in which people are born and live impact on their lifestyles and behaviours. This means that wealth, revenues, education, housing, living conditions, employment, the cultural background, discriminations (etc.) are all factors that will impact what they eat, drink, and breathe. (www.epha.org/)
This organisation believes that too strong a focus exists on competitiveness and GDP and that this results in a tendency for policy-makers to focus insufficient attention on public interest including health and wellbeing.

The European Union treaty makes provision for the EU to take action on health. This action includes responsibility to improve health, to prevent illness and human diseases and to seek to identify issues which pose a risk to human health. However, the individual member states of the EU remain responsible for the organisation and delivery of health services and healthcare, and these functions are not centrally determined by the EU.

HEALTH AND WELLBEING

REFLECTION POINT

Reflect for a moment:
● What does ‘wellbeing’ mean to you personally?
● If you had to describe it in five words, which words would you use?
● Does wellbeing depend on other factors? And if so, what are they?

Linking health with wellbeing raises another issue to consider, namely the place of wellbeing in considerations of health improvement. This is a more contested concept than that of health.

The WHO (2014) conflates the definition of wellbeing with mental health, stating:

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (www.who.int/features/factfiles/mental_health/en/)

The UK Government document Our Health and Wellbeing Today (DoH, 2010a) fails to clearly define wellbeing but states:

… we take a broad view of what health means. We care about the physical and mental wellbeing of everyone and we recognise that there is a huge range of societal factors that affect this. By its nature, public health often takes a population view of health – this is important as we know that individual health and wellbeing cannot be seen in isolation from wider society. We also recognise the health inequalities that exist and the importance of addressing them in order to improve the health and wellbeing of society as a

This tends to suggest that there is acknowledgement that wellbeing is complex and difficult to define. It also suggests that wellbeing is susceptible to being interpreted differently in different contexts.

The *Oxford English Dictionary* defines wellbeing as the ‘state of being comfortable, healthy or happy’, whilst the WHO (2014) as already mentioned views wellbeing as ‘realizing potential’ and ‘able to make a contribution to the community.’

This last definition fits alongside the WHO definition of health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. The definition defines an absolute state of ‘health’. Wellbeing can become conflated with consideration of how people feel and therefore can be problematic for policy-makers. In the EU some of the public surveys have encompassed a tendency to do this, defining wellbeing as contentedness or happiness. This then links the health agenda to an unachievable set of measures and unrealistic expectations on practitioners. Happiness is in itself an elusive concept, and many individuals will define it by its absence; that is, they are ‘not unhappy’. And happiness, like blood pressure, may fluctuate through a day, through a week, through a lifetime. This presents a challenge when policy-makers attempt to measure indicators of happiness. Like measuring blood pressure, it is dynamic and not a static measure. Unlike a blood pressure measurement it is hard to provide a fixed measurement at a given point, and therefore it is a subjective estimation of wellbeing in many instances.

**REFLECTION POINT**

- Is happiness a constant state or is it transient?
- Would you describe yourself as happy today?
- What are the contributing factors to your choice — are they short-term or long-term issues or circumstances?

If government and other organisations seek to conflate wellbeing with contentment and fulfilment, does this matter? What are the implications of these loose definitions and assumptions?

How can we effectively measure wellbeing?

It is often assumed by politicians that economic growth and wealth lead to increased health. There is a longstanding debate as to whether economic growth and technological advances lead automatically to better health and wellbeing. However, it could also be argued that economic growth has a tendency to be unequal within countries and societies, leaving some groups and geographical areas substantially
poorer than others. In short, the argument is that economic growth widens the wealth gap and also the health gap between the richest and the poorest in society, and that this in turn becomes a challenge for public health.

The question then focuses on how the workforce in general and individual practitioners, as well as the lay population, can be equipped to deliver health improvements; these considerations include the identification of the technology and tools to be used for the delivery of services and better prevention. Additional areas include identification of which aspects of the workforce are to be actively involved in working towards improving socioeconomic benefits and the impact on health.

**REFLECTION POINT**

- How do we engage people in health initiatives and measures to improve health?
- Who do we identify as having a role in public health work and people with whom we can work collaboratively?
- Who would you include on your list?
- In the language of contemporary health and social care who are the stakeholders and service-users?

When thinking about engaging people in health improvement, who did you include in your list? And where did you begin? Did you begin with colleagues and like-minded individuals and work outwards thinking who might be involved? Or did you begin with a wish list of people who would need to be involved in order for you to ‘change the world’? Was it an extensive list? Or did you find it hard to think extensively and expansively? To some extent the answer to these questions will be influenced by where you are situated and the experiences you have had, the education and training you have received, by what you understand by public health and to what extent you perceive a need for social change in the pursuit of health improvement.

For example: Did you include any members of the public in your list? Who do you feel should be involved and how should they be involved?

Much has been written about public and patient involvement, engaging service-users in decision making around care and service improvement. In terms of public health we are all ‘service-users’ in the settings where we live our lives as workers, residents, citizens and communities.

It is via the medium of community engagement that much of the work with service-users takes place in public health. This might be through a geographical community, people living or working in one location. But other communities also exist. These may be groups of people with a shared experience and so a single unified focus; it could be a neighbourhood, or a social group experiencing the same shared constraints (or opportunities); it could be a group across the globe with a shared interest
(e.g. sustainability and transition towns); or a demographic group.

It is worth considering how we work collaboratively with community groups and stakeholders, but also how opportunities to engage in this work can be fostered, encouraged and supported, whilst noting the difficulties inherent in working with under-represented and marginalised groups, those who experience social exclusion in one form or another. It is a common experience in a professional career to be invited to join a community group, a committee or a governing body that has a broad remit which may have a community focus and also involve public health issues. So, an understanding of the broader context, the interplay between actions and policies and the impact on public health, can be very useful to the practitioners, not least in identifying the opportunities for working in partnership.

**CONTEXT**

The context of public health is increasingly complex. There are multiple global challenges incorporating not just health improvement but also risk management and response to health threats. The latter category includes the known health threats and those yet to be identified; previous examples of emergent crises include pandemic influenza or developing threats such as the SARS epidemic of 2003/4 or the Ebola outbreaks of 2014. There is also a widening health gap between sectors of the community, and between rich and poor nations. Coupled with the impacts of the global recession on economic policy and provision of services these lead to significant challenges for public health providers. On a different level there are also the impacts of dwindling minerals and raw materials, which are driving new thinking in the search for sustainable health solutions as part of wider social change in the way we live in a world of diminishing resources. This is accompanied by the increasing need for interconnectedness and concerted actions, from local to global contexts in relation to management of resources, but also to manage health risks and address wider issues.

**EXERCISE**

Consider the differences between different locations in the world and even within specific countries. The following link highlights the difference in resources between countries: www.guardian.co.uk/news/datablog/2012/jun/30/healthcare-spending-world-country

- What impact does this have on the practice of public health?
- What are the challenges?

Contemporary life increasingly involves the use of technology, and health services are increasingly experienced via some form of engagement with technology-based intervention from the service-provider or involvement with technology from the
service-user. It is clear that health (and learning) technologies are transforming healthcare delivery, and the use of social media is transforming relationships both personal and professional, as well as increasing the scope for more relationships and the possibility for wider collaboration. In addition there is the development of technology and approaches designed to support remote consultation, such as telmedicine and the development of health pods which capture and transmit health data for interpretation by an appropriate practitioner. There is a contrast between the benefits of technology and also the challenges which these and other innovations bring. For example, widening access to information can be viewed as a positive factor for both practitioners and service-users, but the indiscriminate use of information can raise levels of anxiety and also levels of expectation. For the workforce there is the associated need to navigate the educational landscape of information application and interpretation. With the explosion of access to information there is a constant challenge to keep abreast of developments and emerging issues without letting go of the core values and philosophies which underpin and shape the practice of public health.

Frenk et al. (2010) highlight the growing gaps within and between nations, between the wealthiest in society and the poorest together with the continuing silos and hierarchical relationships which continue to affect the delivery of health and health improvement.

They state ‘the need for change in the education of health professionals and the requirement for transformational education’. They describe ‘transformative learning’ as: ‘the proposed outcome of instructional reforms’ which foster interdependence in learning based on reform of the educational institutions. These reforms should in their view encompass ‘competency driven approaches to instructional design’, allowing adaptation to the rapid changes in local conditions and use of limited global resources. This is accompanied by an emphasis on interprofessional and transprofessional education that breaks down silos based around professions, ‘while enhancing collaborative and non-hierarchical relationships in effective teams’. Frenk et al. also emphasise the need for implementing the latest technologies in learning and focus on professionalism and notions of social accountability based on shared values. Furthermore there should be a shift towards joint education and the extension and enhancement of global networks and alliances around health. Other recommendations include developing a ‘culture of critical enquiry’ and health planning that ‘takes into account crucial dimensions such as social origin, age distribution and gender composition of the health workforce’ (Frenk et al., 2010).

Frenk and colleagues also highlight the rapid changes and developments impacting health such as health security, global crises, the volume of information circulating and the subsequent impact on information, rise of health technologies and the increasing complexity of populations and health needs. These are the challenges facing strategic and operational decisions around delivery of appropriate public health. This in turn drives the economic decision making for countries around the world in
relation to spending on healthcare (e.g. see www.guardian.co.uk/news/datablog/2012/jun/30/healthcare-spending-world-country).

POLICY DOCUMENTS

The challenge for different countries and communities is to use the resources in the most cost-effective and equitable way to improve the health of the public and to measure the impact of initiatives aimed at reducing mortality and morbidity.

UK governments in the last 15 years have adopted a target-driven approach to policy-making in public health. These include policies such as: giving all children a healthy start in life; reducing drugs misuse and dependence; reducing smoking; reducing obesity and improving diet; helping more people to survive cancer; reducing harmful drinking; and planning for health emergencies (www.gov.uk). The Government White Paper Healthy Lives, Healthy People: our strategy for public health in England (DoH, 2010b) focuses on the following areas: protecting the population from serious health threats; helping people to live longer, healthier and more fulfilling lives; and improving the health of the poorest, fastest. However, it is important to acknowledge that collaborative working in public health involves not just working in settings which directly relate to areas of public health policy, but also in the more complex areas of life which benefit from factoring in health impacts when developing and working with a broader range of policies. This is described as ‘healthy public policy’ ensuring that initiatives and actions developed and implemented by national and local government contribute to health benefits and do not lead to health deficits. Therefore, all policy needs to be considered in the context of the health of citizens, from housing policy to environmental policy, transport policy to social welfare. It may not seem at first glance that policies relating to public transport, policy on who has the right to buy property in a national park or broadband access in rural areas are related to public health, but it is clear to see that if people become isolated from services or social contact, or if communities become fragmented and seasonal, these are factors which directly impact on the health and wellbeing of citizens. The considerations are all encompassing if health concerns are to be kept at the centre of the public health agenda. The successes of the Healthy Settings movement have been documented in relation to a joined-up approach to health promotion and improvement based on the fundamental position encompassed by the Ottawa Charter for Health Promotion (WHO, 1986): ‘Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love.’

Nor is it possible in the 21st century to ignore the consequences and imperatives of being part of an interconnected global community. This includes consideration of the role of aid agencies, the emerging threats from diseases such as Ebola, the need for new ways to think about strategies and the ethics of using newly developed treatments and approaches. From global warming to depleting resources and the growth
of the sustainability agenda and the transition towns movement, to the emergence of new diseases and other health threats, global issues rapidly can become local and vice-versa. Therefore it is important to recognise continental and international strategies. The EU Strategy Together for Health (2007) supports the European 2020 strategy, which sees a healthy population as a prerequisite for creating a smart, sustainable and inclusive economy. Investing in Health (European Commission, 2013) supports ‘spending smarter, but not necessarily more in sustainable health systems, investing in people’s health, particularly through health promotion programmes and investing in health coverage as a way of reducing inequalities and tackling social exclusion’. All of these policies are bound up with global and international health preoccupations in multiple areas which are at the heart of the health promotion programmes and health projects.

The European Public Health Alliance (EPHA: a network of NGOs and other not-for-profit organisations working in the field of public health in Europe) focuses on the role of innovation and research in health, the socioeconomic conditions in which people live and the measurement of health and wellbeing (www.epha.org/). The European Public Health Association (EUPHA: an umbrella organisation for public health associations and institutes in Europe) along with other organisations, aims to provide information on European institutions including strategy, impact of strategy, EU budgets, funding and the variations between nations (European Public Health Association: www.eupha.org/). Central to all the shared concerns of such groups is the pursuit of transparency and governance in policy making relating to health. These are examples of the many organisations working at different levels to influence policy and practice. It is important to recognise and acknowledge the breadth and scope of EU policies which impact on health and health systems and which range from food policy to employment mobility.

Hence it is important to recognise that there are both micro and macro effects of policy implementation. This is accompanied by a need to influence policy making and evaluate the effects of existing policy in order to ensure that not only public health policy but also healthy public policy is instrumental in bringing about effective and equitable social change. This change should take into account the imbalances in socioeconomic circumstance which exert such a significant impact on health and wellbeing both within and between countries.

OVERVIEW OF BOOK CHAPTERS

The issues discussed above are timely concerns and this book seeks to explore some of them more fully. Using a study of traffic as a vehicle to explore the importance of collaboration, Hannale Weir looks at some of the sociological issues which underpin the practice of public health. She offers insights into the complexities of how different groups might work together, enrolling in the creation and delivery of public health
INTRODUCTION

policy and also healthy public policy. Russell Gurbutt, working with colleagues in Canada, examines examples of technology used to enhance learning and practice in collaborative working in public health, including immersive and game applications. Practice learning opportunities and moving out of silos is an important factor in promoting collaborative working, not as shared occasional endeavour, but as the underpinning experience for practice. Jonny Currie and Liz Anderson focus on the setting of primary care to explore significant points for consideration using a case study approach. It is important to recognise that however local the practice of an individual or team may be, public health is a global endeavour, not just in terms of collective action, but also in relation to learning from and understanding the context in other countries. To this end midwifery educators Pat Donovan and Lucy Kululanga contribute a study of interprofessional and collaborative working in Malawi.

There are other areas to consider, too, which due to the limitations of scope and space are not addressed in detail here. The provision of clean water and sanitation is a huge issue, concerning many areas of the world. Although in the West such provision is taken for granted and seen as a given for public health workers in many settings, disease control through access to clean water and sanitation remains a key area of work.

Nutrition and food safety is another important area which is only touched on in this text but holds central importance. This is an area in which the wide envelope of global public health agendas is rendered visible, from the initiatives to combat starvation and malnutrition in some parts of the world, to the efforts to tackle obesity in other countries. Add to this considerations around food security: ensuring crops thrive; debates on genetically modified foods; food safety including integrity of the food supply chain and managing contamination in the food supply (e.g. the recent horsemeat scandal in the UK, the BSE crisis in the UK); the politics of food and poverty (emergence of food banks in Western economies); or the issues around food waste. Globalisation also plays its part in the politics of food, from the slow food movement in Italy, attempting to resist the move away from traditional diets to fast food diets, with the accompanying effects of obesity, to the air miles associated with food provision, and the movement to considering transition towns which source materials from the local region. Thus food and nutrition are central to the public health agenda and could form the topic for a whole text on collaborative working.

So this book does not cover all aspects of collaborative working in public health, but selects areas for consideration which illustrate the wider issues.

Overall this book aims to help the reader to recognise the debates, contexts and identity issues relating to working in public health along with understanding some of the context of public health work at local, regional, national, international and global levels via access to case studies. In addition there will be an emphasis on considering how students and practitioners can usefully approach interprofessional practice/collaborative working and reflecting on the process of this engagement; whether this constitutes the whole or a part of a practitioner’s occupational role. At all points the
reader is encouraged to engage with the topic, to reflect, consider and apply the material to their own context in order to enhance learning and identify opportunities for change and the extension of collaborative working.

**EXERCISE**

Take a moment to think about your own engagement with public health matters:
- Who do you connect with?
- How do you connect with them?
- Why do you connect?
- Is this entirely a professional or occupational engagement?
- Are you connected with other groups which work to improve public health – in your neighbourhood? In your areas of interest?

Try to map your engagement with public health. You might want to use a spider diagram or mind map to help you to do this.
- What makes it easy to connect?
- What makes it difficult?

**REFLECTION POINT**

- How do you describe your professional role to friends, colleagues, service-users and members of the public?
- Is your professional identity connected with public health, and to what extent?
- How do you describe public health?
- How does your view of what constitutes public health inform your practice and your engagement with others?
- How is collaborative working relevant to public health work and practice – in a wider setting? In your own setting?
- How do you understand the diversity and difference which are encompassed by the term public health?
- What are the current debates and identity issues relating to how public health is configured?
FURTHER READING

Department of Health (UK): www.gov.uk
European Health Alliance: www.epha.org/
European Public Health Association: www.eupha.org/
Faculty of Public Health (UK): www.fph.org.uk
Rosling, H. Gapminder World: diagrams of the wealth and health of nations: www.gapminder.org/
WHO: www.who.int/trade/glossary/story076/en/

REFERENCES

European Public Health Alliance: www.ehpa.org/
Faculty of Public Health. (2013) www.fph.org.uk
HEA case studies: HEAcademy.org.uk/health/internationalization
Rosling, H. Gapminder World: diagrams of the wealth and health of nations: www.gapminder.org/
Introduction: threads, challenges and the context of working collaboratively in public health

Department of Health (UK): www.gov.uk
European Health Alliance: www.epha.org/
European Public Health Association: www.eupha.org/
Faculty of Public Health (UK): www.fph.org.uk
Rosling, H. Gapminder World: diagrams of the wealth and health of nations: www.gapminder.org/
WHO: www.who.int/trade/glossary/story076/en/
European Public Health Alliance: www.ehpa.org/
Faculty of Public Health. (2013) www.fph.org.uk
HEA case studies: http://HEAcademy.org.uk/health/internationalization
Rosling, H. Gapminder World: diagrams of the wealth and health of nations: www.gapminder.org/

Everybody’s business: working and learning together for public health practice

Centre for Workforce Intelligence: www.cfwi.org.uk/
Public Health Observatories: www.apho.org.uk


Public health skills and knowledge framework. (2013) PHORCaST: public health online resource for careers, skills and training. Available at: www.phorcast.org.uk/page.php?page_id=44


University of Central Lancashire. Healthy & Sustainable Settings Unit. (2006□□□ ) Healthy Universities. Available at: www.healthyuniversities.ac.uk/


**Tackling traffic issues with a public health focus**

Air quality in London (research) : http://test.londonair.org.uk/


Department for Environment, Food and Rural Affairs: www.defra.gov.uk


NERC Planet Earth: http://planetearth.nerc.ac.uk/accessibility/transcripts.aspx?t=0&id=223

Interprofessional education and Malawi


Collaborative working for public health in the voluntary sector

Age Concern Cheshire East Health and Wellbeing initiative: www.ageuk.org.uk/cheshireeast/health-wellbeing/

Be a Star: www.beastar.org.uk/links

Healthcare Professionals Network: www.theguardian.com/healthcare-network

Lanarkshire Healthy Valleys project: www.healthyvalleys.org.uk/

Little Angels, breastfeeding support group, Blackburn with Darwen: www.leedsbeckett.ac.uk/health/piph/documents/makingbreastfeedingfashionable


Thornhill Plus You: www.plusyoulimited.co.uk/


Blackburn with Darwen Healthy Living Project: www.bwdhealthyliving.co.uk/


Health Action Local Engagement (HALE), Shipley: www.haleproject.org.uk/

Collaborative practice for public health: opportunities and reflections from primary care

Linking service learning with community-based participatory research : an IP course for health students: www.ncbi.nlm.nih.gov/pubmed/21256362
Faculty of Public Health . (2014) What is Public Health? Available at: www.fph.org.uk/what_is_public_health
Using technology to enhance learning and practice in collaborative working in public health
Conclusions: the learning continues

Change4Life: http://change4life.co.uk
Commission on Ending Childhood Obesity: www.who.int/dietphysicalactivity/en/
Food Alliance: http://foodalliance.org
Five a Day Campaign: www.nhs.uk/livewell/5aday/Pages/5ADAYhome.aspx
Food for Life Partnership: www.foodforlife.org.uk/
Food Standards Agency: www.food.gov.uk/
Half Your Plate (Canada): http://halfyourplate.ca/about-us/campaign
Jamie Oliver Food Foundation: www.jamieoliverfoodfoundation.org.uk/

References


Journal of Interprofessional Care: http://informahealthcare.com/jic