Withymoor : A Health Hive. A Review of Creative Arts in Primary Health Care

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Introduction

We hope that this case study will serve a dual purpose. Our intention has been to produce a report which is of relevance to those commissioning services, the providers of primary care services and those agencies with whom they currently collaborate or would wish to collaborate. Its purpose is primarily to support the move towards a public health orientation in primary care. We also hope that this report will provide encouragement and theoretical support for those who have adopted a 'salutogenic' approach and are already 'working upstream'.

The report is divided into three parts. The first part provides a case study of Withymoor Village Surgery. The second gives a detailed analysis of the theoretical underpinnings of the Surgery's salutogenic approach. The final part discusses lessons drawn from the case study and identifies implications for primary care.

We are grateful to Mike Farrar and Karin Sowerby of the NHS Executive for supporting this research. We are indebted to all those who have generously given their time and experience. We are particularly indebted to Malcolm Rigler and his colleagues at Withymoor who made this study a reality. We have been impressed, not only by their frankness, but also by their eagerness to talk with us and supply us with documentary information. Their vision and the commitment and energy given to realising it is truly inspiring! Thanks are also due the Pioneer Health Foundation www.thephf.org which encouraged publication of this report – and in particular Malcolm Rigler and Clive Donald.

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Executive Summary

Part A: The Case Study

1. Aims of the Case Study

1.1 Transfer Potential

The aim of the research is to provide a case study of Withymoor Village Surgery (hereafter referred to as WVS). There were five main reasons why this particular general practice merited an in-depth appraisal.

- It had, for some time, adopted a broad 'salutogenic' and collaborative approach to health promotion and patient care. Moreover it had particular relevance for recent government initiatives relating to *The 'New NHS'* (Dept of Health, 1997) and '*Our Healthier N*ation' (Dept. of Health, 1998).
- Given its emphasis on community involvement, needs assessment, collaborative working and a 'public health' approach generally, there was a possibility that WVS might offer guidance for the commissioning role of the new Primary Care Groups (PCGs).
- It recognised the importance of education in enabling patients to make appropriate use of primary care and maximise their degree of control over their health. Moreover, it recognised the potential of other agencies and new technologies to effectively reach a wider audience.
- It had a remarkable history of using creative arts – an approach which seemed likely to add a novel and productive dimension to the issues mentioned in the two preceding paragraphs above.
- It had recently been successful in its bid for funding under the new PMS Scheme (NHS Executive, 1997) and thus provided an opportunity for making a tentative contribution to the assessment of this scheme.

1.2 Construction of a Theoretical Framework for 'Salutogenic' Practice

The term 'salutogenic' is used here as a form of shorthand for the philosophy underpinning the kind of approaches adopted by WVS. A full explanation of its subtleties and complexity is provided in the main body of the text. Indeed, one of the main aims of the case study is to provider a comprehensive analysis of the 'salutogenic' approach so that the philosophy and practice of WVS can be located within a coherent theoretical framework. The main reasons for such an analysis are that it will:

- Provide an explicit rationale and justification for the salutogenic approach (including a demonstration of how that approach relates to more traditional primary care practice).
- It provides a theoretical framework within which other practitioners might reassess their approach to primary care.
- It should assist others, who might be contemplating the need for change, to make more reasoned and committed decisions.
- It will help with the process of developing evaluation tools.

2. Research Methodology

The research commenced in August, 1998 and employed a conventional qualitative methodology associated with case studies. In addition to documentary analysis, semi-structured and telephone interviews with WVS, its 'role set' and various more 'distant' referents, it invited written responses to requests for information from a number of significant informants.

3. The Withymoor Experience

3.1 History

The history of the practice dates from 1979. This report provides a resume of key influences on the development of WVS mode of working – including its adoption of the creative arts. Dr Rigler, rather appropriately, described the practice as a 'Health Hive'. Indeed the relevance of the Health Hive's activities for those seeking to move from a conventional, individualistic and preventive focus on diagnosis and treatment towards a more client-centred holistic mode of working was very apparent to the authors of this report. Similarly, the broadening of focus to include community oriented health promotion activities – in line with 'new public health thinking' – is, of course, highly congruent with current NHS initiatives. In a real sense, it seems that WVS is a practice whose time has come!

3.2 Critical Reflections

In addition to reviewing activities past and present, the report provides a critical assessment of the strengths and weaknesses of WVS – and draws a number of lessons for other practitioners seeking to emulate its philosophy. Four major conclusions have been drawn.

- WVS already offers a working model for the adoption of approaches embodied in current government policy and to which other practices may well seek to aspire.
- WVS and Dr Rigler's 'mission' receives the often wholehearted admiration and support of a number of lay and professional constituencies – including such influential figures as the former Chief Medical Officer. It is, however, viewed with a degree of scepticism by some GPs. However, there are others within general practice (albeit a small minority) who have a similar approach – and some early signs that it is recognised in medical training. The most enthusiastic support is likely to be forthcoming from sectors with an explicit

commitment to education, social and community work and health promotion, i.e. whose core values are congruent with those of the practice.

- There is convincing evidence of a significant and beneficial impact on patients and the local community; patients' support for Dr Rigler can verge on hero worship!
- Under conventional arrangements for funding primary care, community-based health promotion work does not attract fees. Such health promotion work may, therefore, be seen as a drain on practice resources and lead to financial difficulty.
- There are a number of problems and costs associated with the WVS approach. These give rise, for instance, to a need for team building, ensuring project sustainability, and solving funding problems associated with its innovative but unorthodox mode of working.

3.3 The PMS Scheme

Even at this early stage in its existence, it is clear that the PMS scheme has provided a number of important benefits for WVS – not least to rescue it from quite severe financial difficulties. It has resolved many of these major funding problems and thus helped it continue with its creative mission. On the evidence of the Withymoor experience, PMS can indubitably provide major support for valuable initiatives which cannot operate within the confines of standard primary care practice and its 'shopkeeper mentality'. It would be remiss, however, to ignore the problems which may be associated with the scheme. WVS is now effectively employed by the Trust and the case study demonstrates that there are several adjustments to be made and barriers to be overcome. These arise from the clash of cultures between the intrinsic (and inevitable?) bureaucratic procedures of the Trust and professional autonomy generally and, in some instances, the free-wheeling and even casual approaches frequently associated with creative individuals and organisations.

Part B: Praxis

4. Introduction

Part B provides a critical review of relevant theory, showing how it relates to WVS practice and where appropriate, providing illumination by means of examples from Withymoor – and other related ventures. The term 'Praxis' is considered especially apposite to this section since it refers to the way in which effective practice can arise from critical reflection based on theoretical appraisal. This is its major raison d'etre.

5. Key Theoretical Analyses

5.1 The WHO Position

The guiding principles emerging from the WHO formulation of health promotion are:

- equity
- empowerment

Strategies for achieving effective health promotion include:

- community participation
- settings approach
- inter-sectoral working
- re-orientation of health services
- developing personal skills.

Whereas globally WHO has recognised the strategic importance of primary *health* care, within the UK this has had relatively little impact on general practice. However, although WVS may not have deliberately set out to incorporate the WHO stance, in practice it has operated from the same value position and adopted many of the recommended strategies.

5.2 A Salutogenic Approach

Following Antonovsky's analysis, the main element of salutogenesis is a sense of coherence, i.e. manageability, meaningfulness and comprehensibility. While the focus of a salutogenic approach is on positive health and wellbeing, at the same time, it is likely to be the most efficient way of achieving conventional preventive health goals.

5.3 Empowerment

Empowerment is significantly related to the concept of salutogenesis – particularly in respect of such notions as manageability and control. There is an important difference between individual and community empowerment. Individual empowerment is concerned primarily with the strengthening of personal competencies and characteristics. This can be achieved, at least in part, in the context of the encounter between doctors – or other health professionals – and patients, provided that due attention is given to the requisite educational processes. Community empowerment, on the other hand, is concerned with creating social cohesion and mobilising popular action. As such, different strategies are needed – such as those normally associated with community development.

5.4 Needs Assessment

Assessment of need is an essential feature of programme planning and should focus on the real needs of the community. Enabling people to express their felt needs will:

- increase the acceptability of the programme
- enhance the effectiveness of the programme
- contribute to the process of empowerment.

5.5 Education

Education is an essential requirement for enabling people to take control of their own health. However:

- education is more than communication
- effective education involves recognising and meeting different learning needs
- appropriate methods need to be identified to meet those needs
- involvement and participation are essential for learning.

5.6 Creative Arts

Creative arts have great inherent potential for empowerment and health promotion in relation to:

- involving individuals and communities
- identifying and articulating felt needs
- encouraging inter-sectoral working
- supplying the conditions necessary for achieving particular learning outcomes not amenable to alternative methods

The use of creative arts is rare in primary care and yet it offers many potential benefits for this setting.

Part C: Lessons from Withymoor

6. Implications

6.1 Implications at Practice Level

It is possible to re-orient primary care away from a narrow focus on individuals and disease towards concern for the health of communities.

There is a false dichotomy between 'salutogenic' and 'orthodox' methods of working provided that:

- commitment is achieved through consensus and team building
- satisfactory funding arrangements are made
- attention is paid to maintaining quality and continuity of care.

The 'core income and items of service' funding mechanism for primary care is a disincentive to developing innovative ways of working. The flexibility offered by the PMS scheme has proved invaluable for WVS, although there have been attendant costs.

Working towards the new public health agenda and responding to *'The New NHS'* and *'Our Healthier Nation'* involves:

- identifying and responding to community needs
- community participation
- inter-sectoral working
- addressing health promotion and health education goals.

The experience of WVS has convincingly demonstrated that the Creative Arts can provide an effective means of addressing this broad remit. An additional benefit is that the use of Creative Arts also contributes to individual and community empowerment – consistent with WHO's view of health promotion and health development.

There are major advantages for individual and community health from this re-focusing of effort up-stream. These can be summarised as:

- promoting positive health and creating 'social capital'
- reducing the burden of ill health
- reducing unnecessary use of clinical services

Attempting change on the scale observed at Withymoor may be daunting for many practices. However, partial adoption of some of Withymoor's ideas may be more feasible and could result in considerable benefits.

6.2 Implications for PCGs and Commissioning

If PCGs are to embrace the innovative style of working embodied in *the 'New NHS'* and *'Our Healthier Nation'* it is important to ensure that a diversity of perspectives is represented in the structuring of the groups. Health Promotion Units are uniquely placed to provide specialist advice and strategic support in relation to health promotion goals. This could be further supplemented by involving a range of 'external agencies' with relevant specific expertise – such as community education and the Creative Arts.

6.3 Evidence-Based Practice

This case study contributes to evidence of the effectiveness of a salutogenic approach and the use of Creative Arts as a means of achieving this. It also emphasises the importance of having a sound theoretical base.

Evaluation should be routinely incorporated, not only at the commissioning level, but also at the practitioner level. In order to adequately assess the complexity of the salutogenic approach a variety of relevant indicators should be developed.

PART A

THE CASE STUDY

A1 Background to the Study and Research Methodology

A1.1 *Introduction*

The purpose of the research described below is to provide an in-depth analysis of the Withymoor Village Surgery, a general practice which has had for many years a record of activities of particular relevance to currently emerging philosophies in primary care and public health – and to the principles and practice of health promotion. A particular feature has been its commitment to the value of creative arts in health care and the promotion of health. Furthermore, this is one of the first practices to be funded under the PMS Pilot Scheme. As will become apparent the practice in its entirety is genuinely unique - in the true sense of that word. A central concern of the study has, therefore, been to identify those components which might be more widely applicable and which could usefully be adopted by more 'orthodox' practices.

This report provides a detailed case study of the Withymoor Village Surgery which critically appraises its approach to primary care, its activities and its actual and potential relevance to contemporary developments such as:

- PMS Pilot Scheme
- the Green Paper *Our Healthier Nation*
- the White Paper *The New NHS*
- Primary Care Groups and their commissioning role
- Healthy Living Centres
- Health Action Zones

It will also focus on key current issues in primary care such as needs assessment, involving communities and inter sectoral working. Additionally, the case study will explore the relevance of the Withymoor approach to wider global concerns and initiatives, such as inequality, empowerment and community participation.
A central theme will be the role of creative arts in what we will argue is essentially a *salutogenic* approach.

A1.2 ***Aims***. The aims of the research are summarised below.

- To provide a case study of the Withymoor practice involving:
  - operationalising main concepts and principles relating to *salutogenesis* , equity and empowerment; community participation and community development; patient communication and education; inter-sectoral working.
  - identifying issues having relevance to the envisaged expanded role of primary care – including the former public health functions of needs assessment and commissioning.
- To develop a framework within which to locate activities within the practice and serve as a potential evaluation tool. This will be derived from models of communication, patient education, empowerment and inter-sectoral working.
- To provide a tentative assessment of the effectiveness and impact of current and past practices at Withymoor.
- To assess the feasibility and transferability of the approach to a range of different primary care settings.
- To assess the contribution of the creative arts to the components mentioned above.

A1.3 ***Research Methodology***

After preliminary exploratory work, the present research commenced in August 1998. In order to disinter the complex realities of the Withymoor experience, the approach was based on the conventional qualitative techniques for case studies that are listed below.

- Initial documentary analysis
- Mapping of key activities and principal informants.
- Semi-structured interviews with principal informants.
- An iterative process of: interviews interspersed with periods of reflection, further documentary analysis, identification of emergent themes for incorporation in subsequent interviews, respondent validation.
- Telephone interviews

- Written responses to requests for information

The sample of informants was derived ‘purposively’. On the basis of initial discussion and analysis of written ‘evidence’, a core of principal informants, who were judged to be representative of the key constituencies, were interviewed. These are listed below.

- GPs
- Nurse Practitioner
- Health Visitor
- Practice manager
- Receptionists
- Dudley Priority Health
- Dudley Health Authority
- Thorns School and Community College

Additional informants were subsequently identified utilising a ‘snowball sampling’ approach. This led to further tranches of interviewing and requests for written information. The cycle described above was repeated until no new insights emerged, i.e. ‘saturation’ had been achieved. The groups interviewed included a wide variety of individuals – both lay and professional.

Where possible and appropriate, interviews were tape recorded.

The main groups are listed below.

- Creative artists and organisers
- Health Specialists
- Teachers
- Community Education
- Pupils
- Pharmacists
- Church
- General Public

A complete list of contacts is at Appendix I

A2 Case Study: the Withymoor Experience

A2.1 *History*

The history of the practice dates from 1979 when Malcolm Rigler was encouraged to build a new practice in Withymoor – one of Britain's largest new housing estates. The philosophy underpinning the development of the practice can be traced to Dr Rigler's earlier experiences including his work at Balsall Heath and incorporates both medical and spiritual dimensions. More particularly the ideas of Robert Lambourne, Tom Heller and Michael Wilson have been instrumental in shaping his approach. Central to his philosophy has been a concern to explore the role of the doctor in society and the nature and form of communication between doctors, patients and the wider community. His vision of health has always been holistic and concerned with promoting positive health – in short, 'salutogenic'.

His early experiences at Withymoor made him aware of the extent of unhappiness, loneliness and isolation in the community: this manifested itself in patients presenting at the surgery with depression and other clinical symptoms. At the time the surgery was the only source of support. Dr Rigler attributed these problems to the rapid expansion of housing without the accompanying infrastructure necessary to support social cohesion together with an influx of newcomers who worked outside the area. He saw the solution to this community malaise as requiring the 'prescription of ideas not medicines'.

While his vision has remained constant over time, his ways of working towards his goals have evolved. The use of creative arts has always figured prominently. As he himself notes:

'I first came to understand the importance of the waiting room. We made it homely, welcoming, part of the community…' The arts had a significant part to play in this

welcoming process and in enhancing communication. *'… communication in its truest sense is not a matter of words – either spoken or written – alone. The medium, said Marshall McLuan, is the message and the waiting room communicated the message to patients that they were valued people, equal partners in the management of their health concerns.'* (Rigler, 1996)

The year of 1988 was a watershed in the development of the creative arts at Withymoor. According to Mike White, currently Assistant Director Arts, Gateshead Central Library and, at the time, a member of the Welfare State Theatre Co., the first primary care 'residency' in the country was established at Dr Rigler's practice. A week was spent in discussing ideas about the use of the arts in general practice and developing some practical work. Alison Jones of Celebratory Arts (now Pioneer Projects) was also involved and continued the work. A variety of projects and collaborative links emerged over subsequent years – these will be more completely described below.

The Withymoor practice has been consistently innovative and always ready to grasp new ideas and envision connections not always readily apparent to others. Within the context of current funding for primary care, this creativity has not always been without problems – as will be noted later! Accordingly, one of the most significant recent developments was the practice's success in gaining entry to the PMS Pilot Scheme – another new opportunity seized!

A2.2 *Withymoor Village Surgery: an initiative whose time has come?*

Dr. Rigler's philosophy has a particular relevance to current developments in health care and health promotion both nationally and internationally. They are congruent with World Health Organisation's Health For All movement and the numerous statements on health promotion which have emerged in recent years. These have asserted the importance of a positive, holistic, social approach emphasising:

- equity
- empowerment
- active community participation.

Within the United Kingdom there are signs that this type of approach is beginning to attract increasing interest and support. The green paper '*Our Healthier Nation'* (Dept. of Health, 1998), for example, focuses on tackling inequality and the problem of social exclusion and emphasises the importance of involving local communities in partnerships to improve health and building *social capital*. Similarly, the Withmoor style of working is entirely consistent with new initiatives such as Healthy Living Centres and Health Action Zones. The structure emerging as a result of the white paper *'The New NHS'* (1997) places primary care centre stage. Primary Care Groups will occupy a key position and will need to consider their role in improving the health of the community in addition to providing personal health care. The development of this broader public health function will require a shift from a narrow bio-medical focus on the individual towards involvement of communities and '*building healthy alliances'*. Although this is a novel orientation for a majority of practices, it is already central to the philosophy of Withmoor Village Surgery. Key features include:

- holistic approach
- concern to promote positive health
- involving people in their own health care
- patient education
- patient empowerment
- community education
- development of lay referral systems
- fostering a sense of community
- active community involvement
- advocacy on behalf of patients and community
- tackling inequality.

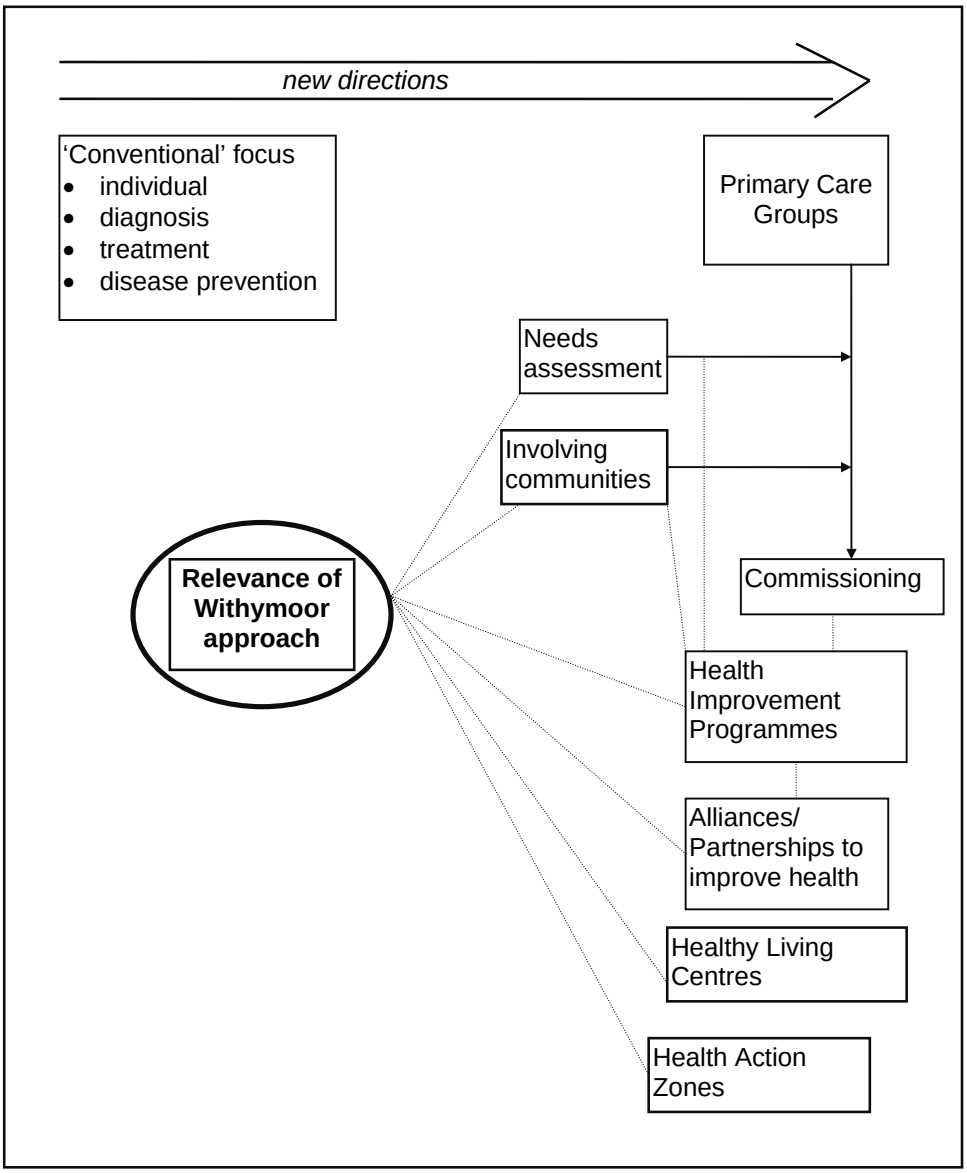
The term '*Health Hive'* is indeed apposite to the number and variety of activities undertaken which can be broadly characterised as involving:

- the use of creative arts
- inter-sectoral working
- an educational focus
- eagerness to harness new techniques and technologies.

Clearly there is much to be learned from the innovative approach adopted by the Withymoor Surgery. This might usefully inform future developments in primary care. Figure 1 provides an overview of this potential contribution.

While it is true to say that, at the present time, this approach is unusual in primary care, recent interest in incorporating humanities in medical training may be indicative that times are changing!

Figure 1: The relevance of Withymoor to recent developments in primary care



A2.3 *The Withymoor Village Surgery - a Health Hive*

Since April 1998 the practice has been one of the pilots for the Personal Medical Services (PMS) scheme (NHS Executive, 1997) and, as such, is managed by Dudley Priority Health NHS Trust. Details of staffing are provided in Appendix II.

The philosophy and holistic approach described in A2.1 and A2.2 above, particularly the emphasis on education and involving individuals and communities predate the pilot scheme and have resulted in a practice which is unique by virtue of:

- the plethora of activities undertaken
- the number of links with other agencies - both local and national
- its focus on the health of the community
- recognition of the importance of communication and education
- commitment to the value of creative arts in promoting health.

A central concern has been to tackle the psycho-social determinants of health and to focus on the actual needs of the community. A common theme linking many of the projects is enhancing communication, involving patients, building lay referral networks and establishing a sense of community. Education to improve understanding of health issues also features prominently and is based on the premise that this will lead to more appropriate use of medical care and a reduction in unnecessary consultations. The role of the various projects in promoting health will be explored more fully in Part B and a framework for locating them on a continuum ranging from individual communication through to community empowerment is developed in Section B12.

Over the last 10 years there has been a stream of creative ideas from the Withymoor Village Surgery and numerous interlocking activities have been undertaken. Many of these involve the use of creative arts - for which the practice has acquired a reputation. However other initiatives to achieve salutogenic goals include more conventional educational approaches and advocacy. Further discussion of the categorisation of activities will be provided in Section B12. An attempt will be made here to provide an

overview of what is a highly complex and ever changing scene, followed by more detailed description of some of the projects.

A2.3.1 *Surgery environment*

Early on, attempts were made to change the image of the waiting room so that it:

- was more welcoming
- became a source of useful information
- encouraged communication
- more explicitly reflected concern with well being and not just disease.

Characteristically this was achieved through the involvement of the local community - a competition was held in a local school to produce a mural; patients helped with the refurbishment. A play area for children was created. Plants, fish tank, piano and an increasing range of artwork, artefacts and information were assembled and a bulletin board for community notices was set up. While it might be said that the fabric of the surgery as a whole requires redecoration, the waiting area undoubtedly stimulates interest, provokes enquiry and conveys the message that people can ask questions. The general ambience improves communication, both in the waiting area and in the consulting room. It was felt that as a result of these changes people using the surgery started to talk more and it became a focus for the local community. Two photographic displays have been held at the surgery and it has also been used for discussion groups and for some community activities - fashion shows, quiz nights, workshops. There have been close collaborative working links with Thorns School and Community College, which will be described more fully below, and instrumental groups from the school have played music to patients in the waiting room.

Various drama performances have involved the local community e.g. on family crises and how to cope with them. Women in Theatre, funded by Dudley Health Authority and RHA, conducted focus groups with mothers and daughters exploring why it is difficult to talk about sex in the family. This was followed by the development and performance of a drama which was well attended and generated lively discussion.

The organisation of clinics also consciously attempts to meet the needs of patients. For example, combining post-natal and developmental checks is easier for 'mums' and open access to a clinic staffed by a doctor, health visitor and the practice nurse means that mothers can come along with any problem. The best way of organising clinics to address men's health (one of the PMS objectives) is currently being explored using questionnaires and focus group discussions.

The Receptionists

The role of the receptionist is recognised as being of central importance to creating a welcoming environment. Receptionists were appointed who already had good links with the local community and related empathically to patients. Some also have an informal role in the community and provide support outside the surgery, i.e. they form part of the community's lay referral system. Initially the layout of the waiting room was such that there was no barrier between patients and receptionists. Re-design, following the movement to larger premises, created a separate area for the receptionist, but may also have made communication between patients and receptionists less easy than it had been.

A2.3.2 *Provision of information and education*

In the surgery

A wide range of professionally produced leaflets and posters have been used but it was felt that these 'missed the mark' and there was a need for locally authored material and a more creative approach - as provided by the arts. These have been developed during the course of some of the projects described below and include:

- personal accounts of illness
- posters and postcards on smoking (*Breath of Fresh Air*)
- CD ROM on asthma (*Asthma Attack*)
- lung box.

A co-operative venture with the University of Central England aims to develop self help information for patients on CD-ROMs which will be accessible through touch screens

Schools

A number of projects have been developed with schools, notably Thorns School and Community College. Some of these have had an educational focus. They have contributed to the learning of the pupils involved, but have also taken the message to the wider community through drama productions (on the immune system), puppet shows (on asthma) and production of CD-ROM (on asthma). An eye catching mobile on *'Breath of Fresh Air'* dominates the entrance to Thorns School. Rather more conventionally, a Health, Leisure, Advice and Drop-In Information Service was set up at Thorns School in December 1995.

Community

As noted above, performances of street theatre on the immune system and the puppet show on asthma have been used to good effect.

There are also numerous plans to further develop community education about heath issues and a variety of potential channels are envisaged. Dr. Rigler has been quick to identify the opportunities created by recent developments in computing and the electronic media. He has a long term vision of a network of learning centres for patients, accessible through surgeries, health centres and community centres. More immediately, he is hoping to tap into Dudley's Pathfinder project, which aims to improve the provision of information technology in schools, and use the computers out of school hours as a health information network for the wider community.

Other discussions and plans include:

- work with The Museum Service to set up information points and improve access to health information and involvement in the planning of Walsall Museum and Art Gallery as a central resource with outreach activities;
- development of a mobile 'bus shelter' which can be used as a meeting point for young people and also contains health information;

- work with the local pharmacy to improve access to health information and discussion with Lloyds Pharmacy who have just opened a 'Chat Centre' in neighbouring Netherton.

A2.3.3 *Development of community and lay referral systems*

As already noted, rapid housing expansion and an influx of young families resulted in a practice population which had no sense of community and little access to the advice and support that might have been available in more established communities. Many of the activities mentioned above could be seen to contribute incidentally to the creation of a sense of community and to support the development of networks which might offer advice and support. Activities which **explicitly** address the development of lay referral systems include:

- *Meet a Mum* - patients were asking for appointments for problems that they might have discussed with family or friends. A group was initially set up in the surgery for first time mothers. This group now meets twice a week in the Methodist Church Hall and is run by one of the original members. The Health Visitor also runs a Baby Club at the clinic for babies up to 7 months - this combines developmental checks with the opportunity for social contact and is felt to make more economic use of staff time;
- *Access to a grandparent* - a scheme giving children access to a grandparent figure is planned;
- Parent discussion groups;
- Oral history and ideas to develop visual history through CD-ROM.

A2.3.4 *Residencies*

The creation of a series of residencies has been instrumental in focusing ideas and initiating some of the activities referred to elsewhere in this section. The first of these was in 1988 when Alison Jones, Art Hewitt and Mike White from Celebratory Arts for Primary Care had a one week residency and set up storytelling sessions for patients and children and a craft workshop for mothers to make cards welcoming new mothers. In

1990 Alison Jones took up a further residency funded by a grant of £1,000 from Theatre in Health Education Drama Group and West Midlands Arts; this residency culminated in the development of the lantern procession. Work was also undertaken with pupils from Thorns School and Community College on the *Breath of Fresh Air* project (see below).

In 1991 Dave Rees was a writer in residence and collected experiences of illness from primary school children and older residents. This formed the basis of a prescribed reading/writing project and also served to build up history and tradition.

Brian Lamas was seconded from Thorns School one day a week as 'artist in residence'. This followed on from work done with the school in developing a castle and materials for immunisation parties based on the *Harold the Hedgehog* character. Sculptures and pieces of artwork in the surgery generated interest and prompted conversation, which included problems like loneliness and other health issues. Working with school children, comic strip ideas were developed, problem and answer pages produced and the *Desmond the Dragon* puppet show on asthma created.

A2.3.5 ***Making links***

One of the characteristics of Withymoor Village Surgery is its outward-looking focus; indeed it is unusual in the number of connections it has established with other agencies - both local and national (see Appendix III). The more obvious of these links include:

- arts groups such as Jubilee Arts; Celebratory Arts; No Exclusion Zone;
- Local Education Authority - particularly with the Arts Adviser;
- schools - Thorns School and Community College, Quarry Bank Primary School, Withymoor Primary School, Peters Hill Primary School;
- colleges - Bilston College;
- universities - University of Central England;

In addition to these more formal links and involvement in joint projects, it is acknowledged that Dr. Rigler's ideas may have indirectly shaped the development of

other projects in the Borough. Specific examples of this 'ripple effect' can be seen under the *Asthma Attack* project for example.

There has been a conscious attempt to disseminate the philosophy and practice of the surgery in a number of ways including:

- publications - booklets on the surgery; journal articles;
- attendance at and participation in numerous conference press coverage;
- letters informing prominent figures in the arts and health about the surgery;
- invitations to leading figures to visit the surgery.

It is also noteworthy that Dr. Rigler's work is frequently cited in reports and texts on the creative arts (see for example McDonnell (u/d)).

A2.3.6 *Funding*

Financing the range of activities described above is at the very least problematic given the strictures imposed by conventional funding for general practice. Some would go as far as to see it as a drain on the practice - an issue which will be discussed more fully in Section A2.4.5 below. The PMS scheme was seen to offer more flexibility and is discussed in Section A2.4.6. There have been a number of successful bids for money to support individual projects. For example, the following have all provided support:

- Dudley Priority NHS Trust
- Dudley Health Authority
- West Midlands Health
- Local Education Authority
- Dudley Arts Council
- West Midlands Arts
- Pharmaceutical industry - Lloyds, Glaxo, Astra, Pfizer
- Cadbury Trust
- Wellcome Foundation
- Lottery.

Furthermore, it is noteworthy, and indicative of the high regard that some individuals have for the practice, that bequests have also been given to support its work.

Opportunities for obtaining funding to support work promoting the community's health have been readily identified and numerous bids submitted. However, as with the project funding, many of these are 'one off' grants. The new Healthy Living Centre initiative offers the prospect of providing longer term funding.

The Healthy Living Centre Bid

The values underpinning the Withymoor Village Surgery are entirely compatible with those of the original Peckham Experiment, recently updated and re-iterated by The Pioneer Health Centre (1997):

- health is more than the absence of disease
- participation
- inclusion
- sustainability
- co-operation
- use of modern technology.

These values are also fundamental to the new Healthy Living Centre initiative and practices such as Withymoor are fore-runners of the idea. The absence of designated, secure funding has created some difficulty in fully operationalising the breadth of activity envisioned and in developing longer term strategic plans. Availability of money from the New Opportunities Fund clearly offers a possible solution.

There are plans to submit a bid as part of a consortium with Newtown, Brockenhurst and Gillingham, which will be co-ordinated by the Community Education Development Centre (CEDC). The rationale for this is to enable each centre to work with local partners to promote the health of it own community, and also to share learning between the centres in the first instance, but also more widely by becoming an information/ resource centre. The relative advantage of submitting individual or consortium bids is

currently being reviewed. Similarly there is on going discussion in the Borough about the precise nature of the Dudley bid.

The immediate gains to Withymoor of being successful would be greater security of funding and also legitimisation of the practice's wider health promotion role. It would further acknowledge the innovative 'pathfinder' work being done by Withymoor (and the other practices in the consortium) and provide a forum for disseminating it more widely - consistent with Withymoor's vision and mission.

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A2.3.7 ***Examples of projects***

Lantern Procession

The first lantern procession took place in 1990 as a result of Alison Jones' residency. It has now become an annual event and a tradition. (Although it is likely that in 1999 it will be held in neighbouring Netherton rather than in Withymoor because of problems with obtaining funding). In the first year only 15 families took part. By 1992 this had increased to 250 people and by 1996, 400. Lantern making workshops are led by professional artists in the surgery and local school. The event itself is highly symbolic - there is a procession around the local houses, lighting the streets and drawing people out of the isolation of their houses, followed by a party. The value of the lantern procession lies, in part, in establishing a tradition and contributing to a sense of community. It is certainly well known in the community; people talk about it readily and associate it with Dr. Rigler's surgery. The lantern making workshops are also an important element in that they bring people together, open up communication, develop skills and build self esteem. People have the opportunity to take on a variety of organisational responsibilities, developing their confidence and sense of community.

Prescribed reading/writing project

Patients wrote about their own experience of illness and their accounts were made available in the surgery. This material was seen as a way of supplementing the

information that could be provided in the limited time of the consultation and local authorship enhanced both relevance and impact.

Immunisation Parties - Harold the Hedgehog

A number of factors led to the development of this initiative - concern to avoid the experience of immunisation making children frightened of visiting the surgery; low uptake of immunisation; and, the availability of an anaesthetising cream. Because the cream took some time to work activities were developed to occupy children. These were based on *Harold the Hedgehog* and involved a story, colouring sheets and a 'party'. A large Harold character and a flexible castle were constructed in part of the surgery. The numbers coming for immunisation increased dramatically; the children enjoyed the whole event - with some reluctance to go home - and had a non fearful attitude towards the surgery. Pupils from Thorns School were also involved in designing and constructing the materials, providing child care and music.

Desmond the Dragon Puppet Show

GCSE pupils and staff from Thorns school developed and performed a puppet show for younger primary school children to help them understand asthma. A roadshow subsequently toured local primary schools

Breath of Fresh Air

Artists in residence based in Thorns School and Community College worked with pupils on the theme of lungs and fresh air, health and the joy of breathing and environmental pollution and smoking. A series of posters were produced which were displayed in the surgery. They were also made available nationally and a series of postcards produced. Posters on display in the surgery were also made into postcards. A giant mobile was constructed and now hangs in the school entrance and a 'lung box' was made for use in the surgery to demonstrate the effect of smoking on the lungs.

Drama/Street Theatre on the Immune System

The idea underpinning this was to improve public understanding of the immune system and reduce unnecessary demands for antibiotics - highly relevant to recent concern about the emergence of antibiotic resistance strains of bacteria as a result of over-prescribing. A member of staff at Thorns school developed the script and worked with 'No Exclusion Zone' and pupils to develop the performance. The pupils gave a performance to year 7 and year 6 (imported from the local primary school) which, according to observers, were 'incredibly well received'. The quality of the production and the script, which adopted an inter-active gameshow format, fully engaged the audience. Performances were also given at Merry Hill - a major local shopping area..

Asthma Attack

In 1995 a project was set up which involved Jubilee Arts working intensively with 20 GCSE students for two days to devise a CD-ROM to help people understand asthma. Dr. Rigler, Lynda Lawley and a consultant chest physician were on hand to give medical advice. By the end of the second day the pupils had successfully completed the task and developed a high quality product. The benefits to the school were considered to be its contribution to GCSE coursework, the opportunity to work with professionals and access to good technical equipment. The benefit to the practice was the production of educational material in a very short space of time. There were further ripple effects - a presentation on the Project may have contributed to the allocation of funding from the Wellcome Foundation, Jubilee Arts submitted a major lottery bid; and the education adviser set up a major digital media project.

Needs Assessment (Quest Project)

Staff from Bilston College developed an arts project based at Peter's Hill Primary School. This was essentially a normal art workshop including children from Peter's Hill, Year 10 from Thorns School, parents and the elderly, but it also served to explore the health needs of the community. The picture which emerged was, in the words of the Arts Adviser, 'chilling'. It revealed fear of crime and going out at night; the problem of traffic; and, loneliness. Year 10 pupils were also asked to put their ideas into words and these were subsequently typed up in anticipation of wider dissemination.

Advocacy

Awareness that a number of patients were presenting at the surgery with symptoms of stress and depression because of subsidence and damage to their homes prompted Dr. Rigler to make representations on their behalf. Involvement in other advocacy activities which address the broader social and economic determinants of health include:

- employment training
- social centre for Sikh women
- meeting area for teenagers.

A2.4 *Critical Reflections*

A2.4.1 *Vision and practice*

The range of activities and ideas emanating from Withymoor Village Surgery stem from a vision of health that is holistic and which places emphasis on the welfare of patients and the community rather than the **business** of running a practice. As we have noted above, it is consistent with recent developments in primary care, notably the move towards:

ways of working which require,

- the development of a broader public health function
- broadening the conventional focus beyond individuals and disease to include the health of the community
- assessing the health needs of the community
- involving communities
- building alliances

and,

emerging structures, such as,

- Healthy Living Centres

- Health Improvement Plans
- Health Action Zones

> The green and white papers require a re-orientation of primary care.
> This will involve moving in a NEW direction for many practices, but is ALREADY central to the philosophy of Withymoor.

The 'pioneering' work of the Withymoor Surgery is clearly of current interest in the context of these developments. However, key questions are:

- What are the particular characteristics of Withymoor that have resulted in these developments?
- What evidence is there that it is successful?
- To what extent is the approach transferable?
- Are there any negative outcomes or 'costs' in the broadest sense?

A clear vision about health and the role of the doctor in contributing to the health of the community (c.f. the historic function of the Medical Officer of Health) has been instrumental in shaping the style of working. The Withymoor Village Surgery embodies those activities that Dr Rigler considers should be the core values of general practice. Similarly, concern to meet patients' needs and involve them in their own care by improving communication and education has resulted in a practice which is patient centred rather than doctor centred.

Solutions to the broader social and environmental causes of ill health were necessarily seen to be broad in scope themselves; to cut across structural boundaries - and to go beyond the orthodox remit of general practice. Involving other sectors has therefore been

fundamental to achieving goals. Dr. Rigler has a remarkable capacity to communicate his vision to others and to motivate those who identify with it.

The use of creative arts has been an on-going feature of the approach of the Withymoor Village Surgery and, as we will show later, is well suited to its broad salutogenic goals. As is apparent above, very many different activities have been attempted over the years. The wealth of ideas must largely be attributed to Dr. Rigler's personal qualities and his single-minded commitment to the needs of his patients. Characteristically, the potential that any new local or national initiative might have to offer is explored and numerous creative opportunities identified. At a more practical level, funding opportunities are also identified and bids submitted. There is general acknowledgement of his unusual abilities in the following areas:

- awareness of new developments
- awareness of sources of funding
- cutting across structures, local politics etc.
- making original connections between ideas
- making original connections between agencies
- attracting public and media interest
- communicating his vision
- motivating others
- obtaining funding to support initiatives.

However, while the capacity to identify and seize the initiative is laudable, there is a danger that the style of work becomes ad hoc with insufficient attention to longer term strategic planning and funding. Similarly the absence of a theoretical base or of methodologically sound evaluations can make the approach seem intuitive rather than strategic. Inability to locate activities within an explanatory theoretical framework can create barriers when trying to disseminate ideas and convince the more sceptical. The success of some of the initiatives has been attributed not so much to conscious and explicit planning, but rather to the fortuitous involvement of individuals who contributed the following:

- ‘artistic talent’
- shared vision about the role of creative arts and health
- commitment of time and energy
- organisational skills
- practical skills
- management skills.

While Dr. Rigler’s vision and creativity may be responsible for the initiation of many of the projects, it must be emphasised that their successful implementation has been dependent on the involvement of others. In short, innovative activities of the kind described in Section A2.3 above require teams which **collectively** have the vision and the combination of skills listed above to operationalise it. A number of individuals have worked tirelessly to bring the ‘Withymoor’ projects to fruition and it is essential that their contribution is fully recognised. This can all too easily be overlooked - especially when other ideas take over and results in people feeling used, demotivated and reluctant to participate in future projects. Clearly a systematic approach to project development cannot be based on the serendipitous coming together of able and well motivated individuals. Team building and team maintenance activities should be recognised as essential features of programme planning.

Vision and creativity are important in initiating innovative working methods.

A range of complementary skills is needed to secure successful implementation of projects.

Opportunism needs to backed up by longer term strategic planning.

Team building and team maintenance activities are essential components of project development.

A2.4.2 *Modus operandi considered*

As will be evident, the over-riding goal of the practice is to promote the health of the local community and to act as a resource for others seeking to develop this type of work in primary care. Some of the projects, notably the Lantern Procession, explicitly address salutogenic goals of the type referred to in Section B4. Other initiatives could equally be entirely compatible with conventional preventive medicine. The *Harold the Hedgehog Parties*, for example, could be seen at one level to achieve preventive goals by increasing uptake of immunisation. However the process contributes to the broader salutonegic agenda by virtue of the additional benefits it generates - involving children; reducing the fear of injections; and avoiding apprehension about future visits to the surgery.

One of the particular strengths of the creative arts is that they can have the type of multi-dimensional effect just described. The use of creative arts features prominently in Withymoor's portfolio of activities, which are widely regarded as innovative. However, it must be emphasised that it is the use of these methods in **primary care** which is unusual. In other contexts such as schools, community development and the arts themselves, similar methods would be regarded as unexceptional or even mainstream. Furthermore, although Withymoor's use of creative arts is ahead of its time, the methods used are not necessarily considered the most up to date in the other contexts listed. For example educationalists are highly sceptical of the value to children of 'colouring-in' activities, i.e. merely using crayon or pencil to colour in existing diagrams and pictures, and yet these feature as one component of the *Harold the Hedgehog Parties*.

Recognition of the value of the arts by a general practitioner and commitment to deploying them in his practice is unusual and generally warmly welcomed by those working within the creative arts field. Involvement of a general practitioner in projects is considered to give kudos and credibility. It also has a certain novelty value which attracts media interest. However to ascribe Dr. Rigler's ability to get media coverage for his projects to this alone would be unfair. The more important point is that many of the

issues tackled are newsworthy in their own right and address topical issues - the work on bacteria, viruses and appropriate use of antibiotics for example.

It is accepted that the principal effects of 'creative arts' work derive from the 'creative' element and therefore those actively involved in the creative process are the main beneficiaries - a point which will be more fully developed in Sections B12.3 and B12.5. The various artefacts could be expected to have comparatively little value as visual or teaching aids for others who were not involved in the process of development - i.e. it is the process rather than the product which contributes most to communication and learning. It is paradoxical that the Withymoor practice is committed to the value of creative arts and yet at the same time has an exaggerated faith in the artefacts to achieve not only effective communication, but more complex educational goals. Furthermore, some of the materials have been on display for considerable periods, despite the fact that their impact can be expected to decline over time. Conversely, accepted good practice concerning classroom displays is that they should be changed regularly.

A2.4.3 *Support for the aims of the practice*

The broad salutogenic aims of the practice were supported to a greater or lesser extent by everyone interviewed. Support tended to be greatest in:

- those less directly involved in the delivery of primary care;
- those organisations whose values are most congruent with those espoused by Withymoor - for instance, those involved in education generally/ the creative arts/ the churches are fulsome in their praise.

It is also noteworthy that in addition to this local perspective, the practice has been visited by a wide range of dignitaries (including the former CMO) and there is a substantial dossier of written support for the activities being undertaken by the practice. A list of letters and statements of support is provided in Appendix IV.

Both the Health Authority and the Trust are generally supportive of the ideals and goals driving the Withymoor Village Surgery. However, the mechanism by which projects

involving the use of creative arts actually achieve precise health objectives is not always clear and as we have noted, they can appear ad hoc and atheoretical. The Trust's wider accountability for achieving organisational objectives and delivering general medical care therefore generate some concerns and reservations. These centre on the need to:

- explicate clearly the full range of activities being undertaken;
- identify how these activities might achieve disease prevention or positive health outcomes;
- provide reassurance that the quality of conventional medical practice need not be compromised and that there is no conflict of interest with the requirements of clinical governance.

Some, or all, of these reservations are likely to be expressed even more forcefully by other general practitioners. Within the immediate area there is some scepticism and reported low credibility among other local general practitioners, some of whom are dismissive of the general approach. (The views of other members of the primary care group which will include Withymoor would, of course, be highly relevant. Because the structure of PCGs had not been established before the end of the interviewing phase of this case study, it was not possible to investigate further.)

Even within the Withymoor Practice there is some disagreement and concern about the time spent on 'unconventional activities'. Essentially these concerns centre on the potential impact on the quality of care provided and derive from different interpretations of the role of the general practitioner. The reality, however, is that some of the other practice GPs feel that their 'conventional' workload has increased because of Dr. Rigler's involvement in these broader 'health promotion' activities. Even when locum services are used to provide cover, the issue of ensuring continuity of care remains unresolved. There is also a feeling that insufficient attention is paid to the provision of basic equipment and the efficiency of administrative systems. While there is support for his general aims, Dr. Rigler is alone among the GPs in the practice in his commitment to this unorthodox style of working. (Throughout this document, for simplicity, we have referred to the Withymoor Village Surgery or the 'practice', but it will be clear that there is no

practice consensus. The driving force behind the approach and activities described is Dr. Rigler joined by Lynda Lawley as the other key player on the surgery 'team'.)

Although there may be some doubts in the minds of GPs, Dr. Rigler is highly regarded by his patients. The practice population is stable with a very small drift away - patients only leave if they have to and some have even planned house moves to avoid going out of the practice catchment area. Dr. Rigler is reportedly very popular with his patients: 'they love him'. His approach is known to have 'changed lives' and patients have faith that he will mobilise all available resources and make all necessary contacts in their interest. His health promotion work in the community is not restricted to the practice population and Dr. Rigler is well known and respected in the local community and almost deified - one publican suggested that they should erect a statue of him!

Support for creative arts; community development approaches; and education is strongest in those most familiar with the use of these methods.

Confidence in the utility of this type of approach could be increased by showing clearly how these broad and often intangible methods can achieve precise health outcomes - either empirically or locating the methods within a theoretical framework.

It is important to demonstrate clearly and convincingly that there need be no conflict of interest between involvement in more holistic approaches and delivering high quality medical care and meeting the standards of clinical governance.

A2.4.4 ***Achievements***

The practice has been patently successful in developing numerous initiatives involving patients and engaging with a wide range of agencies in pursuit of shared goals. Taylor et

al. (1998) identified these as essential components in the shift toward a *'public health model of primary care'*. To note but one example, the Withymoor Practice and Thorns School have worked together in an exemplary way to tackle problems which were identified as relevant by both parties.

The energy, commitment and creativity of key individuals (notably Malcolm Rigler and also Lynda Lawley) is acknowledged as the prime reason for the numerous links and the diversity and originality of the various projects. The use of creative arts also provides a forum which can effectively bring different agencies together and allow them to simultaneously achieve relevant goals (e.g. working towards an educational and a health agenda at the same time).

The practice has also been very active in attempting to attract external funding to support these activities. Indeed, opening up opportunities to apply for funding, which would ordinarily not be available, was one of the advantages identified by schools of working with the practice.

It is clear that many of the creative arts activities have already achieved a number of different goals ranging from preventive medical outcomes through to enhancing a sense of community and appear to have been welcomed by patients. Positive effects on patients include:

- access to information (e.g. in consultation; in waiting areas; through access to lay referral systems; through electronic media);
- increased understanding of health issues (e.g. *Desmond Dragon/ Breath of Fresh Air);*
- development of and access to lay referral systems (e.g. *Meet a Mum*);
- development of communication skills and confidence (e.g. writing workshops/ lantern making);
- reduction in social isolation (e.g. *Meet a Mum*, social events);
- development of sense of community (e.g. *Lantern Procession*/ photographic displays);
- increased confidence to tackle causes of ill health (e.g. housing problems);

- reducing stress/ anxiety associated with visiting the surgery (e.g. contact with receptionist/ immunisation parties/ social events in the surgery);
- involvement in their own care;
- improved understanding of their own and the community's health needs.

In addition to these benefits for individuals and the community there were also perceived benefits for the practice in that patients made more **appropriate** use of medical services. Improved understanding of health issues and access to sources of support and advice in the community decreased the number of unnecessary consultations. The time devoted to these more holistic approaches could in principle be offset against such savings - in effect a refocusing of effort 'upstream'. However it was not possible to attempt any quantification of net gain. Similarly, increased understanding could reduce unnecessary requests for prescriptions (particularly of antibiotics with the attendant risk of drug resistant strains) with potential financial savings.

While there is clear evidence of the range of activities that have been attempted and a number of testimonies to their value, it should be noted that there has been no formal evaluation of Withymoor Village Surgery and its use of creative arts. A rigorous evaluation using qualitative methodology appropriate to the broad salutogenic approach would be valuable both to the Surgery, as a basis for planning future activity, and more broadly by contributing to the empirical evidence supporting this type of work in general.

A2.4.5 *Associated Costs and Funding*

Associated 'costs'

The time and energy devoted to these many and varied activities, although worthwhile and, as we have noted, consistent with recent developments in primary care, does create pressure in relation to maintaining:

- quality of clinical care
- continuity of care
- efficient administration systems.

This pressure falls on all members of the practice - not just those actively involved in the wider range of projects and activities. Indeed, some GP colleagues favoured more conventional approaches. It is important therefore that **all** members of the practice are consulted and a consensus reached on the value of these initiatives. Similarly the value of the supportive role of other individuals - who may not wish to be directly involved, but whose background efforts may create opportunities for others to do so - also needs to be recognised. The role of the whole primary care team needs to be considered and the complementary contribution of different individuals recognised.

Much effort was devoted to building and maintaining links with external agencies. However it was clear that within the practice communication between staff was poor. Individuals were often not informed about what was happening and there was a lack of understanding of the methods being used and how these might achieve goals.
A team approach, rather than individuals pursuing their own schemes, could increase the scope for activity and the potential impact. This would require:

- team building and acknowledging the value of all members;
- developing and maintaining good communication systems;
- considering the optimal skill mix required to carry out the various activities at minimal cost to the practice.

Funding

Conventional funding arrangements for general practice, based on core income and items of service, create difficulties in relation to any large scale involvement in the type of work described above. Many of the activities do not attract funding in their own right and may involve sacrificing income, since time spent on them reduces the capacity to generate income for the practice. In short, they are seen by some members of the practice as a drain on profitability. Their concern about the time spent on these less orthodox aspects of practice has been expressed informally - and formally - to the Trust. It should also be noted that practice funding is based on actual numbers of patients, whereas some of the initiatives are not restricted to members of the practice population but operate

community wide (e.g. the *Lantern Festival* and school based projects). Similarly the inter-sectoral work does not qualify for fees and so, people other than the practice population may be beneficiaries of the practice's efforts. Clearly Dr. Rigler's vision about the role of the general practitioner is in advance of current thinking. Funding mechanisms based on 'orthodox' practice do not accommodate broader salutogenic approaches. If other practices are to be encouraged to involve communities, work with other sectors and assess the health needs of the community as required by *'The New NHS'* and *'Our Healthier Nation'* then funding mechanisms will need to be adjusted to take account of this.

We noted earlier that Dr. Rigler's prime concern has been the needs of his patients rather than managing the business of general practice. As a consequence the practice has faced severe financial difficulty. Dr. Rigler has been very active in seeking funding for his ideas and a number of grants have been obtained. However, most of this funding has been for individual projects resulting in short term planning and becoming locked into a cycle of repeated funding bids. Sustainability of initiatives and obtaining longer term funding is therefore an important consideration, both for the practice and for others seeking to develop this type of approach. The PMS pilot scheme provided the opportunity to develop different ways of working, which would be more in tune with the salutogenic goals. Similarly a Healthy Living Centre bid could, if successful, secure longer term funding.

A2.4.6 *The PMS scheme*

The PMS pilot scheme (NHS Executive, 1997) was seen to offer a solution to some of the difficulties experienced by Withymoor Village Surgery, notably the financial and management problems. A particular strength of the scheme was that it offered the flexibility to organise the practice in ways which are more consistent with its salutogenic goals and innovative portfolio of activities.

The application to the PMS scheme involved the practice withdrawing from the Dudley Multifund and GP Fundholder status and becoming integrated into and managed by Dudley Priority Health NHS Trust. All practice staff are employed by the Trust including 4 half-time salaried GPs (one of these half-time posts is currently vacant). Following a transition period from January to March the 3 year pilot became fully operational in April 1998. Detailed objectives for the practice, as set out in Dudley Priority Health NHS Trust's contract with Dudley Health are listed in Appendix V. Dr. Rigler is employed for 5 sessions (i.e. half time) as a general practitioner and for a further 2 sessions to do health promotion work. It was anticipated that these new arrangements would release Dr. Rigler from the burden of managing the practice and additionally provide time for his health promotion work. It was also expected that Dr. Rigler's remaining time might be funded from external sources. At the moment Dr. Rigler has an honorary lectureship with the University of Central England linked to the research and development unit Professor Casteldine is hoping to set up. The difficulty in filling the remaining GP post has been attributed in part to national recruitment problems but also to the comparatively low salary attached to it as compared to other non PMS practices.

The potential of the scheme was clear to Dr. Rigler and the Trust was also keen to work with him - in part to help resolve the financial problems, but also because the pilot scheme would open up new ideas about ways of working in primary care and, if successful, bring prestige. The benefits to be derived from the pilot were listed in the proposal document as:

- *planned service developments*
    - patient information project
    - mental health promotion
    - better targeting of services for the elderly
    - men's health
- *additional developments and benefits*
    - practice premises
    - integration of professional staff
    - financial stability

- *benefits to patients*
    - continued existence and development of a popular local practice
    - additional GP resources
    - development of additional and improved services
    - possibility of a new larger practice.

Some members of the practice team - particularly the administrative staff - were less enthusiastic and found the imminent change threatening. Furthermore, they were not always kept informed about the developing situation. Particular concerns were job insecurity, lack of confidence and the possibility of having to give up familiar and comfortable ways of working to conform to the bureaucracy and culture of the Trust.

Perceptions of the actual experience of working under the new arrangements include the following:

positive aspects

- freedom from the burden of generating income and associated financial management
- sound financial management
- payment and support for health promotion work
- security regarding salaries and pensions for all staff
- the opportunity to deliver medical care in a more creative and holistic way
- more time for working with the 'well' on health promotion
- access to funding for training and study leave
- personal appraisal and career development for administrative staff
- some items of basic equipment made available (e.g. oxygen and anaphylactic shock pack).

negative aspects

- loss of independent status by becoming part of the Trust
- the requirement to adhere to the Trust's systems with some loss of flexibility
- strict standing financial instructions which can be cumbersome at the practice level
- accountability for achieving objectives
- insecurity (particularly among administrative staff) during the transition phase.

Although, as anticipated, the pilot seems to have removed the need to worry about items of service, there are areas in which it has not fully met expectations. There has not, as yet, been any major improvement regarding the premises. The costing of health promotion work has not included the necessary administrative support and so this is still not adequately funded. The Trust bureaucracy creates tension and there is some frustration that Trust managers do not fully understand how the methods used contribute to health goals. There has also been a loss of autonomy and a sense that GPs are not being left alone to practice as they see fit.

Part B

PRAXIS

THE PHILOSOPHY SCRUTINISED

THEORY INTO PRACTICE

B1 Introduction

In Part A above, it was argued that the Withymoor approach to primary care was congruent with contemporary salutogenic and empowerment philosophies. Indeed, in many ways, Withymoor is at the leading edge of this movement. The present section will provide an outline and summary of the philosophy and values stance to which Withymoor subscribes and to which the UK government is committed at the present time. Accordingly, an analysis will be provided of the related notions of salutogenesis and empowerment. As the World Health Organisation (WHO) formulation of Health Promotion has had considerable influence on popularising and proselytising the centrality of empowerment in achieving public health goals, the major principles underlying WHO's conceptualisation will be summarised below.

B2 Health Promotion: the Contribution of WHO

B2.1 *From Alma Ata to the Ottawa Charter*.

Interestingly, in the context of this report - and somewhat ironically - the roots of the Health Promotion movement may be found in WHO's review of world health at the Alma Ata Conference (WHO, 1978). In short it emphasised the importance of Primary **Health** Care in contrast not only to curative interventions but also to Primary **Medical** Care (authors' emphasis). The development of the concept of Health Promotion per se emerged some six years later (WHO, 1984) and acquired 'campaign status' in the Ottawa Charter (WHO, 1986).

The Ottawa Charter listed five specific strategies for health promotion:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- reorient health services.

The following five assertions incorporate and elaborate on these strategies and encapsulate the philosophical stance underpinning them:

- *Health.* Health should be viewed holistically and its positive aspect (i.e. wellbeing) should be acknowledged. However, it should not be primarily considered as an end in its own right but rather as a *means* to an end, viz.: the achievement of a 'socially and economically productive life'.
- *Equity***.** Inequalities between and within nations are intrinsically unacceptable; moreover, the achievement of preventive medical outcomes and 'health gain' generally will be in proportion to governments' success in ensuring a more equitable distribution of resources.
- *Healthy Public Policy***.** Since the major determinant of health and illness is the physical, cultural and socio-economic environment in which people live and work, a narrow *individualistic* concern with personal responsibility is both inappropriate and unethical since it 'blames the victim' of these macro level circumstances. Accordingly, 'building healthy public policy' in order to create a supportive environment and 'make the healthy choice the easy choice' is, arguably, the most important single purpose of health promotion.
- *Reorientation of Health Services***.** Health is too important to be left to the medical profession (and professions allied to medicine). There must be a 'reorientation' of health services. Since medical services often fail to meet people's real needs and are often de-powering, they should be reformed. 'Demedicalization' is, therefore, an important goal of health promotion: it is concerned not only to shift the balance of power from doctors and medical establishment towards patients and clients, but it also seeks to acknowledge the substantial contributions which other services make to health (and illness). Services such as housing, transport, economic development and leisure and recreation may all influence health, for good or ill. 'Healthy alliances' based on efficient inter-sectoral collaboration should be established so that the health promoting potential of these services might be harnessed for the public good.
- *Empowerment.* The achievement of 'active participating communities' is a prime goal of health promotion. Empowerment is worth pursuing in its own right: it is a sign of

individual and social health. It is also an essential means to ensure that individuals and communities will be able to make healthy choices and work proactively to enhance public health generally. Empowering strategies and tactics should operate in all situations and at all levels. The major purpose of health education is, therefore, to raise critical consciousness, provide supportive health skills and facilitate co-operation rather than compliance with health advice.

B2.2 *Jakarta: Priorities for Health Promotion in the 21st Century.*

The 1997 Jakarta Conference (WHO, 1997) reiterated and re-emphasised the canonical principles listed above and re-stated the importance of the 'five Ottawa strategies'. It provided a reminder that there was clear evidence that:

- *'Comprehensive approaches to health development/promotion are the most effective. Those that use combinations of the five strategies are more effective than single-track approaches.*
- *Particular settings offer practical opportunities for the implementation of comprehensive strategies. These include mega-cities, municipalities, local communities, markets, schools, the workplace and health care facilities*
- *Participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective.*
- *Health learning fosters participation. Access to education and information is essential to achieving effective participation and the empowerment of people and communities.'*

These assertions were immediately incorporated into the first ever formal resolution on Health Promotion at the Fifty-First World Health Assembly (WHO, 1998). A little reflection on the principles enshrined in this militant clarion call for enhancing public health should lead to recognition of how Withymoor's philosophy and its commitment to initiatives such as Healthy Living Centres genuinely reflects the radical agenda of WHO.

Moreover given the contemporary concern with demonstrating effectiveness and the health sector's pursuit of 'evidence based medicine', those who advocate non-traditional empowering and salutogenic actions should take some comfort from Jakarta's claims for the effectiveness of its strategy. It states that, 'There is now clear evidence that:

'*Research and case studies from around the world provide convincing evidence that health promotion is effective. (*They*) can develop and change lifestyles, and have an impact on the social, economic and environmental conditions that determine health. Health promotion is a practical approach to achieving greater equity in health' (page 4).*

B3 Empowerment

B3.1 *Operationalising Empowerment*

Empowerment is central to the notion of health promotion and is also central to the Withymoor philosophy. However, if empowerment is to be more than a vague, contested concept (like health promotion itself) it must be operationalised – i.e. translated into concrete actions which can, in turn, be translated into objectives and, ultimately, be measured in some form or other.

In the last analysis, empowerment has to do with the relationship between individuals and their environment. On the one hand, environmental circumstances – of all kinds – can inhibit or facilitate individual choices and actions. On the other hand, individuals are, to a greater or lesser extent, capable of influencing their own environments. It is generally acknowledged that it is intrinsically healthy to have a reasonable degree of control over one's life and health; a fortiori, it is decidedly unhealthy for individuals and communities to lack control and a sense of control over their circumstances. Accordingly, (to paraphrase a repeated WHO observation), one of the main purposes of health promotion (arguably the *major* purpose) must be to foster both individual and community empowerment. Some brief observations will, therefore, be made below about both

individual (self) empowerment and community empowerment in the context of the complex interrelationships between individuals, the communities in which they live and the all embracing influence of environment. These will be linked with a discussion of the complementary (salutogenic) notion of 'coherence'.

B3.2 *The Dynamics of Self Empowerment*

In short, self empowerment involves the possession of a relatively high degree of control over one's life and circumstances, i.e. having sufficient power and resources to achieve a realistic number of desired goals – consistent with other people's rights to also assert their rights. Self empowerment is associated with certain beneficial psychological characteristics: prominent among these are beliefs about control and level of self esteem. Beliefs about control are associated with self esteem. Although self esteem is substantially influenced by the way we are treated by other people - by, for example, whether we receive love and respect - it is also influenced by the amount of control we have or perceive we have over our lives. Self esteem is deemed to be intrinsically healthy (at least in western cultures) - e.g. as an important facet of mental health - and to contribute instrumentally to healthy choices. At the common sense level, if we value ourselves, we are more likely to respond to exhortations to look after ourselves !
As we will see later, control is not a unitary concept and may vary in degree. Individuals may enjoy a high level of *internality* (i.e. they may believe that virtually whatever happens to them - good or bad - is due to their own initiative). *Externals*, on the other hand, tend to attribute such outcomes to the effects of outrageous fortune and/or to the influence of powerful others.
A more useful and practical notion deriving from Social Learning Theory (Bandura, 1982; 1986) is the concept of *self efficacy*. Quite simply, if people do not believe they are capable of achieving a *specific* goal, they are unlikely to make the attempt even though they might value the outcome. By contrast, the prognosis of a patient who has recently experienced heart surgery, will be much better if (s)he believes it is actually possible to adopt an accelerating programme of exercise without suffering a further heart attack or dropping dead from the effort. Arguably, the greater the number of specific,

positive self efficacy beliefs, the greater the perception of a relatively high degree of internal locus of control.

(The above discussion is derived from Tones, 1998a)

B4 Salutogenesis

B4.1 *The Concept of Salutogenesis*

It is apparent to many that a narrow, medical definition of health as absence of disease fails to do justice to its complex reality as experienced by real people – particularly those living in disadvantaged circumstances. In research carried out in the Withymoor Village Surgery in 1992-3, Durrant (1993) quotes a patient who intuitively recognises the limitations of the physical disease focus:

'… if there isn't enough money to pay for the rent or food or clothes, then you can't begin to think of other things. You have to have these things, like a roof over your head, a job, for self-respect, a coat on your back and food in the stomach. I've got 'good health'. I've not been in hospital, I don't take tablets, but that's not health to me. I'm sick because I have trouble paying my bills, I have trouble feeding the kids at times, so bodily I'm all right, but up here (indicates head) I'm terrible, 'cos I worry and that's not health is it?'
(p. 98)

The term, 'Salutogenesis' chimes with the perceptions of the patient quoted above. It is used in two senses in this report. The first of these refers to the kind of holistic and positive notion of health archetypally represented in WHO's original 1946 definition of health – i.e. wellbeing and not merely the absence of disease or infirmity. The second definition is somewhat more technical and associated with Antonovsky (1984). It is clear from earlier reviews of the Withymoor approach that the underlying philosophy is essentially salutogenic in the first of the two senses mentioned above. The holistic

dimension is very nicely defined in Sweeney's 1997 James Mackenzie lecture and reported in the British Journal of General Practice (Sweeney, 1998). Sweeney cites Cassell's (1991) concept of 'personhood':

'… include(s) personality and character; a past with life experiences that provide a context for illness; a family with ties that may be positive or negative; a cultural background; a variety of roles and relationships; a body and a self-image of that body; a secret life of fears, desires, hopes, and fantasies; a perceived future and… a transcendental dimension (that is some sort of life of the spirit, however that is expressed).'

' … each aspect of personhood is susceptible to injury and damage, and …this injury is what causes suffering. … Suffering can occur in relation to any aspect of a person and it occurs when the person perceives his or her impending destruction or disintegration. The sort of injuries that cause suffering are the death and suffering of loved ones, powerlessness, helplessness, hopelessness, the loss of a life's work, deep betrayal, isolation, homelessness, memory failure, unremitting fear, and physical agony.'

Many of the more technical and 'scientific' accounts of the personal and social attributes associated with self empowerment are entirely congruent with Cassell's rather more 'poetic' analysis of personhood. Similarly, the notions of coherence and *community* empowerment - that will be discussed below - are inherent in his multidimensional portrayal of individual people within their immediate circumstances. Furthermore, like Durrant (op.cit.) Sweeney argues that:

'… reflection on literature and the arts can produce an understanding, a realization, of the ambiguities and complexities that characterize each life.'

We will, in Section B12, seek to provide a more detailed and technical analysis of how the arts can operate – not only in the service of salutogenic outcomes but also as a prime method for achieving the prevention of disease.

B4.2 *Salutogenesis and the Sense of Coherence*

Antonovsky's (1984, op.cit.) Theory of *salutogenesis* has a double relevance for health promotion. Firstly it emphasises positive aspects of health and well-being and legitimises a degree of deviation from a preventive medical model. Secondly a key component of the theory - the *sense of coherence'* has particular relevance to the promotion of both mental and social health. The notion of coherence is compatible with the empowering beliefs about control mentioned above but adds an extra dimension. 'Salutogenesis' is, in Antonovsky's words, '*negentropic*' - i.e. coherence represents characteristics which help individuals *'.. do battle with the entropic forces.… which lead to chaos and meaninglessness'.*

'The sense of coherence is, '… a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected.' (p.123)

The three main components of coherence are:

- c*omprehensibility*: the world is ' .. ordered, consistent, structured and clear .. and the future predictable..' rather than, '.. noisy, chaotic, disordered, random, accidental and unpredictable.'
- *manageability:* individuals believe they have the kinds of resources at their disposal which will help them manage their lives.
- *meaningfulness*: Life makes sense emotionally; people are committed; they invest energy in worthwhile goals.

Clearly, the concept of manageability incorporates beliefs about control (e.g. internality or self efficacy). Moreover, together with the idea of meaningfulness, it also includes those situations in which individuals are patently not in control - e.g. they may be terminally ill. It refers to circumstances in which individuals do not exercise control but can impose meaning on their circumstances and are thus relatively content. For instance,

they do not feel victimised because they believe that powerful others are *legitimately* in control - e.g. ' .. *friends, colleagues, God, history*' (Antonovsky, op.cit.).

B5 Participation and Empowerment: A Spectrum of Participation.

As will be apparent from previous discussions, community participation is considered de rigueur in current health promotion philosophy and practice – at least by those subscribing to WHO's philosophy. It is certainly central to the recent government initiatives mentioned above and, of course, to the Withymoor philosophy. Accordingly, a brief review of key concepts and principles will be provided below. They will include comments on different degrees of community participation; different desirable empowering outcomes including a 'sense of community' and the importance of social support; the social change potential of 'active participating communities'; the 'community development' strategy.

Community participation is not an all or none phenomenon and various community theorists and practitioners have identified different degrees of involvement. Figure 2 below is derived from one of the most common analyses (Brager and Specht, 1973). Clearly Action Stage 7 involves maximum participation. It should also be noted at this point that for maximum empowerment, the community should be involved at each stage of the health promotion process. For example, they should be involved in needs assessment (see Section B 10 below), programme implementation and evaluation.

Fig. 2 Degrees of Participation and the Nature of Community Involvement

Degree of Participation	Action		Nature of Community Involvement
LOW ↓ HIGH	None	1.	Community told nothing
	Receive information	2.	Organisation makes plan and announces it. Community expected to comply.
	Consulted	3.	Organisation tries to promote plan and develop support in order to have it accepted.
	Advises	4.	Organisation presents a plan and invites questions. Is prepared to modify plan only if absolutely necessary.
	Plans jointly	5.	Organisation presents a tentative plan subject to change and invites Recommendations from those affected.
	Has delegated authority	6.	Organisation identifies and presents a problem, defines the limits and asks the community to make a series of decisions to be embodied in a plan they will accept.
	Has control	7.	Organisations asks the community to identify the problems and to make all the key decisions about ways and means. It is willing to help the community accomplish its own goals at each step, even to the extent of giving administrative control of the programme.

B6 Community Empowerment

B6.1 *A Sense of Community*

There are some who contend that an empowered community is no more than the sum of its empowered members: for example, where the majority of individuals in a neighbourhood have a varied repertoire of relevant '*lifeskills*' and competencies and are confident of their capacity to influence their circumstances and their health, then it is reasonable to assume that that particular neighbourhood will, as an entity, be 'actively empowered'. Certainly an empowered community will be more readily mobilised in the pursuit of health and, generally, conform to the criteria of an *'active empowered community'* which received prominence in the Ottawa Charter. It will also contribute to individual empowerment, both directly and indirectly, by means of the processes of socialisation. Others, however, consider that a kind of gestalt effect operates – and, in some way, an empowered community is somehow more than the sum of its empowered parts. There is certainly one aspect of community empowerment that fits this contention - and this relates to the concept of a 'sense of community'.

McMillan and Chavis (1986) identify four main characteristics of a sense of community:

- membership: a feeling of belonging;
- shared *emotional connection*: *' … the commitment and belief that members have shared and will share history, common places, time together, and similar experiences.'*;
- influence: a sense of mattering;
- integration and fulfilment of needs: *' … a feeling that members' needs will be met by the resources received through their membership in the group';*

It is, hopefully, apparent that this particular definition of a sense of community almost exactly describes the goals of the Withymoor Lantern Festival.

The first three of McMillan and Chavis' criteria have an obvious similarity with the sense of coherence mentioned earlier. It seems highly likely that an individual who is a member of such a community might well be socialised into a degree of 'healthy' commitment and concern - provided of course that the community norms are consistent with such altruistic motives!

The fourth criterion also relates more directly to the empowerment dimension - provided that the community actually has genuine resources to offer, individuals might acquire the competencies and confidence needed to tackle environmental constraints and generally act in a proactive fashion.

Certainly, it seems clear that many, if not most, people would feel more comfortable in a community enjoying a sense of coherence – and many examples exist of the use of creative arts to achieve a 'healthy' sense of community.

B6.2 *Community Empowerment: Social Support and Active Participation*

Galbraith (1992) sums up the situation of disadvantaged communities with characteristic power and elegance:

' The present and devastated position of the … underclass has been identified as the most serious social problem of the time, as it is also the greatest threat to long-run peace and civility. Life in the great cities in general could be improved and only will be improved by public action – by better schools with better-paid teachers, by strong, well financed welfare services, by counseling on drug addiction, by employment training, by public investment in the housing that in no industrial country is provided for the poor, by private enterprise, by adequately supported health care, recreational facilities, libraries and police. The question once again, much accommodating rhetoric to the contrary, is not what can be done but what will be paid..'

Whatever the benefits of a sense of community, little will be done to remedy the social problems underlying ill health that Galbraith identifies without further more substantial measures. Three such measures may be specified. The first of these is the provision of social support; the second and third related initiatives are the presence of what WHO termed in the Ottawa Charter, 'active participating communities' together with the building of 'healthy public policy' - which, in turn, substantially depends on community action.

- *Social Support.* It is assumed here that a community having a sense of coherence, shared values and the like will be likely to exert a relative tangible effect on the wellbeing of that community. This effect is due to the provision of social support. Although there is debate about the precise mechanisms whereby social support exerts an effect, it is clear from the wealth of studies - according to Gottlieb and McLeroy (1992), 100 articles per year from 1989-1991 - that the impact is real. The extensive literature on social support provides additional justification for assertions about the benefits of a sense of community.

  A recent report from WHO European Region on the Social Determinants of Health (WHO, 1998) comments as follows on the role of social support in health promotion and, especially, in combating *social exclusion*:

  'Support operates on the levels of both the individual and the society. Social isolation and exclusion are associated with increased rates of premature death and poorer chances of survival after a heart attack. People who get less emotional and social support from others are more likely to experience less wellbeing, more depression, a greater risk of pregnancy complications and higher levels of disability from chronic diseases. In addition, the bad aspects of close relationships can lead to poor mental and physical health. Access to emotional and practical social support varies by social and economic status. Poverty can contribute to social exclusion and isolation. Social cohesion – the existence of mutual trust and respect in the community and wider society – helps to protect people and their health. Societies with high levels of income inequality tend to have less social cohesion, more violent crime and higher death rates. One study of a community with high levels of social

cohesion showed low rates of coronary heart disease, which increased when social cohesion in the community declined.'

- *Healthy Public Policy.* In the last analysis, as Galbraith noted, dealing with the social and environmental determinants of health and illness requires political will – and money! As remarked earlier, current UK government planning appears to both recognise the problem and be committed to addressing it - certainly, Health Action Zones, Educational Action Zones, Healthy Living Centres and the like have been established for this purpose. What is not clear is just how much money will be available!

- *Active Participating Communities.* Since it is notoriously difficult to expect governments (or anyone else) in power to take radical and expensive political measures, advocacy by the relatively powerful will be needed (and examples of Withymoor's involvement in such advocacy were provided in Section A). However, many involved in health education and health promotion have argued that social change will only result from substantial *popular* pressure. Freire's (1974) use of *'critical consciousness raising'* is frequently cited as an appropriate strategy. This approach not only seeks to raise people's awareness of social, economic and other environmental factors that militate against healthy choices but also aims to create a sense of indignation and even anger – which, hopefully, will be translated into popular pressure being brought to bear on politicians at all levels and all those who are in a position to influence the determinants of health. There is, however, an important prerequisite for social action: people must believe that they are actually capable of influencing the power base and the political system – and have the skills and know-how to exercise their power. WHO's emphasis on the creation of *actively* empowered communities should be viewed in this context. Although an example of the use of creative arts in consciousness raising will be discussed in Section B 12 below, it is useful to signal this here in a quotation from Goodchild about the use of theatre in Durrant's (op.cit. p. 75) review of the Withymoor Surgery:

- *'… the theatre can be used to transfer power to the people, the theatre is a weapon, that people can use to show their feelings, to harness power to change society. The people don't ask for the arts. They ask for jobs, housing, education, health and power over their lives. Drama is a way to give people the skills to demand change, demand their rights. Drama is a way for the people to articulate their needs.'*

B6.3 *Participation and Community Change*

Well established research on '*Communication of Innovations'*, i.e. those conditions that determine if and how communities come to adopt or reject innovation, has identified the following principles determining the likelihood of a new idea or practice being adopted:

- it should be simple rather than complicated;
- people should believe that it is quite easy to try it before making a full commitment;
- people should believe that beneficial effects should be observable sooner rather than later;
- the new practice should be compatible with existing culture and norms;
- it should be seen to offer greater advantages than existing practices;
- it should not apparently incur any substantial costs – financial, psychological or otherwise;
- it should be advocated by credible people – preferably by those who share the cultural, social and economic background of the community (or professionals who have a high level of empathy).

As Figure 3 below shows, a community is most likely to change if community members *themselves:* (1) identify problems and issues and (2) identify the solution to those problems (or, through the sensitive and tactful work of professionals, *believe* that they have identified the solution!).

Figure 3: Conditions Determining Likelihood of Change in Communities

	Need Recognised by Community Itself	Need Recognised by External Professionals
Solution Identified by Community Itself	*Very Rapid Change*	*Medium Level of Change*
Solution Prescribed by External Professionals	*Medium to Slow Level of Change*	*Very Slow Change or No Change at All*

B6.4 *Empowerment through Community Development*

It should be clear from discussions so far that the position adopted in this report is one that advocates the adoption of an approach which maximally involves patients and the community. Such an approach is not only consistent with the WHO philosophy outlined earlier but is also central to recent UK government initiatives *to build social capital* (a currently popular notion defined by Puttnam et al (1993) as ' … features of social organisation, such as networks, norms, and trust, that facilitate co-ordingation and co-operation for mutual benefit.') and address problems of inequity. The Indeed, there is evidence of advocacy for such an approach (Russell, 1995; Health Promotion Wales, 1998). Furthermore there is support developing from within the profession – note for example a recent editorial in the European Journal of General Practice (De Maeseneer and Derese, 1998) which commented on WHO's urging the creation of 'five star doctors' for the 21st century. The editorial describes these five star qualities and suggests reasons

why this status may be difficult to achieve:

'One of his or her qualities should be that he or she is community oriented and can reconcile individual and community health requirements and initiate action on behalf of the community. (Boelen, 1993). Nowadays only a limited number of European general practitioners are involved actively in a community approach, most of them in medical care in deprived areas. There are many reasons for this. First of all, we are trained for individual curative care of health problems. The contribution of aspects of community orientation to medical curricula is limited, with sociology, behavioural sciences, anthropology, health promotion, health care organisation, needs assessment and epidemiology in a rather marginal position'.

Following these remarks about training, it is apposite to acknowledge the recent observations by Sir Kenneth Calman on the relevance of humanities and the arts in medical education (Calman and Downie, 1996).

B6.5 *The Nature of Community Development*

If primary care is to become seriously involved in fostering community participation, community development offers a useful model. Some of its key features will, therefore, be briefly reviewed.

Community Development (CD) is:

"a process by which ordinary people can have some say in prioritising, planning, delivering and reviewing services"
(UKHFAN, 1993).

Its approach is fundamentally 'bottom-up'. Its purpose is to help a community identify its 'felt needs' and then, through a process of empowerment, provide support to help people satisfy the needs they have identified. Their perceptions of their health needs

may, of course, not match the traditional epidemiological objectives established by health authorities - in fact it would be quite unusual if they were to do so. However, given the assertions below about the compatibility between salutogenic goals and the agenda of preventive medicine, an empowering CD approach could well satisfy both sets of interests. The potential links are most obviously revealed in so called community health projects, i.e. projects which frequently apply CD principles to the achievement of what are commonly traditional preventive outcomes. Rosenthal (1983) listed the characteristics of these 'community health projects' as follows:

- they are firmly based outside the health professions;
- they are concerned with addressing inequalities in health and health care provision;
- they are concerned to promote collective awareness of social causes of ill health;
- they assert that the monopoly of the information about health and ill health by professionals must be challenged both individually and collectively;
- activities centre on work with small groups of local people;
- projects have a catalytic function in stimulating local health, social and education services.

B7 Empowerment, Salutogenesis and Preventive Medicine

While it can be argued that salutogenic goals are worthwhile in their own right, managers, workers and, particularly, doctors in the National Health Service are, not unreasonably, primarily concerned with the prevention and treatment of disease; they are, therefore, likely to remain sceptical about the relevance of what they might consider to be the nebulous concerns of empowerment and salutogenesis. Accordingly the final remarks in this section concern the relationship between an empowering, salutogenic approach and the more traditional health service concerns with the prevention of disease at primary, secondary and tertiary levels – and the promotion of 'proper ' use of services. We may state quite briefly that no substantial inroads will be made into the burden of disease until underlying social and environmental problems such as inequity are seriously managed. At the individual level, it is evident from both research and common sense,

that empowered people who value themselves are on the one hand motivated to avoid illness and improve their health and, on the other hand, have the belief systems and personal resources to enable them to do this.

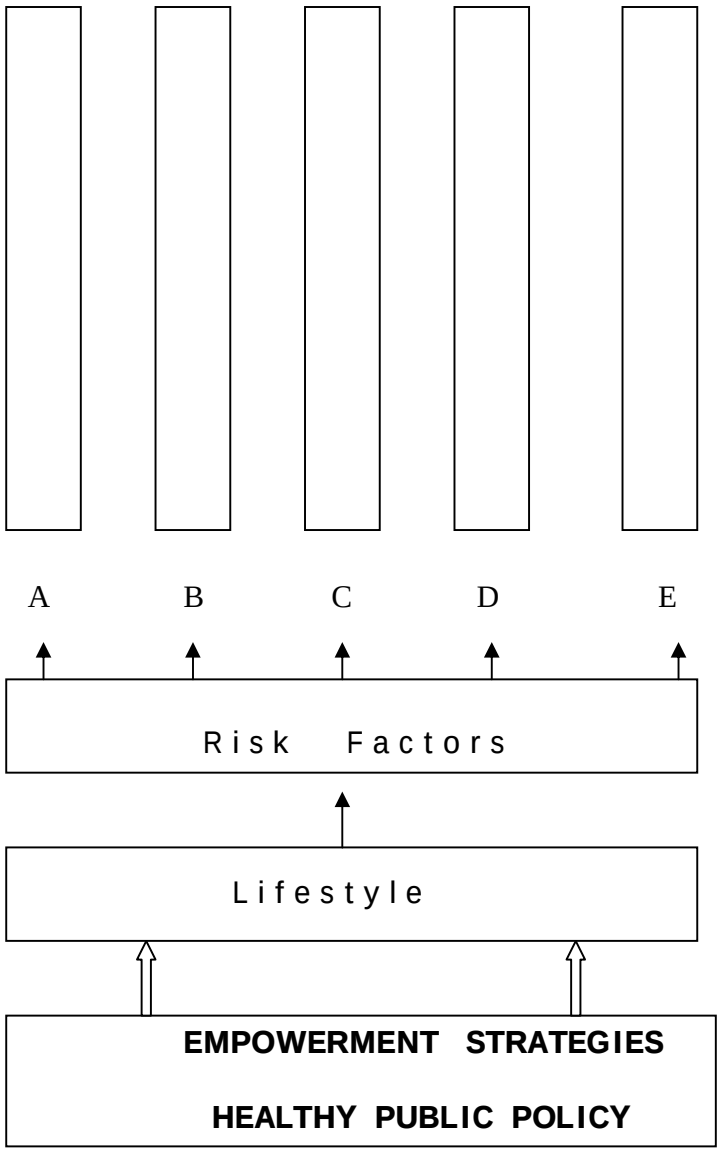
B8 Horizontal vs. Vertical Programmes

The importance of the social, economic and environmental determinants of health has received consistent emphasis in this report. The central rationale of an empowering and salutogenic approach is that the effectiveness of health promotion programmes will be proportional to the extent that they 're-focus upstream' and directly address these broad and basic influences on health and disease. The implication is that health promotion should concentrate less on 'vertical' (i.e. disease specific) programmes and concentrate on 'horizontal' programmes (Tones, 1993a).

In brief, it is conventionally acknowledged that specific diseases may have common risk factors and that it is, therefore, sensible and economical to adopt programmes that will contribute to the prevention of more than one disease. Furthermore, it is hardly revolutionary to suggest that influencing lifestyles may contribute to a reduction in several risk factors. However, planners may find it more difficult to recognise how the reciprocal interaction of broader-based empowerment and salutogenic strategies might not only achieve desirable salutogenic outcomes but might also be the most effective strategy for attaining more traditional health service targets.

Figure 4 below shows how these different levels of action might contribute to the prevention of the five vertical health issues identified in 'Health of the Nation' (1992). It is fortunate for those who are committed to the salutogenic approach encapsulated in Withymoor's philosophy that the new health policy, '*Our Healthier Nation'* (1998 op.cit.), while retaining some specific, vertical targets, implicitly places much greater emphasis on the importance of horizontal approaches.

Figure 4: Horizontal Solutions for Vertical Problems



A = Cancers B = Sexual Health C = Cardiovascular Disease

D = Mental Illness E = Accidents

B9 Healthy Alliances: Achieving Inter-Sectoral Working

B9.1 *The Settings Approach.*

The 'settings approach' is a key feature of WHO's approach to health promotion and a significant development of its Healthy Cities programme. Apart from envisaging various geographical settings as locations for delivering health education, WHO argued that settings should embody the philosophy and principles of health promotion. And so, for example, a setting such as the school should not merely provide education, it should also provide a supportive ethos and environment. Similarly, a health promoting clinic or surgery should embody principles such as empowerment – and not just for patients but also for staff. An 'outward looking' stance should also characterise a health promoting setting: its focus should not just be on the world of the client or patient, it should, in addition, seek to establish co-operative relationships with other health promoting settings.

B9.2 ***Intra*-Sectoral Working**

Evidence from research into health promoting settings such as the school has demonstrated unequivocally that effectiveness depends substantially on the setting having a unified and co-ordinated approach so that, for instance, all members of staff understand the general philosophy, share the vision and contribute their own particular skills to the common purpose. The present research has indicated the particular importance of this observation for situations, like the Withymoor surgery, where a complex mix of standard medical practices co-exist with more innovative and radical approaches such as the use of creative arts. Team building is thus an essential pre-requisite.

B9.3 *Inter-Sectoral Working*

Reference is made on several occasions in this report to the importance of inter-sectoral working. For instance, the centrality of collaboration for such healthy alliances as Healthy Living Centres and Health Action Zones has been noted. The logic is simple enough. If a number of different settings and sectors adopt similar health policies and deliver similar messages in different ways, in different places and at different times, the resulting synergy should produce a much higher degree of success than when the settings operate separately. It is, of course, a major contention of this report that any collaboration should maximally involve communities and clients - and a community development strategy should form an integral part of inter sectoral working. Indeed, some of the more effective examples of '*community organisation'* have deliberately sought to enhance the empowering effect of community participation by establishing coalitions of the great and good (or, more accurately, of the powerful and wealthy). With some justification, they consider that truly disempowered communities cannot 'pull themselves up by their boot straps' without such inter-sectoral support.

As mentioned earlier, Withymoor has both been involved with lottery bids for Healthy Living Centre funding and, at the same time, is already operating as a prototype healthy living centre in its own right (without having the funds to work in a more ambitious way). Certainly, future developments in general practice will require primary care teams to adopt the principle of 'listening to local voices' and to collaborate with other agencies – such as local authorities and voluntary bodies. It is, therefore, worthwhile acknowledging that inter-sectoral working is by no means easy – and listing some of factors which seem to facilitate collaboration. Indeed, the recent research report on the effectiveness of the Health of the Nation' (Dept of Health, op.cit.) makes some useful comments on factors associated with joint working. It says, for instance, that:

'Pre-existing structures heavily influenced the starting point for joint working. For example, where local government responded to HFA and formed relationship with Health

Authorities, there was already joint machinery on which to build. Where no such activity existed, the HOTN was a suitable spur for action.'

However ……..

' *The different agendas and cultures of health services and local government acted as complicating factors. Health Authority respondents found it difficult to develop relations with Local Authorities where they contained strong, independent directorates, and the more political nature of local government and its different complexions resulted in inconsistent alliances for health promotion activities. Deprivation within an area, however, was often seen as a mobilizing factor'.*

B9.4 *Factors Supporting Effective Collaboration*

The theory underlying the principles and practice of inter-sectoral working is sophisticated and quite complex. However, it is possible to distil a few simple – and, hopefully, common sense – recommendations for facilitating healthy alliances. These are listed below.

- '*Domain awareness*.' Potential collaborators must have a thorough knowledge of the different agencies and bodies with whom they hope to collaborate. They should also know their respective remits and the similarities and differences between their own and other agencies.
- *Shared vision.* It is generally considered crucial that agencies should share a common vision and have a critical mass of common goals.
- *Compromise and bargaining*. Negotiation, bargaining and compromise will typically be needed. Importantly though, it should be noted that not all partners may have equal status and power. The dominance of one or other partner may minimise the contribution of the other(s) and create suspicion and resentment. The needs of all parties should be met.
- *Lead Agencies*. Effective coalitions need appropriate lead agencies to stimulate

development.

- *Resource exchange and commitment*. Clearly, collaboration will be problematic if agencies are seen to compete for the same, limited resources. Resource exchange will contribute to effective working – and it should be recalled that such resources as time and staff skills are valuable. At the same time it is essential to take account of 'opportunity costs'.
- *Formal recognition*. It is important that an alliance and its contributing agencies should receive formal recognition.
- *Organisational and communication structure.* An appropriate, efficient, but flexible system of communication between partners should be established
- *'Reticulist' (networking) skills.* Networking skills are a valuable asset in inter sectoral work. These include, for example, strategic thinking, political skills and an ability to cross boundaries.
- *Interpersonal Contacts*. Although it is crucial to have full commitment from the formal leaders of organisations, the interpersonal element is also important - as is the routine rewarding and recognition of contributions from both individuals and agencies.
- *Structure.* It seems likely that 'flat' organisational structures lacking hierarchies and authoritarian leadership patterns are more amenable to networking and the ability to respond rapidly and flexibly to challenges.

As we have noted, the outward-looking focus and willingness to collaborate with other agencies has been characteristic of the Withymoor style of working. Drawing on the principles listed above, the following may be identified as factors which have been identified in the case study as instrumental to the development of collaborative links by the Withymoor Village Surgery:

- an ability to attract funding not otherwise readily available, e.g. to schools;
- overlapping goals – particularly between health and education;

- the use of creative arts – which, as noted elsewhere – can act as a valuable vehicle for drawing agencies together and allowing them to work towards individual and common goals;
- Dr Rigler's 'reticulist' skills – particularly his enthusiasm for initiating contacts with a wide variety of agencies and individuals who have not traditionally worked with primary care - nor even within the health field generally;
- Dr Rigler's commitment to communicating his vision – and thus inspiring kindred spirits and bringing together an often unusual series of alliances.
-

Appendix IV provided a summary of some of the key groups and agencies with which Withymoor has worked. It will be observed that a salutogenic philosophy can serve as a basis for shared goals and the all important 'vision thing'.

B10 Needs Assessment

The restructuring of the NHS and creation of the internal market focused attention on the identification of need as a basis for commissioning services. Different types of need have been distinguished by Bradshaw's (1972) well known taxonomy and include:

- normative need - based on professional judgement;
- comparative need - resulting from poorer health experience or access to services than other groups;
- felt need - identified by members of the community;
- expressed need – articulation of the felt need by words, actions or other means.

Normative and comparative needs are essentially professionally defined and the perspective of health professionals usually dominates - although *'The New NHS'* and *'Our Healthier Nation'* recognise the importance of involving other professionals and voluntary groups. The assessment of these two types of need is typically located within a quantitative paradigm and uses conventional epidemiological techniques and data. There is a wealth of epidemiological data in primary care - much of it currently untapped. If

this is to be made available to inform the commissioning process then efficient data collection, retrieval and collation systems will need to be in place at the practice level.

Appreciation that complete understanding of the causes and experience of health and ill health also requires qualitative insights has led to calls to broaden the research base accordingly (Department of Health, 1998). The importance of 'listening to local voices', which taps into the reserves of lay knowledge and experience (William and Popay, 1994), is also currently receiving increased recognition. It is also compatible with community development approaches to health needs assessment (Peckham and Spanton, 1994). The 'Principles for Action' of the 'Leeds Declaration' (Appendix VII) incorporate an endorsement of the expertise of lay people – and indeed are generally congruent with the salutogenic approach presented in this Report.

The felt needs in the community are clearly of central importance but the expression of these needs in a systematic way is dependent on the creation of opportunities which will facilitate the process. There has been recent interest in the use of Rapid Participatory Appraisal techniques, which consciously attempt to include all relevant groups and perspectives in the assessment of need (for example Ong et al., 1991; Murray and Graham, 1995; Murray et al., 1994).

The newly established Primary Care Groups are required by *'The New NHS'* to develop a multi-sectoral approach and to involve local people. Revealingly, Peckham (1998) notes that *'GPs, despite some heroic exceptions, are not known for their skills in collaboration or for their appreciation of the potential contribution of their patients'*.

The creative arts can be used in the context of needs assessment and have a valuable contribution to make. They 'put people in touch with their feelings' and enable them to express them in often graphic and moving ways. We noted in A2.3.7 the 'chilling' depiction of fear in the art work on health - something which may not have emerged using more conventional research methods and would certainly not have been communicated with such impact. By drawing on the imagination the arts allow people to

see how things might be rather than becoming inured to how they are. They also provide a forum for different agencies to work together and so additionally contribute to inter-sectoral collaboration. The empowering dimension of creative arts work may further enable individuals and communities to begin to take action themselves, once they have identified their own health needs.

B11 Communication and Education for Health

B11.1 *Definitions*

There is no universally agreed definition of communication – although it is unanimously agreed that effective communication is a universally good thing. It is, however, important - certainly for the purpose of this report – to differentiate between communication and education. In this section, therefore, health and patient education will be defined and, following earlier emphasis on empowerment, a simple model will be provided of the 'empowering consultation' between client and health professional.. This review will serve as a basis for locating the creative arts within health promotion generally.

B11.2 *Health Communication and Health Education*

Communication consists of the transmission of messages from a given source to an audience. The audience may comprise one or more individuals. Within the context of this case study, the source or communicator will frequently be a doctor or health professional and the audience a client or patient. It is not appropriate here to provide a detailed review of doctor-patient communication but it might be noted in passing that it is commonly ineffective and figures of 50% dissatisfaction with communication and failure to co-operate with medical advice are not unusual (Ley, 1990; Tuckett et al. 1985).

In the context of this report, it is also of particular importance to note that the communicator may equally be a lay person communicating with other lay people or with professionals. Indeed, as noted in Part A above, one of the more interesting developments in the Withymoor Village Surgery was its locally authored accounts of illness.

Whether the communicator be professional or lay, the communication process has certain common elements and Figure 5 below represents these schematically.

Figure 5: The Communication Process

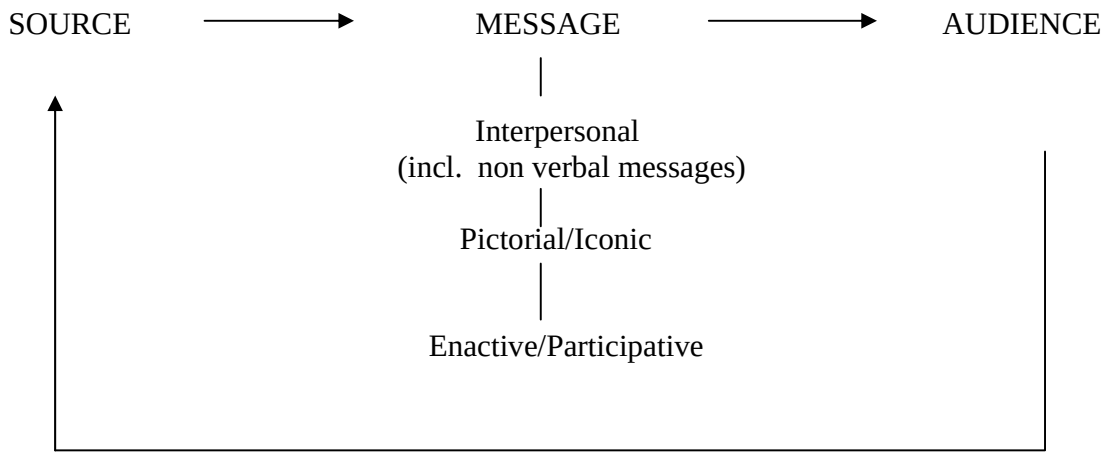


Figure 5 indicates that messages communicated to an audience may comprise both verbal messages and messages in 'iconic' (pictorial) formats; messages may also be communicated by an 'enactive' process involving active participation by the audience itself. Even when the communication is essentially verbal, it is always accompanied by non verbal cues and these may be more significant for the audience than the mere words. It will doubtless be apparent that there is an interface between the arts and iconic representations and, even more so, between the arts and active participation. The distinction will be drawn in section B 12 below between *creative* arts and, for example, the use of pictures as visual aids for communication. The importance of the 'feedback loop' should also be noted: communication cannot be successful unless communicators check the effectiveness of the process during and/or immediately after the interaction by asking questions or noting non-verbal reactions.

From the audience point of view, satisfactory communication has the following requirements:

- the message must reach the audience's senses
- the audience must pay attention
- the audience must correctly interpret the message

It could, with justification, be said that successful communication occurs when the audience's interpretation matches that of the source.

B11.3 *The Educational Process*

Unlike communication, successful education requires not just correct interpretation but also changes in various characteristics of the audience. In other words it requires *learning*. This assertion is best explained by defining health education. Health education involves learning related to health outcomes (*patient* education refers to health-related learning by people designated as patients – either by themselves or by professionals).

' Health education is any intentional activity which is designed to achieve health or illness related learning, i.e. some relatively permanent change in an individual's capability or disposition. Effective health education may, thus, produce changes in knowledge and understanding or ways of thinking; it may influence or clarify values; it may bring about some shift in belief or attitude; it my facilitate the acquisition of skills; it may even effect changes in behaviour or lifestyle.'
*(*Tones and Tilford ,1994)

The effective attainment of learning goals depends on the selection of the most appropriate educational methods, i.e. strategies and techniques that provide the conditions for learning in the most efficient way. A full discussion of educational methodology and pedagogical techniques is beyond the scope of this report. However some further reference will be made in Section B 12 when the educational role of creative arts will be

discussed. It should, perhaps, be noted here that the creative arts can be viewed not only as visual aids to communication but may also be functionally equivalent to other educational methods such as face-to-face counselling, group work and the use of simulation and games.

B11.4 *Education in School and Community*

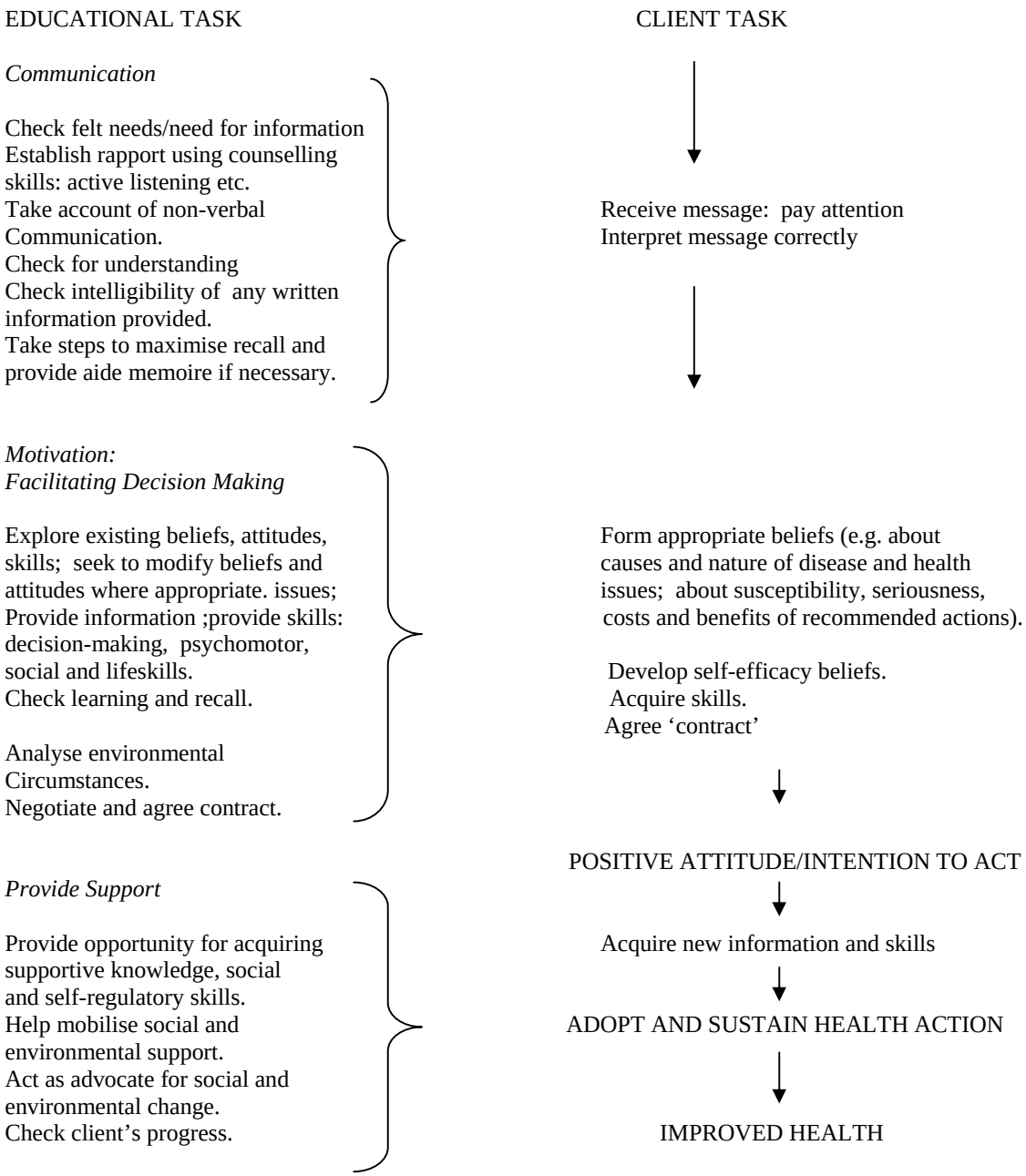
The 'Health Promoting School' is perhaps the most obvious setting for delivering health education - and reference was made earlier to the Withymoor Surgery's productive relationship with Thorns College. Many other settings can also be used and some of these were mentioned in Section 'A' when the contribution of Withymoor was discussed. The educational potential of the pharmacy has, for example, long been recognised and should be routinely included in a Healthy Living Centre or other coalition. One of the contacts made by Dr Rigler was with Lloyds Pharmacies and their 'Chat Centre' initiative in neighbouring Netherton provides a nice example of how a drop-in centre can provide advice and education as part of a broader 'empowering' community development programme. Withymoor's exploration of collaboration with museums is a further example of community based education – as was the attempt to launch a 'Science Literacy Group'. Again, one of the main agencies with which Withymoor had established links was the Community Education Development Centre (CEDC) in Coventry – itself an internationally recognised body specialising in the provision of community education both formally and informally. One of the more interesting proposals from the Withymoor coalition was the use of a network of PCs and a web site for the provision of education in a variety of settings - for example, surgeries, community centres – or indeed anywhere people gather. The implications of such a scheme is broader than the provision of readily accessible 'user-friendly' technology; it has the potential for contributing to social cohesion in a community by emphasising identity and co-operative links.

B11.5 *Health Promotion in the Surgery - the Empowering Consultation*

It is useful at this stage to provide a reminder of the distinction between health education and health promotion. Health promotion involves both education and supportive health policy – typically in the form of a supportive environment. Health education is essential to this process – both in relation to creating understanding of issues, providing personal competencies and influencing those beliefs and attitudes in relation to control , which contribute to self empowerment. As noted in the review of community empowerment, 'critical consciousness raising' is an educational strategy that is essential for generating healthy environments through 'building healthy public policy'. There are clearly limits to the possibilities of achieving this latter goal in the context of a face-to-face consultation between health professional and client. Nonetheless, some not insubstantial degree of empowerment is possible provided that the right methods are used. Indeed the adoption of client-centred consultations should be, not only a component within a broader coalition utilising creative arts and other techniques, it should be a *pre-requisite* for achieving salutogenic, empowering outcomes.

Figure 6 below (from Tones, 1998b) provides a summary of the features of a health promoting consultation involving not only education but attempts to provide a supportive environment that 'makes the healthy choice the easy choice'.

Figure 6 Health Promotion and the Consultation



B12 The Creative Arts in Primary Care

B12.1 *Definitions and Introduction*

Historically, it is possible to note a kind of general progression in the use of arts in the health field. Initially, the main focus of arts work appears to have been in the area of tertiary and secondary care – initiatives typified by art therapy. More recently, health personnel and artists have come to appreciate the value of using arts in *primary* care and in health promotion – both in relation to primary prevention and to the achievement of salutogenic goals. The beginning of Withymoor Village Surgery's major involvement in the arts in 1988 occurs, at an approximate point in time when this latter focus on primary care gathered pace. Indeed, it is likely that the Withymoor developments contributed in a not insignificant manner to this shift in emphasis in different parts of the country. This report is, self evidently, concerned with creative arts in primary care and – while acknowledging their importance - will make no reference to the secondary and tertiary arenas.

It is no simple matter to provide a precise definition of the creative arts nor to provide a precise categorisation of the plethora of health-related arts projects. It is, however, important to note that there are significant differences between projects – particularly in relation to the degree of creativity involved. Whatever other benefits are involved in the use of arts, the peculiar advantages of art work must centre on this imaginative, creative element. For example, Tom Heller, a GP having a substantial commitment to the arts in primary care, provides some indication of the special potential of creativity when he noted how:

'… the 'Art Works For Health project briefly sampled ways that health workers, individual people who are labelled as patients, and whole communities can use the range of art forms to connect with important things about (their) own lives: the core of

meaning about health … and possible ways to combat the harm that others do to us. It seemed to work for many of the people who had the courage to try to use some form of creativity to break through internal and external barriers. It was fun, but serious fun at that.' (Heller in McDonnell, u/d).

With regard to what should or should not be included within a taxonomy of the creative arts, it is our view that the mere use of imagery and pictures should be excluded. For instance, although mass media and properly selected audio visual aids are essential to properly designed health promotion programmes, their function is typically different from the use of creative arts. Observations were made in the previous section about the meaning of communication and education; mass media are best conceived as a strategic support for educational programmes and audio visual devices should be considered as learning resources within the context of a total programme. Clearly this does not mean that they may not include 'artistic' imagery; it does not mean they cannot be creative. However, the creative arts will be considered here as more specific *methods* that contribute in their own especially effective way to the achievement of important health related learning outcomes. As will be apparent from later comments, client involvement and participation are central to this 'special way'

As noted above, particular arts methods can vary in their degree of sophistication, depth and 'creativity'. For instance one of the 'Quick Ideas' described in McDonnell's (op.cit.) compilation of arts projects is designed ' …*to get more young single mums to come to a post natal drop in.'* The answer is to take photographs of the babies provided that the mums came to the centre. Accordingly a photographer was hired and mums were offered a free photograph. The outcome was considered to be cost effective – it increased attendance substantially. Moreover, this fairly simple procedure illustrates the multiple benefits to be gained from many arts ventures. Not only was attendance increased but the activity altered the whole ethos of the setting, creating fun and pleasure and, arguably, enhancing participation and client ownership of the 'clinic'. Clearly this simple venture cannot be compared in terms of creativity and sophistication with some of

the other projects mentioned elsewhere in this report. It is, however, very definitely not mass media nor does it operate as a visual aid as part of an educational programme – certainly not in the accepted sense of the term.

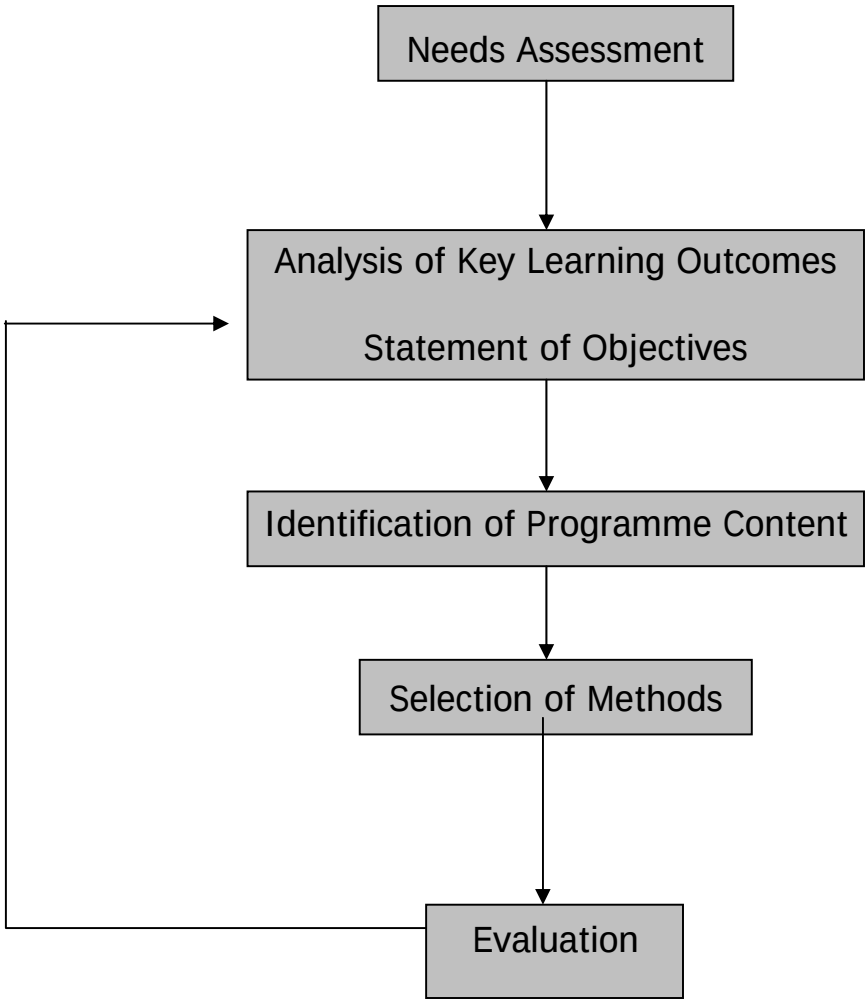
This particular section of the report will, then, provide a quite detailed analysis of how various types of creative art contribute to the achievement of learning outcomes. It will locate this function within a simple but systematic planning framework and emphasise the contribution to empowerment goals – both at individual and community levels. It will also comment on the arts contribution to the achievement of effective inter- sectoral collaboration and refer to the role of the artist in health promotion and primary care.

B12.2 *Health Promotion Planning and the Use of Creative Arts*

A comprehensive discussion of systematic programme planning is beyond the scope of this report. Suffice it to say that without such an approach, there is a risk of initiatives being intuitive and haphazard – and, perhaps more importantly within the present climate, of failing to provide convincing evidence of the undoubted successes that may be achieved. Figure 7 below presents an outline of a programme planning device. It is designed to be applicable to any programme whether it be community wide – perhaps within the collaborative context of a *Healthy Living Centre* or, less ambitiously, at the level of interaction between a doctors or other health workers and their clients or patients.

In brief, figure 7 urges the importance of performing a detailed and sensitive needs assessment prior to developing programme objectives. It is, not unreasonably, assumed that valued goals are more likely to be achieved efficiently if intended outcomes are precisely stated. Moreover, the more precise the statement, the easier it is to evaluate programme success. It should be noted that a statement of objectives does not preclude taking advantage of unforeseen opportunities during the encounters with clients nor does it preclude client participation in deciding objectives. Indeed an opportunistic, participative mind set should be a feature of health promotion!

Figure 7: Systematic Programme Design



Having carefully analysed the kinds of learning required by the educational encounter and developed precise objectives, it should be easier to determine the actual content of the encounter and, importantly for our discussion of the role of the creative arts, should

enable the health promoter to identify the most appropriate method. The creative arts – in part because of their multidimensionality – will frequently be the method of choice. Finally, for reasons which are doubtless obvious, the impact of the programme must be evaluated. Hopefully, the lessons learned will used to good effect and analysis of the relative effectiveness of programme content, methods used etc. should result in improvements in subsequent programmes. If a critical approach is adopted as a routine part of practice, it is both possible and desirable to change the ways in which the programme is provided and the very nature of the encounter as it progresses.

A more comprehensive discussion of the processes involved in systematic programme planning may be found in Tones (1998b, op.cit.; 1993b).

B12.3 *The Creative Arts in Needs Assessment.*

The general nature of needs assessment and its importance for effective programme planning has been discussed in Section B10. Both the literature and the experiences of those who have used creative arts in needs assessment testify impressively to their power and validity. Not only are people typically immersed in and engaged by the activities, but those activities seem to provide often moving insights into client needs in a way that other techniques fail to achieve.

Three further examples of the effective use of arts in needs assessment will be provided below.

Banners.

According to McDonnell (op.cit. page 9), an evaluation of a Celebratory Arts initiative in Airedale NHS Trust was the first conscious attempt to assess the use of the arts in health needs assessment. A major part of this 18 month project involved the production of banners in Arts Workshops. Participants were challenged to create a work of art which would also express something central to their feelings about their lives and health. The following needs were identified within the different settings of youth club and health centre:

- bored, angry teenagers – lots of energy, nothing to do – no future – graffiti and vandalism;
- depression – especially among young adult men – lack of work, no hope, no direction;
- older people – loneliness – worries about ill-health, housing and dying;
- health centre staff seem 'too busy', 'no time for patients' feelings' – reception un-welcoming – criticism of some doctors;
- housing needs for young adults in particular – shortage of affordable homes.

It will be apparent that these felt needs typically bear little relationship to the needs identified by more traditional epidemiological analysis – a point noted in earlier observations about the importance of rapid participatory appraisal. Again the multiple outcomes of creative arts work is demonstrated by this creative arts project. It reached its climax with a banner procession through the town and an exhibition in the town hall. The evaluation concluded:

'The production of works of art enabled people to express their views on their health and social status and needs as individuals and as members of a community. Clear messages were received for agencies to use as a basis for implementing findings into practice. In addition, broader strategic recommendations for planning and commissioning in North Yorkshire are to be forwarded to relevant agencies.'

(Authors' emphasis – with regard to possible implications for Primary Care Group commissioning procedures).

The Brothers Grinn

In 1993/4, Doncaster FHSA was concerned by the results of an *epidemiological* needs assessment that underlined an increasing trend in teenage pregnancies. It commissioned Doncaster Arts to explore the problem. A theatre process centred on local youth centres

was used to explore teenage needs, beliefs and attitudes. A theatre group, the 'Brothers Grinn', developed a serial style 'soap opera' on the issues. It played in three parts on consecutive nights. The audience was engaged in a debate that, according to workers, *'…..stimulated and entertained them – and profoundly affected their health.'*

In addition *to* exploring values, influencing beliefs and attitudes and affecting other forms of learning discussed below, important needs were identified:

- young people found existing sexual health literature boring and alienating;
- using the surgery clinic made them feel exposed and embarrassed in such tight knit communities;
- schools and medical centres did not liaise as a matter of course.

The results of this exercise included:

- institution of regular 'surgeries' for young adults at the youth club;
- a practice nurse and school nurse collaborated to promote the surgery services;
- sex education programmes were reviewed.

Smears and Statistics

The nature of the distinction between arts and other promotion techniques is revealed by the project described below which arose from concern about the low up-take of cervical cytology. The FHSA also commissioned Doncaster Arts for Health to undertake a study of the problem. An analysis was conducted of leaflets provided by local surgeries. Consumers were unimpressed by the leaflets and, *'… most staff had never read the leaflets.. and had no idea what they were like, or how accurate they were.'* The arts workers, in collaboration with health visitors, brought groups of women together to review leaflets, decide on improvements and involved them in the design of a new leaflet. A new leaflet was commissioned on the basis of the women's involvement and produced. The following points can be made:

- the process seemed to be very similar to the standard social marketing procedure using focus groups to test concepts and pre-test media materials;

- the activity led to a more generalised outcome in that , *'… a dialogue was opened up between the women and medical staff in which other issues related to their needs were aired… (it) subtly altered patient/staff relationship to the benefit of both….. good health is the outcome of partnership.'*

In short, it might be argued that this particular venture was not really an example of the use of creative arts and might just as well have been carried out by sensitive market researchers exploring client needs, developing prototype materials and basing the finished product on their reactions. On the other hand, it would have been a *true* example of creative arts had the clients actually produced the leaflet for themselves and for their peers - an approach described earlier in the context of Withymoor's writers and artists in residence.

It could, of course, be argued that such fine distinctions do not matter so long as the outcome is effective. However, as will be noted later, it is important to ensure that health promotion contributions should be provided by those whose skills, competence and credibility best fit them for a particular task. Accordingly, if the task is to produce leaflets or other media for a given purpose with a given audience, then workers having the necessary social marketing skills should be used. It is essential – in the interests of both efficiency and economy – that enthusiastic amateurs should be discouraged from re-inventing the wheel! As will be asserted later, there should be a limit to doctors' pretensions to be artists; on the other hand, there is no reason to use artists when other workers might be more knowledgeable and more skilled.

B12.4 *The Community Arts as Methods for Influencing Learning*

In Section B of this report, it was argued that it is useful to define health promotion as a synergistic interaction between health education and 'healthy public policy'. The emphasis in Figure 7 above is on education but it is important not to lose sight of the importance of policy development and implementation to provide a 'supportive

environment' for educational initiatives in order to 'make the healthy choice the easy choice'. Indeed an elaboration of Figure 7 would, necessarily, include a policy implementation pathway. It was also earlier emphasised in Section B 11 that education was more than communication. Education is concerned with the achievement of learning outcomes and creative arts should form an important part of the repertoire of methods and techniques designed to achieve those outcomes as efficiently as possible.

Discussions about the role of creative arts frequently contain illuminating comments about the functions and advantages of the arts in achieving various learning outcomes (though typically the term 'learning' is not used). These comments are frequently at the level of metaphor and often 'poetic'. For example reference has been made to the arts, 'crystallising metaphor' and assisting explanation. McNaghton (1998) cautions against ignoring more clinical considerations in general practice, but nonetheless observe that,

'Well-written plays, poems and novels can enhance our understanding of the human condition and deepen our sympathies towards those who suffer through it.'

Again, 'Arts on Prescription', the Campaign to Improve the Nation's Health (Nuffield Trust, 1998) notes that , '*… the benefits likely to arise from the use of the arts in complementing scientific and technological modes of diagnosis and treatment'* might include, inter alia, the following empowerment outcomes:

- patient empowerment through creative expression;
- growing confidence and self-reliance of individuals and communities.

Such observations are undoubtedly helpful, but the approach here is more in keeping with that of the educational psychologist and curriculum planner. Learning outcomes would include one or more of the following:

- knowledge and understanding;
- changes in beliefs and clarification of values;

- changes in attitudes and emotional states.

The important empowerment outcomes can be usefully operationalised in relation to:

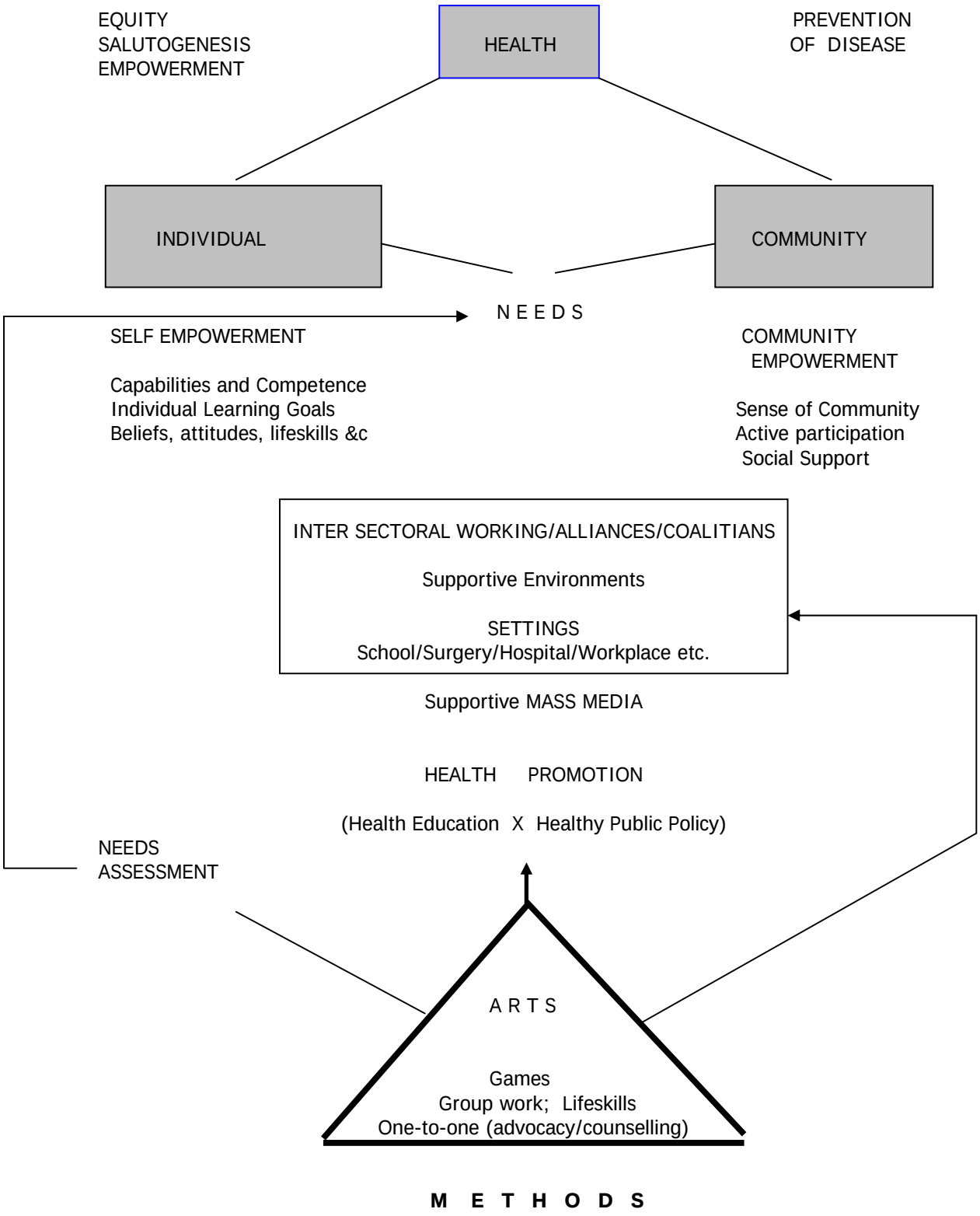
- particular 'salutogenic' beliefs and attitudes involved in achieving a 'sense of coherence';
- an appropriate level of self esteem;
- Possession of a series of 'life skills' or 'action competences' including creativity and imagination; assertiveness; IT skills; 'joke and storytelling skills'.

Health promotion already has at its disposal, a wide variety of tried and tested educational methods – in addition to 'class teaches'. These include for example:

- group discussion
- lifeskills training
- simulation and games
- theatre in education
- counselling.

They are routinely used in a number of contexts – for instance in *personal and social education* in the school curriculum and within the informal setting of community work. It is argued here that the creative arts are an integral part of these various methods and that each method or combination of methods should be selected according to the desired programme objectives and learning outcomes. Figure 8 below locates their contribution within the broader strategic planning process. (See also Appendix VI for a short taxonomy exemplifying the contribution of different arts projects to different learning outcomes).

Figure 8: The place of Creative Arts in Health Promotion



Moreover, it identifies the joint contribution of the creative arts and other methods to the achievement of health goals and makes the following points:

- it notes two broad categories of health goal. It identifies what was earlier called a salutogenic approach and compares this with a preventive 'medical model' of health;
- it emphasises the joint influences on health of individual and community empowerment;
- it depicts the contribution of arts (and other approaches) to individual and community needs assessment;
- it shows how the arts contribute to the establishment of inter-sectoral working.

These points will receive further elaboration below but first it is important to note the importance of using educational methods and the creative arts, more particularly, in achieving learning objectives by encouraging client participation.

B12.5 *The Importance of Participation*

It is generally recognised in education that participatory methods must be used to achieve certain learning outcomes. These include not only influencing values and emotional states but also the acquisition of skills of all kinds. The **creative** arts are, by definition, participatory and therefore enjoy a particular advantage when learning goals are of the kinds mentioned above. Earlier, we noted the important distinction between creative arts and audio visual aids. Consider, for instance, the difference between using a video as a teaching aid with clients and the clients themselves being involved in video production.

Joint Tales.

Art Works for Health describes an initiative stemming from a practice nurse who wished to create a support group for arthritis sufferers (McDonnell, op.cit.) . Twelve patients responded to an invitation to attend the surgery and one of the standard educational

methods – group discussion – was used to enable the patients to explore their condition and define their health needs. They viewed existing videos and decided to make their own. A film maker ran five sessions and the result was a thirty minute video entitled 'Joint Tales'. Apart from the opportunity provided to share experiences, this participative initiative achieved the over-riding health promotion goal of empowerment: after all, the group had acquired skills and created a valuable product. It would inevitably have enhanced their self esteem. Moreover, the resulting video had a special authenticity and could, therefore, be used with others suffering from the condition in the practice. The rationale of this particular project is, of course, the same as that underpinning the materials produced in Withymoor as a result of the work of the Writer in Residence. The theoretical basis for its effectiveness is well recognised and encapsulated in the term '*homophily*'. Briefly, this phenomenon refers to the way in which individuals are more likely to accept and be influenced by messages presented by people with whom they identify – i.e. people who are similar to themselves and who share their predicaments.

The Good Enough Parent.

Drama and Role Play are important participatory techniques and reference was made above to its use in needs assessment. The 'Good Enough Parent' project was instituted by Art Works for Health (McDonnell, op..cit.) . A surgery counsellor had observed how a number of single parents had experienced negative relationships with their own mothers which had apparently affected their capacity for parenting their own children – thus creating stress and unhappiness. Eight of these parents were provided with an opportunity to explore their feelings in workshops which used drama, role play and painting. The experiment was considered sufficiently successful to merit establishing a permanent support group using FHSA funding.

B12.6 *Creative Arts, Salutogenesis and Prevention*

As noted earlier, Figure 8 above contrasts a 'salutogenic model' of health with the more traditional medical model. Clearly, a major concern – and perhaps **the** major concern of

creative arts is the achievement of outcomes such as empowerment, the enhancement of self esteem and the creation of a sense of coherence.
However, the contention made earlier is that 'horizontal programmes' designed to achieve these outcomes are likely to be more effective in achieving preventive goals than more traditional 'vertical' programmes which concentrate on specific diseases or the use of particular preventive services. It would, nonetheless, be wrong to imply that all creative arts programmes adopt the broader holistic approach. There are, indeed, a considerable number of initiatives that focus on well recognised preventive objectives. The following project will serve as examples of this assertion.

The Denaby Main Dental Health Project.
Doncaster Arts worked with local schools to improve children's dental health. The following arts-related resources and activities were used:

- badges
- puppet making
- paintings
- 'Pop-Ups'
- videos and jingles (including creation of a short video)
- 'Quick Draw Stories'
- making toothbrush holders.

Like the Withymoor project on *Harold the Hedgehog* mentioned earlier, its primary focus was prevention. As has been noted earlier, the use of arts is characterised by multiple gains and in this project, as with *Harold the Hedgehog*, there were 'value-added' benefits for the participants. For instance, in addition to reducing the children's fear of dentists, a 'healthy alliance' between health services and school was created and this, in turn contributed to the establishment of a healthy eating policy in local schools. Again, by the creation of a dedicated display, parents were involved (and a crèche provided to facilitate this involvement). As will be observed below, any number of specific initiatives can serve as a starting point for the development of community participation –

itself, arguably, a more important outcome than the overtly stated preventive objectives. Although, clearly it was not possible to observe longer term effect on children's dentition, the achievements documented provide very real 'intermediate' indicators of success.

B12.7 ***The Creative Arts and Community Empowerment.***

Substantial emphasis has already been placed on the importance of community participation - both generally in relation to the mission of health promotion and, more specifically in respect of needs assessment. It is now opportune to consider the important role of creative arts in the process of community empowerment. Reference will be made first to the importance of creating community 'ownership' of health services and the need to make those services more user-friendly; secondly, we will consider the question of community coherence; finally, the role of creative arts in fostering 'an active participating community' will be addressed.

B12.7.1 *Reorienting Services: Power to the Client ?*

We reflected earlier on WHO's commitment to demedicalisation and the 'reorientation ' of health services in the interest of patient and community empowerment. One of the more common functions of the arts in health is to change the image and environment of health service premises in order to make them more attractive and, more importantly, to contribute to the process of demystification of medicine and to stimulate active participation through ownership.

In paragraph '12.1' above, a project was described which provided an opportunity for mothers to have their children's photographs taken as an incentive to persuade them to use the preventive services of the surgery. Although this is an interesting and inexpensive device to achieve standard preventive goals which doubtless contributes to making the surgery more attractive, community 'ownership' is not its main aim. By contrast, as was apparent from the case study in Part A, Withymoor made heavy use of

the arts to provide an attractive, stimulating and thought-provoking ambience that was part of a continuing general effort to gain community involvement. One further example is worth quoting from Celebratory Arts.

The Lampshade: Helping the Community Own the Surgery
The empowering rationale of this kind of project is stated succinctly as follows:

'Central to Celebratory Arts' work at Withymoor had been the challenge it offered to everyone's experience of the medical centre. The creation of decorations not only makes the waiting room more pleasant to be in, it subtly alters the way patients and staff see the surgery itself. It ceases to be the territory of experts and becomes a public space which can reflect the communities' own perceptions of themselves and their world.' (McDonnell, page 10).

The approach in Withymoor was followed by the making of a 'surgery lampshade' at the Laurie Pike Medical centre in Handsworth. The lampshade was decorated with a fabric paint and showed, '… *people of all ages dancing, skipping and flying around the central band, the words of Welcome, and a mother and child on the underpanel.'*

Clearly the lampshade is a mere device and, as reported in the Highbury and Islington Express of 31st October, 1997 under the headline, '*Surgery is cosm(et)ic, man'* , an artist, Tim Meacham, constructed a 100 foot circuit of water-filled plastic tubing looped around the waiting room ceiling. An electric pump propelled a toy figure on a two-minute journey around the tube. As one of the GP partners (unsurprisingly) observed, '*It makes people talk to each other. Kids actually want to come back to the doctor to see it.'*
Patients were duly impressed:

'It brightened up my visit to the normally boring environment of a waiting room'.

'Good idea, kept my son amused while waiting'.

- and less prosaically:

'He says he's a sailor with life jacket on. To me it symbolises someone going through life with all the ups and downs, quite a soothing effect.' (!)

Apart from its general positive impact *("I love the joyous spring of it !" said an elderly woman.)* , the venture triggered further community involvement. Local Asian shopkeepers were widely consulted about the most appropriate Hindi, Urdu and Punjabi translations for 'welcome'. Individuals thus consulted were apparently flattered to be involved – one small, but significant, contribution to the promotion of self esteem!

Again, following the Withymoor experience, it is not surprising that a lantern festival emerged. Its relevance for community empowerment will be discussed below.

B12.7.2 *Creating a Sense of Community: the Lantern Festival*

As noted earlier, a sense of community and social cohesion are important empowering/salutogenic goals. At first glance, a lantern festival involving a parade through the local community might seem to be an enjoyable and interesting piece of street entertainment but little else. It is worth providing a reminder at this point that such an event may be the first step in creating awareness in the locality outside the surgery that there **is** a neighbourhood. It might almost be described as a kind of anticipatory 'beating of the bounds'! A good deal of effort and groundwork will, of course, have been committed to lantern construction and the organisation of the event prior to the parade. The involvement of local people at this stage sets the scene for the later development of networks and norms that make up a true community. The preliminary phase may well identify the local opinion leaders who will take an active part in later community development.

As the Report 'Arts on Prescription' (Nuffield Trust, op.cit.) observes, the arts could and should be , *'… an essential aid in combating social exclusion'* and be a central feature in community development.

B12.7.3 *Critical Consciousness Raising: Creating Active Participation*

Durant's (op.cit.) report placed great emphasis on the empowering characteristics of the surgery , its value stance and its practices. Durant cites Malcolm Rigler as follows:

'We have seen people grow in confidence, make important decisions, get on better with their families, have more patience with their children, make friends, and grow as people, all because of the arts in the surgery.'

This sense of self empowerment was corroborated by some of the patients themselves, one of whom commented:

'I now tackle things I would never have thought of doing before. … it has made me stronger ..'

Another observed:

' …the sense of satisfaction that the arts work gave me, made me value me for the first time. This made me able to do things – only on a small front – like make decisions that I would've taken in my life, that before I had not control over. I haven't changed the world, but I'm doing little things for me, like writing to shops to complain, to the bus station about the lack of buses, things like that.'

The research in question, however, also provided some intimations of how, by working together, patients could achieve some degree at least of <u>community</u> empowerment. For instance, one of the interviewees who was a member of the primary health care team,

provided a rather nice interpretation of how patients could move towards a sense of community:

'The community must function properly. Ill-health occurs when people do not care for each other, do not work together. People feel better about themselves here in Brierly Hill since they feel wanted, that they are part of something, a belonging.'

However, as stated earlier, creating a sense of community is but one of the elements of community empowerment. The most important aspect is what WHO defined as an 'active participating community' – which, of necessity, must develop from the creation of networks and that shared purpose generated by the development of a sense of community. As noted earlier, Freire's (1974, op.cit.) notion of 'critical consciousness raising' is considered as an essential precursor to community action. In other words, in the health context, the community must become conscious of unhealthy situations and their socio-economic and environmental determinants. The creative arts are especially suited to generating awareness and the sense of indignation that might hopefully lead to action. Again referring to Durrant's work (op.cit.), a community health worker associated with the Withymoor surgery described her perception of the impact of consciousness raising on at least some of the patients:

'As they gain confidence in the sessions, they take this out onto the street, and this is seen in their daily lives. They feel they can apply for jobs they thought they never could have applied for, moved to better houses, taken on the council about the poll tax ore the water meters, or allowances. We have people here now who wouldn't think twice about making a banner and campaigning outside the Town Hall to save local amenities. It might be down to other things, but most of it I would say, with these people, would be due to the theatre group. It made them think again, it has made them believe in themselves.'

This view receives support from a patient's observations:

'We got in touch with very high up influential people … and I've really gone to town on them. It makes me stronger in that respect and I've got confidence.'

The Childhood Asthma Campaign initiated by Art Works for Health provides a good illustration of this process (McDonnell, op.cit. page 22). As noted earlier, asthma figured prominently in the discussion of the various arts activities undertaken by the Withymoor Village Surgery – including Desmond the Dragon! It was clearly one of the more ambitious and successful of these initiatives. However, the Art Works for Health project adopted a more radical advocacy stance and, in its own words, sought to generate 'patient power'. . As with the majority of arts projects a number of different objectives were targeted in the pursuit of three major goals:

- to campaign for a coherent and universally applied school's protocol on asthmatic children;
- to use the arts to create educational materials for the achievement of this;
- to build an alliance that would help focus on the disease and point up its socio-economic roots, and the need for strategic responses in all agencies.

A school nurse took a leading liaison role and enabled contact to be made with the local infants and junior school. Painting helped with the assessment of need: children painted images of their asthma attacks and facilitated discussion of the main issues. Using mural/montage work, a group image of the situation of asthmatics was created and this helped identify through words the attitudes they felt others had towards them – both peers and professionals. Theatre workshops explored images, feelings and ideas. A video session taught children – and parents – basic camera techniques. The result was production of what might best be described as an 'edutainment' video - 'Breathe *Eazy, Live!!'* The concerns expressed therein were an attempt to sum up the debate from the children's point of view and identify changes which they considered necessary. In addition, a child-friendly leaflet was developed.

Evaluation revealed benefits for both the surgery and the children themselves. More particularly, there was – according to the GP – a greater awareness and confidence in schools about medication (and a reduction in enquiries at the surgery). The children enjoyed and were proud of their work - thus acquiring value-added benefits of video production and other arts skills together with enhanced self esteem.

From the particular perspective of community empowerment, the greatest success was the implementation of 'healthy public policy': a new protocol was drafted for the school. The subject of childhood asthma reached the press both locally and nationally - and asthma education was included in the purchasing arrangements of Sheffield Health Authority.

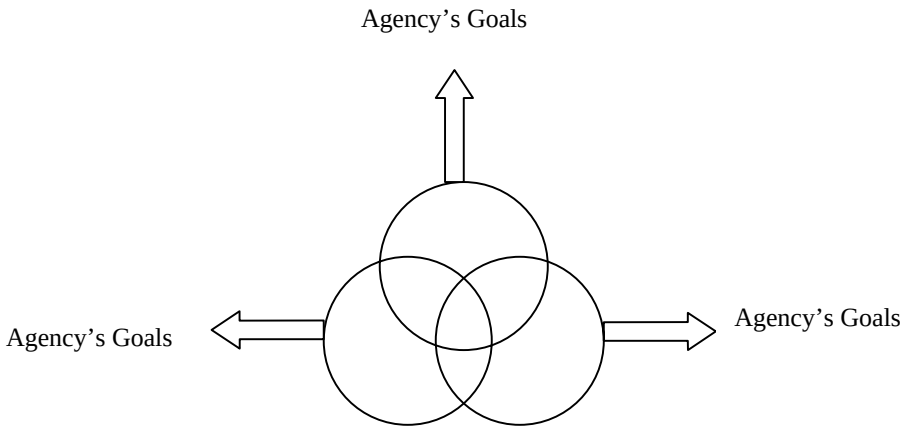
This project illustrates nicely the consciousness raising possibilities of creative arts for health promotion within the context of inters sectoral working. As part of the activities of a Health Action Zone it is not unrealistic to envisage its potential for influencing local policy in respect of remedying problems of damp housing.

B12.8 *The Arts and Inter-Sectoral Working*

We asserted earlier the importance of inter-sectoral working in order to maximise the impact of community wide health promotion programmes. Reference was also made to the involvement of Withymoor in seeking joint funding for the creation of a Healthy Living Centre – an arch example of a 'healthy alliance' and the importance of inter sectoral collaboration. Indeed it was suggested that the Withymoor Health Hive itself might be considered as a kind of proto healthy living centre! The problem of achieving effective 'joint working' was also reviewed and a number of suggestions were made for maximising the chances of success. One of the more important of these principles was the need to ensure that the benefits for all partners in the alliance were maximised and the costs were minimal. In short, it will hopefully have been apparent from the discussions above that one of the most productive features of the creative arts is the multiplicity of outcomes that can be generated from one series of activities. These outcomes will often

serve to provide the gains for a maximal number of partners, i.e. a classic ‘win-win’ situation. As Figure 9 demonstrates below.

Figure 9: The Creative Arts and Agency Goals



B12.9 ***The Role of the Artist***

The relevance of the role of the creative arts in primary care has, hopefully, been demonstrated above. A few further observations must be made about the role of the artist and the art co-ordinator. These relate to the issue of professionalism and the need for training and sustainability.

Professionalism vs Amateurism.

The research on which this report has been based supports the common sense observation that arts work should not be left in the hands of amateurs – however gifted. Apart from the need to ensure that work is of good quality, it should be self evident that would-be artists – whether they be doctors, nurses or community workers – must have some better contribution to make to community wide initiatives, such as Healthy Living Centres, namely those contributions which lie within their own professional sphere.

Furthermore, a lesson which has emerged strongly from this present research is that there is a real danger of 'adhocracy', i.e. short term , short lived initiatives which, like badly planned community development, may create initial interest and enthusiasm but which can leave participants disappointed and de-powered unless work can be sustained. This is, of course, not to deny the importance of *opportunistic* work, i.e. taking advantage of serendipity – *and building on it*! In the last analysis, the solution to adhocracy is to establish the funding mechanisms needed to commission and, where necessary, train artists for specialist work in the health field.

The Arts Co-ordinator

It follows logically and a fortiori from the remarks made above, that any collaborative Creative Arts venture needs a skilled arts co-ordinator. In the words of one respondent, the arts co-ordinator typically possesses not only artistic skills but community sensitivities paralleling those of the counsellor or community development worker together with a raft of organisational skills. Bearing in mind earlier observations about the role of community arts in inter-sectoral working, he or she might usefully operate alongside the lead agency in any community coalition Anticipating recommendations in Part C, it is perhaps useful to signal here the potential advantages to Primary Care Groups of commissioning arts residences.

McDonnell (op.cit.) lists a range of agencies which might not only be partners in a 'healthy alliance' but may also provide access to funding. In addition to the Health Service, they include: regional arts boards; National Lottery Arts for Everyone; arts and leisure departments in local authorities and other LEA agencies; WHO Healthy City Programme; charitable trusts and foundations; corporate sponsorships.

B12.10 *Evaluation*

Some evidence of effectiveness and indicators which might be used to judge the success of arts initiatives have been mentioned almost incidentally in this particular section. The evidence reviewed is strongly indicative that the arts have a major part to play in

achieving health gain – in respect of both salutogenic and preventive goals. The issues of evaluation will be discussed further in Part C.

PART C

LESSONS FROM WITHYMOOR

Implications for primary care

C1 Introduction

It will be apparent from the content of this report that the authors recognise the centrality of the salutogenic and empowerment approaches to health promotion discussed at length in Part B above. Indeed one of the main purposes of Part B has been to explicate the main features of what the authors have called a salutogenic and empowering approach to health promotion. These terms are, to some extent, used as a kind of shorthand to encapsulate the complex of current international developments in health promotion and the various recent government initiatives designed to bring to fruition the goals described in '*Our Healthier Nation'*. It is hoped that the report may thus facilitate health promotion in primary care by making explicit and operationalising what are complex and often confusing and contested concepts. This final section of the report will also seek to draw a number of conclusions and lessons which might assist the planning process. Lessons may be drawn for:

- individual general practices
- Primary Care Groups and other collaborative ventures
- health promotion generally.

By making more transparent and operationalising the concepts of salutogenesis, empowerment and related notions in the context of primary care, it is anticipated that the following benefits will ensue:

- assisting with the assessment of the feasibility of adopting similar approaches;
- demonstrating the relationship between the broader, holistic goals of the empowerment approach and the goals of preventive medicine;
- providing a framework to enable the identification of appropriate outcome and intermediate indicators which might be used in evaluation and the accumulation of empirical evidence;
- providing the theoretical understanding which might illuminate the ways in which innovative approaches, e.g. the creative arts, influence health related learning and behaviours.

C.2 Implications at the Practice Level

C2.1 *Consensus and Commitment*

It is important to recognise that many stresses and strains will arise in any organisation, regardless of size, involved in developing innovative - or even revolutionary –practices. The stress is likely to affect everyone in some way and in order to avoid adverse effects on individuals and working relationships, due attention should be given to securing maximum levels of commitment. At the *very* least, everyone must be kept informed. Ideally, consensus should be achieved through the well recognised democratic process of consultation. Within any consensus individuals will almost certainly differ in the degree to which they are committed. For instance, some may wish to take a lead in relation to an innovation, whereas others may prefer to continue as usual. However, if the consultation process accommodates a range of preferences, and both innovative and conventional roles are equally valued, then a high level of commitment is more likely. Key features of the consensus building process are summarised below:

- information sharing;
- consultation with all staff;
- ensuring that the 'vision' is at least understood if not actually shared by everyone;
- adopting democratic decision-making process which value all participants equally;
- making explicit a commitment to democratic principles by using such techniques as rotating leadership in accordance with the nature of the task in hand;
- provision of any necessary skills and competences;
- valuing the contribution of all members of the team equally.

It might be noted, incidentally, that consideration for the morale and welfare of all staff should be integral to a health promoting general practice. For both reasons, *team building* should be a routine part of the life of a practice.

Finally, it should be noted that successful projects do not depend solely on innovative and creative ideas, but also require, apparently more prosaic, yet invaluable, complementary practical organisational and implementation skills.

C2.2 *Innovation and the Core Values of Medical Practice*

There are those who consider there is tension between the innovative style of working described in this report and 'orthodox' medical practice. However, the theoretical analysis presented above demonstrates convincingly that this is a false dichotomy. Rather than detracting from the quality of care, empowering strategies that enable people to take control over their health and illness can result in significant improvement. The benefit accrues not only to individuals themselves, but also to the practice by reducing the number of inappropriate and unnecessary consultations. Nevertheless, practices seeking to develop an innovative portfolio of activities should ensure that due attention is paid to maintaining:

- quality of care
- continuity of care
- efficient administrative systems.

C2.3 *Funding*

Current funding arrangements for primary care are inappropriate for:

- community wide initiatives
- inter-sectoral work
- more salutogenic aspects of health promotion.

Because involvement in the type of innovative work described in this report may divert time and energy from generating income through conventional 'items of service', practices run the risk of severe financial difficulties. One solution is to seek additional

funding from outside sources. On the one hand this can be a lifeline and open up a range of new possibilities, on the other hand, there may also be negative consequences:

- practices may become locked into a cycle of repeated, time-consuming funding bids;
- short term, opportunistic modes of working rather than longer term, strategic planning.

Accordingly, if practices are to respond to the clear 'steer' from recent NHS policies, the allocation of funding to primary care will need to be more flexible – for example as provided by the PMS scheme.

C.2.4 *The PMS Scheme*

The principle attraction of the scheme is its flexibility, in relation to both financial management and organisational structure. For instance, it is clear that the PMS scheme effectively rescued WVS from major financial difficulties. Indeed, one of the benefits is that it releases practices from the 'core income and items of service' strait jacket. Again, WVS' incorporation into the Trust effectively gave it access to a more efficient management system and financial expertise. Staff are also now entitled to the Trust's Human Resource support services.

It could also be argued that the change in funding mechanism represents a move away from the fee-driven 'corner shop' mentality of general practice towards a more rational , objectives-driven approach – consistent with the move towards adopting a public health role.

There are, however, predictably certain associated costs - notably loss of autonomy and, therefore, the necessity to comply with bureaucratic requirements.

C.2.5 *Working Towards the New Public Health Agenda*

If practices are to contribute effectively to the new public health agenda they will need to consider how they develop mechanisms or ways of working which:

- identify and respond to the need s of the community
- involve communities
- work with other sectors
- address health promotion goals – both preventive and salutogenic.

Drawing on the WVS experience the Creative Arts have been shown to provide an effective means of addressing this broad remit.

C2.5.1 *Needs Assessment*

General Practice is a mine of information – potential and, in some instances, actual – about the health and health needs of the practice population. The increasing emphasis on the involvement of primary care in the commissioning process requires this rich source of data to be fully exploited. At the most basic level, efficient systems for collecting and collating data should be set up in each practice. However in order to gain a broader and more valid perspective, traditional epidemiological data must be supplemented by the wealth of lay knowledge available in the community and incorporate the 'felt needs' dimension. Creative Arts can usefully complement other approaches. Moreover the insights derived from the use of Creative Arts may communicate need in a graphic and powerful way.

C2.5.2 *Community Participation*

Community participation is essential to ensure both effective and ethical health promotion – and for re-focusing upstream. Generally speaking, primary care (although with some notable exceptions) has had a poor track record for involving communities. Greater awareness should be developed amongst GPs and other members of the primary

health care team of the range of possibilities for encouraging participation within the context of:

- the individual consultation
- the practice
- the practice population
- the local community.

At the very least GPs should routinely adopt the guidelines for an empowering consultation. The more ambitious might be encouraged to participate in fully -fledged community development programmes.

C2.5.3 *Working with Other Sectors*

The difficulty of inter-sectoral working has long been recognised. For instance the review of '*The Health of the Nation'* notes problems in inter-agency working between the health service and local authorities.

'Local Authorities, in general, despite feeling that they contributed more to the broader health agenda than Health Authorities, believed HOTN to be dominated by a disease-based and 'medically-led' approach.'

Target Issue 31 November 1998 (page 10)

Despite practical difficulties inter-sectoral working brings clear benefits:

- for the practice - a holistic collaborative response to the community's needs and increasing the number of individuals and agencies working towards health goals;
- for collaborators – increase in kudos and credibility from GP involvement;
- for both - opens up a wider range of funding opportunities by tapping into collaborating agencies' own funding networks.

Practices seeking to develop collaborative links might usefully take note of the ten factors known to enhance inter-sectoral working in B9.4 above. A key collaborator and useful

source of expertise in health promotion will be the local specialist Health Promotion Service.

A final cautionary note! In order to sustain working links after the first enthusiastic contact, it is essential that the contributions of all collaborators are fully acknowledged.

C2.5.4 *Addressing Health Promotion Goals*

There is clear evidence that health promotion brings a number of important advantages for both patients and for the practice:

- the patient – enhanced control over their health;
- the practice – more effective use of the surgery and a reduction in the burden of preventable disease.

It is, therefore, not surprising that the importance of general practice as a locus for health promotion has again received emphasis. A number of key points can be made:

- at the very least effective communication between health professional and patient is essential if the often demonstrated 50% non-cooperation rate is to be avoided;
- it is important to note that there is a major difference between communication and education;
- proper methods and learning resources should be used to achieve desired educational outcomes;
- client participation is essential to the attainment of many important learning goals , e.g. by means of ‘individually authored accounts’ of health, illness and recovery
- the Creative Arts can make an especially valuable contribution to achieving educational goals;
- health promotion involves more than education and the practice should seek to provide the kinds of environmental and social support needed to ‘make the healthy choice the easy choice’;

- a '*health promoting practice'* should provide a model of empowerment;
- links should be established with other agencies, such as the school, in order to maximise the impact of health promotion activities on the local community and practice population.

C3 Implications for PCGs and Commissioning

The newly established Primary Care Groups' role in commissioning provides an opportunity to respond more explicitly to the needs of the various practice populations – provided systems are in place to identify those needs. We noted earlier the plethora of 'routine' epidemiological data which could be collected at the practice level and which might be used to establish normative or comparative need. Enabling individuals to express their felt need is perhaps more problematic, but the use of creative arts has been shown to be a very effective device for both giving insight into this area and communicating it effectively to others – not least those involved in commissioning and planning services.

Once need has been identified there will clearly be a range of different possible solutions ranging from the more orthodox to the most innovative. The move indicated by *'The New NHS'* and *'Our Healthier Nation'* is towards the more innovative – for example community participation; building social capital; inter-sectoral working. In short – a more salutogenic approach. If PCGs are to embrace this type of approach, it would be helpful to ensure that a diversity of perspectives is represented in the structuring of the Groups. Furthermore they might broaden their focus by consciously including the perspective of a range of 'external agencies' with relevant specific expertise, such as community education and creative arts workers together with the more generic capability of specialist Health Promotion Units.

It should be noted that educated, empowered individuals and communities are likely to use services more appropriately and productively. The commissioning process should,

therefore, include not just conventional 'medical' services, but also have a more wide-ranging portfolio including educational and community building activities – both from within and outside primary care. Apart from the more obvious sources, e.g. *The Health Promoting School*, there are a number of cost–effective alternatives which can be used. Of particular note are the Creative Arts.

C4 Evidence-Based Practice

The commissioning process will patently need to draw on evidence of effectiveness and efficiency. In line with the current emphasis on empirical evidence, this case study provides some support for a more salutogenic approach to primary care and the use of Creative Arts as a means of achieving this. It is equally important to have a sound theoretical base and the purpose of Part B of this Report was to develop the theoretical underpinnings of the work at Withymoor.

C4.1 *Evaluation: Assessing Effectiveness and Efficiency*

Evaluation should be carried out routinely at all levels. At the very least, workers at the practice level should adopt the philosophy of the 'reflective practitioner' and actively seek evidence both to check that interventions have been effective and to use that evidence to enhance effectiveness.

Audit at the commissioning level will doubtless require more comprehensive and thorough appraisal. Proper audit is equally important for efficient working in the 'salutogenic/empowerment' domain as in routine medical practice. Key indicators should be developed.

C4.2 *Indicators*

A range of different outcome, intermediate and process indicators (see Tones and Tilford op. cit.) will need to be identified to provide a comprehensive account which fully

addresses the complexity of the salutogenic/ empowerment dynamic. Reference to the discussion in Part B will assist in the selection of appropriate indicators.

C5 Final Thoughts

It is clear that an increased focus on primary care and a shift in the commissioning process – especially if this is to have a major health promotion emphasis – is an innovation of dramatic proportions. It is salutary to note the following observation from the recent audit of *'The Health of the Nation'*.

'The researchers considered that HOTN did not make a serious impact upon primary care practitioners, and that GPs tended to focus on the health promotion aspects of their contracts alone, giving little priority to strategic action for health beyond this.'
Target Issue 31 November 1998 (page 10)

The Withymoor Village Surgery is unusual in its vision and approach. This vision and approach are peculiarly relevant to current concerns and developments. WVS can be seen as one of a small band of pathfinder practices. Conventional funding and administrative arrangements have not been conducive to such innovation and, indeed, could be a disincentive. Although the PMS scheme has been a step in the right direction, only a substantial review of funding policy and practice will facilitate integration of salutogenic work into the mainstream. Irrespective of funding, unless the philosophy and approach are incorporated into medical education and training change is unlikely.

Given the scale of the innovation, most practices would find emulating the 'Withymoor approach' a daunting task. Nonetheless partial adoption might appear more feasible – and even partial adoption could have major benefits for health. In short a 'softly, softly' approach is needed. As we have noted, WVS could be seen as a blueprint for the new Healthy Living Centre initiative and there is clearly much to be learned from

Withymoor's experience. Concern to disseminate this learning has been integral to its mission.

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Appendix I: Contacts made

Schedule of visits/meetings

21/7/98	Malcolm Rigler	GP	Withymoor Surgery
	John Thompson	Principal	Thorns School
	Basil Moss	Former Bishop	Birmingham
22/7/98	Lynda Lawley	Nurse Practitioner (on sabbatical)	Withymoor Surgery
11/8/98	Malcolm Rigler GP	Withymoor Surgery	
	Sue Preston	General Manager	Dudley Priority Health Community Primary Support Services
	Chris Williams	Practice Manager	Withymoor Surgery
	Kate Hill	Receptionist	Withymoor Surgery
	Dr. Martin	GP	Withymoor Surgery
12/8/98	Henry Foster	Chief Executive	Dudley Health Authority
	Dr. Russell	GP	formerly at Withymoor Surgery
15/9/98	Lindsay Newton	Adviser	Dudley Education Authority
	Liz O'Mara	Health Promotion Specialist	Dudley Health Promotion Service
	John Rennie	Consultant	CEDC
3/12/98	Paul Tromans	Pharmacist	Withymoor Pharmacy
	Mrs Smith	Health Visitor	attached to Withymoor Surgery
4/12/98	Brian Lamas	Head of Art Dept.	Earls High School
	Gloria Smith	Head of Art Dept.	Thorns School
	Rachel Knock	Drama Teacher	Thorns School

	Sam Parrish	Art Teacher	Thorns School
	Steven Burchill	Pupil	Thorns School
	Adam Cadman	Pupil	Thorns School
16/12/98	Laura Taggart	Freelance	Arts consultant

Contacts with members of the community during all visits via:

Pubs
Shops

Telephone interviews

Mike White	Assistant Director Arts	Gateshead Central Library
Sue Roberts	Director	Artservice
Dawn Spears	Practice Nurse	Withymoor Village Surgery

Requests for written comments

Sent to:-

David Anderson	Head of Education	V&A
Dr. Val Billingham		
Alison Blenkinsop	Director of Education and Research	University of Keele
Prof. G. Castledine	Faculty of Health and Community Care	U.C.E. in Birmingham
John Cooper	Head of Education	National Portrait Gallery
Amy Edwards	Health Promotion Division	Department of Health
James Friel		West Midlands Environment Network
Prof. J. Hitchen	Dean Faculty of Health and Community Care	U.C.E. in Birmingham
Karen Kirkman		West Midland Arts
Wendy Shillam	Architect	Shillam and Smith

Peter Stokes		Community Resource and Information Service
Rev. Dr. K. Wilson	Director of Research	Quenn's Birmingham
Rev. J. Woodward	Bishop's Adviser Health and Social Care	Diocese of Birmingham

The Authors would like to express their thanks to all those who kindly agreed to be interviewed and/or made written submissions. Their often eager co-operation made a major contribution to the quality of this case study.

Appendix II: Surgery Staff

Withymoor Village Surgey Staff

Medical Staff

General Practitioners

Joyce Martin	(5 sessions)
Malcolm Rigler	(5 sessions)
Pam Smith	(5 sessions)
Vacancy	(5 sessions)

Nurse Practitioner

Lynda Lawley	(9 hours)

Practice Nurses

Dawn Spears	(17 hours)
Elizabeth Beddows	(12 hours)

Health Visitor

Mrs. Smith

Administrative Staff

Practice Manager

Chris Williams

Receptionists

Carol Andrews
Susan Growcott
Kate Hill
Angela Hughes

Appendix III: List of endorsements

A selection of endorsements sent to the surgery includes letters from:-

David Anderson	Head of Education	V&A
Prof. P. Baelz	Moral Philosophy	University of Oxford
Dr. A. Blenkinsopp	Director Education and Research	Keele University
Sir K. Calman	Chief Medical Officer	Department of Health
Alex Carlile	Health Spokesman	Lib. Dem.Party
John Cooper	Head of Education	National Portrait Gallery
Prof. K.B. Critchlow	Director of Research	The Prince of Wales's Institute of Architecture
Prof. R. Downie	Prf. Moral Philosophy	University of Glasgow
Mark Fisher	Member of Parliament	
The Revd Dr A. E. Harvey	Sub-Dean	Westminster Abbey
Prof. J. Hitchen	Dean Faculty of Health and Community Care	U.C.E. in Birmingham
Dr. L. Smaje	Director	Wellcome Centre
Barbara Ward	Social Services Department	Dudley
The Rev. J. Woodward	Bishop's Adviser for Health and Social Care	Diocese of Birmingham
Dr. P. Wymer	Head Communication and Education	Wellcome Centre

Appendix IV: Objectives

The main objectives for the 3 year PMS pilot involving Withymoor Village Surgery are outlined in Dudley Priority Health NHS Trust's agreement with Dudley Health and include:

'To provide full personal medical service to the registered patient population of Withymoor Village Surgery developing the primary health care team of general medical practitioners, nurse practitioners and practice professional and administrative staff and fully involving community and educational resources.

To create a medical practice which operates within its environment as a learning organisation and which demonstrates how continuing professional education, local audit and research are valued as developmental tools.

To enable the practice to develop work and methods that assists the local community and take in a greater responsibility for its own health and consequently generates a more effective use of health resources to maximise the resources available to the practice through improved management.

The practice will become a focal point for developing patient information initiatives and will work with appropriate educational bodies to test the feasibility of education services in primary care. This will include piloting an open access point for information and providing patients with information appropriate to their needs as a follow up to clinical consultations. The project will aim to test ways of enabling patients to take more responsibility for their use of primary care, health services and be more informed about their medical condition, thus improving concordance.

The Trust will work with the practice to explore concerns about the low uptake by men of targeted and non-targeted services (e.g. men's health clinics) and to encourage men who are registered with the practice to take greater interest in their health.

The practice will work with various organisations to develop a programme of arts and health that will work to promote mental health amongst the practice population. Through this work the practice will pilot a local arts and health strategy that will be adapted as a pilot strategy for the Trust. This programme will also incorporate local volunteers to work in health and encouraging mental health through greater community and creative involvement amongst the local population.

The Trust will support the practice to work constructively within the framework of the local mental health unit, this will encourage referrals to the multi-disciplinary team within the local mental health unit and working closely with an established CPN.

The practice will identify factors which lead to poor health outcomes and stress on health facilities amongst the elderly population in the area. Initially this will be conducted as an audit of elderly admissions (e.g. patients over 60 who are admitted for more than 24 hours from a defined local area). The audit will be designed to indicate what additional local services may be necessary to reduce the number of admissions and to improve the outcome on discharge. The Trust will support the current practice initiative to create a social activities profile of all registered patients over 75 which can be used to facilitate arrangements on admission to hospital/nursing home and to support discharge planning.

The Trust and practice will work with the Authority to further develop quality standards for the delivery of personal medical services. '

Appendix V

Potential Contribution of Creative Arts to Health Gain

Selected Creative Arts	Possible Functions	Examples of Outcomes		Health Gain
		Intermediate	End Points	
Theatre • Drama • Role play • Cabaret *Ritual Celebrations* • Lantern procession *Arts Workshops* • Banners • Surgery décor • Writing *Media Creation* • Posters • Leaflets • Videos • Photos *Audio Visual/* *Communication Media* • Posters/leaflets &c • Internet/Multi- media	Needs Assessment Individual Empowerment Creating Alliances Community Development 'Building Healthy Public Policy' and Infrastructure	Identify Felt Needs// Community Profile Inter-sectoral working across settings Social Support A Supportive Environment	***Salutogenic:*** Self empowerment Sense of coherence Sense of community 'Active participating community' ' Social Capital' ***Preventive*** Risk reducing behaviours; 'Proper' use of services	Wellbeing/ Quality of Life Disease Reduction (1ry-3ry prevention of disease

Appendix VI

The Leeds Declaration

Principles for Action

- There is an urgent need to re-focus upstream, to move away from focusing predominately upon individual risks towards the social structures and processes within which ill-health originates.
- Research is needed to explore the factors which keep some people healthy despite their living in the most adverse circumstances.
- Lay people are experts and experts are lay people – lay knowledge about health needs, health service priorities and health outcomes should be central to public health research.
- The experimental model is an inadequate gold standard for guiding research into public health problems.
- A plurality of methods is required to address the multiple dimensions of public health problems.
- Not all health data can be represented in numbers – qualitative data have an important role to play in public health research.
- There is nothing inherently 'soft' about qualitative methods or 'hard' about quantitative methods – both require rigorous application in appropriate contexts and hard thinking about difficult problems.
- Openness to the value of different methods means an openness to the contribution of a variety of disciplines.
- Public health problems will only be solved through a commitment to the application of research findings to policy and practice.
- Research funding should address the new directions that follow from these principles.

[Nuffield Institute for Health, Leeds.]