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In Practice

Blue light leadership: developing public health consensus agreements with the fire, ambulance and police services

'Never assume the motives of others are, to them, less noble than yours are to you'

– John Perry Barlow, American poet and lyricist, 1977

Recently, we have been involved in developing strategic collaborations between public health and blue light services, along with other partners, at both national and regional levels. Each collaboration has resulted in a consensus agreement, with the aim of providing a focus for better joint work to improve health and wellbeing, reduce inequalities, and reduce blue light demand. This article describes our approaches and discusses our experiences from a public health leadership perspective.

CONSENSUS AGREEMENTS

The desire to reach consensus between health and emergency service partners was borne out of the recognition of shared challenges faced by partners, particularly when working with vulnerable people with complex needs. While acknowledging that joint working arrangements already exist, they are often ad hoc or time limited and a longer term, systematic approach is needed. Common ground for all partners centres on the needs of vulnerable people with multiple and complex needs, for whom siloed working is simply not effective. Rising demand and reducing resources is also a shared context. From a public health perspective, the need to rebalance our focus towards prevention and early intervention is crucial. Many emergency services colleagues are frustrated at seeing people left to reach crisis point again and again, and share that passion for working further upstream.

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The national fire and health consensus was agreed in 2015.[1] It focuses particularly on the needs of the older population and the opportunities provided by 'Safe and Well' home visits. An ambulance consensus followed in 2016.[2] This highlights the potential within the millions of interactions ambulance professionals have with patients each year, and the opportunities to make every contact count. In 2017, the first regional consensus between all three blue light services, Public Health England (PHE) and National Health Service (NHS) England was launched in Yorkshire and the Humber.[3] Finally, a national police and health consensus was launched early in 2018, with a focus on prevention and early intervention.[4]

COLLABORATIVE LEADERSHIP

In their report on the 21st Century Public Servant, Needham and Mangan identify that heroic leadership styles are rejected in favour of 'distributed and collaborative models of leading'.[5] This has been our experience of the approach required to nurture and grow these collaborations effectively. Our role has been to act as boundary spanners,[6] and lead the process rather than the people, facilitating the opportunity for partners to come to agreement.

DEVELOPING THE CONSENSUS AGREEMENTS

Each consensus was developed via a multi-agency working group. Writing the agreements was an iterative process, taking time to identify shared priorities and areas where the most impact could be made.

Organisational politics and Politics

Each organisation had different expectations, sensitivities and needs. The ability to recognise and adapt to these was important in building trust. The language of the consensus statements had to reflect this, while not becoming bland and meaningless.

Language

We often discovered words and phrases (e.g. prevention, evidence and problem-solving) that mean different things in different contexts and to different professionals. Taking the time to make sure that we all mean the same thing and that documents read in a way which feels relevant to each organisation was important.

Culture

Understanding each others' cultures and learning how to make the best use of partners' strengths was a big part of each process. Behaviours that are integral within public health – for example, reflective learning – are less commonplace in more tactical environments. Some traits balance each other well, such as the 'can do' attitude often found in blue light services and the tendency to want to reflect in public health.

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IMPLEMENTATION

The consensus documents are intended as statements of intent, rather than an end in themselves. We have found

sometimes that organisations were willing to be part of a consensus, but struggle with committing to implementing change. Maintaining enthusiasm and channelling it into manageable projects after the consensus agreements are signed and launched has been a crucial part of the processes.

Governance and ownership

While having an open-ended, fluid process is important in a genuine collaboration; there is a balance to be struck. Each consensus still requires a 'host' organisation, particularly moving into implementation. The absence of conventional tools such as terms of reference for working groups risks drift, and different understandings about purpose, particularly as representatives change. Senior level commitment is key to maintaining commitment.

Geographies and structures

In the regional consensus especially, the lack of coterminosity and different sub-regional identities have proved challenging. Differing, complex and changing structures, particularly in the NHS, make it harder to develop meaningful approaches that can be applied across different geographical areas.

Structure vs agent

Collaborations rely on relationships, but people change (particularly fire and police representatives, who are frequently re-assigned), and there needs to be a structure that can sustain progress and withstand churn. Similarly, sometimes a committed organisation may be represented by an individual who is less convinced, or vice versa.

Time and commitment

A great deal of time and thought is needed to build and nurture relationships, especially in national groups that mainly come together via teleconference rather than face to face.

REFLECTIONS

The consensus statements provide a narrative of how health and emergency services and the populations they serve can benefit from collaboration and long-term commitment to closer working. The national groups have provided products which are intended to support local delivery, but the real change is seen in local collaborations. The consensus statements have provided impetus and 'permission' for local initiatives and provide a blue print for place-based approaches to public service. Evaluation and dissemination of these will support spread, scale and sustainability. Changes to values and their impact are harder to measure but securing ongoing commitment to champion the needs of the most vulnerable is an important marker.

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