PLYMOUTH CITY COUNCIL

Subject:	Final Public Health Transition Arrangements
Committee:	Cabinet
Date:	11 December 2012
Cabinet Member:	Councillor McDonald
CMT Member:	Carole Burgoyne (Director for People) and Debra Lapthorne (Joint Director of Public Health)
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Ref:	
Key Decision:	Yes
Part:	I

Purpose of the report:
The purpose of this report is to outline the final transfer arrangements of public health responsibilities to the Local Authority by April 2013, including the recommended model for transition with Shadow Form commencing January 2013, and recognition of the Chief Officer role for Public Health.

Key points outlined in this paper are as follows:
i. The role of public health, and the responsibilities of the Director of Public Health within Local Authorities.
ii. Local transition arrangements in place including human resources, risk management, finance and commissioning.
iii. Public Health model - options appraisal findings and recommendations.

As a result of the Health and Social Care Act 2012 and after nearly 40 years in the NHS, Public Health is returning 'home' to the Local Authority along with a new statutory Chief Officer for Public Health (the Director of Public Health (DPH)), a significant range of new statutory public health responsibilities, dedicated ring-fenced resources and an expert public health team.

It is not however the same 'public health'; specialist knowledge and skills have moved on since 1974 and the evidence base is much better. Neither is it the same local government; modern councils, such as Plymouth, look at their whole population and specific segments within it, and are as interested in the wellbeing of local people as commissioning services for them. Councillors and Officers are better prepared and equipped to handle the many pressures facing local government and the public has also changed, expecting far more responsive and personalised attention from their local councils.

From April 2013 Plymouth City Council will be a major player in shaping a comprehensive health system and the lead organisation for public health and well-being for Plymouth; there is now a real opportunity to

create an efficient and effective public health system geared to improving public health outcomes and general health and well-being for the population of Plymouth.

Transferring the majority of the NHS public health functions to the local authority presents us with a real opportunity in Plymouth to focus on the wider determinants of health as well as to 'join up' health and social care working and to improve health and well-being in our neighbourhoods and communities.

Change however also brings challenge and the structural reforms in the NHS will require the creation of even stronger relationships across an increasingly complex health and social care sector at a local level. The focus of these new relationships will be built via the local Health and Well-being Board (HWBB); the DPH, their specialist public health team and the new public health system for Plymouth will have a lead role in supporting the HWBB in its pivotal role of improving and protecting health for Plymouth.

A Glossary of Terms can be found in **Annexe A**.

Corporate Plan 2012-2015:

The formal transfer of key public health responsibilities to the Local Authority is expected to contribute significantly to addressing long term outcome measures to reduce health inequalities. These include reducing the gap in life expectancy, tackling child poverty and reducing the premature mortality rates in men. This will be achieved in line with the development and delivery of the upcoming Health and Wellbeing Strategy as part of the overall Plymouth Plan.

The public health transition is also expected to impact on the other priorities by shaping local services which influence wider determinants of health for example transport, economic development, housing, culture and leisure, education, environment and public protection.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

From April 2013 public health services will be funded by a new public health budget via Public Health England, separate from the budget managed through the NHS Commissioning Board (NHS CB) for healthcare, as a ring-fenced grant. This will ensure that investment in public health is ring-fenced and protected.

Two separate exercises have been conducted by the Department of Health (DH) to determine the baseline ring-fenced grant for Upper Tier and Unitary Authorities public health spend; an exercise to identify Plymouth PCT public health spend for 2010-11 was undertaken in summer 2011 and a further DH review of 2011/12 actuals and 12/13 budget spend per PCT in 2012.

The DH estimated calculation for Plymouth's PCT public health projected spend in 2012/13 was £10.713 million. The DH has developed an interim funding formula for public health via the Advisory Committee on Resource Allocation (ACRA); their interim recommendations are currently out for consultation. The ACRA interim recommendations projected an uplift of a ring-fenced grant allocation of £12.007 million for Plymouth. The final public health funding formula, along with the final public health grant allocations for 2013-14 will not be known until the end of December 2012 which does not prevent the consideration of where within the authority the Public Health Team is located as the cost of the service will have to be contained to the level of funding received.

The final public health funding formula, along with the final public health grant allocations for 2013-14 will not be known until the end of December 2012.

In the meantime financial 'due diligence' continues alongside building up potential shadow budget based on the PCT submissions and the current spending plans.

The list of employees who will transfer is still being prepared and will not be confirmed until final allocations of people to posts across the NHS area are known. An early indication is that 19 posts will transfer to Plymouth City Council: existing Plymouth City Council staff will not be affected by the transfer. The financial impacts of the final transition model selected have been identified as neutral.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety, Risk Management and Equality, Diversity and Community Cohesion:

1. A local Equality Impact Assessment is being undertaken and will be updated in line with new guidance.

2. The public health outcomes framework identifies two high-level outcomes to be achieved across the public health system as follows:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

These outcomes reflect a focus not only on how long people live but on how well they live at all stages of life. The second outcome focuses attention on reducing health inequalities between people, communities and areas. Both are essential to enable the city to effectively address areas of inequality, in particular health inequalities. The need to address such issues is also embedded within the draft child poverty strategy 2013-2016.

In general, there are significant opportunities to positively impact health inequalities through close alignment with delivery of the public health outcomes as integrated within the upcoming Health and Wellbeing Strategy.

3. A joint risk management register has been developed to identify the key areas of risk to be managed within and beyond the transition period. Significant risks identified continue to centre primarily on the final funding formula and implications of the final staff transfer arrangements. The risk register is included in Annexe H.

4. A Joint Communications Plan has been developed

Recommendations & Reasons for recommended action:

1. To agree the recommended model for the Office of the Director of Public Health to be placed within the People Directorate, operating in shadow form from January 2013. This model will enable the specialist Public Health team, under the direction of the Director for Public Health, to work across all Council Directorates and Departments.
2. When the final financial public health settlement and staff destinations are allocated by Public Health England to Plymouth City Council, final due diligence will be undertaken.
3. Further national guidance and/or statutory requirements, if released, will be taken into account and actioned as required.

Alternative options considered and reasons for recommended action:
A detailed options appraisal was undertaken to identify the best fit model for the transfer of public health responsibilities to the Local Authority. This can be found in Annex G.

Background papers:

Health and Social Care Act 2012

Public Health in Local Government (factsheets): December 2011

Sign off:

Fin	SA-PeopleF-AC1213005-15/11/2012	Leg	LT 16110	HR	BS	Corp Prop		IT		Strat Proc	
Originating SMT Member: Giles Perritt											
Have you consulted the Cabinet Member(s) named on the report? Yes											

1.0 Introduction

1.1 As a result of the Health and Social Care Act 2012 and after nearly 40 years in the NHS, Public Health is returning 'home' to the Local Authority along with a new statutory Chief Officer for Public Health (the Director of Public Health (DPH)), a significant range of new statutory public health responsibilities, dedicated ring-fenced resources and an expert public health team.

1.2 The new public health responsibilities for Plymouth City Council will complement the pre-existing and wide-ranging public health functions in the Council, for example the Public Health (Control of Disease) Act 1984 (as amended).

1.3 From April 2013 Plymouth City Council will be a major player in shaping a comprehensive health system and the lead organisation for public health and well-being for Plymouth; there is now a real opportunity to create an efficient and effective public health system geared to improving public health outcomes and general health and well-being for the population of Plymouth.

1.4 Transferring the majority of the NHS public health functions to the local authority presents us with a real opportunity in Plymouth to focus on the wider determinants of health as well as to 'join up' health and social care working and to improve health and well-being in our neighbourhoods and communities.

1.5 If Plymouth City Council is to become a health improving council all parts of the council will need to take into account their respective impact and responsibilities on population well-being and health.

1.6 Change however also brings challenge and the structural reforms in the NHS will require the creation of even stronger relationships across an increasingly complex health and social care sector at a local level. The focus of these new relationships will be built via the local Health and Well-being Board (HWBB); the DPH, their specialist public health team and the new public health system for Plymouth will have a lead role in supporting the HWBB in its pivotal role of improving and protecting health for Plymouth.

2.0 The new role of Public Health in Local Authorities.

2.1 Following the Health and Social Care Act (2012) the Department of Health has issued guidance on the new role of public health in Local Authorities and the role of the Director of Public Health (DPH).

2.2 From April 2013 Plymouth City Council will take on new mandatory responsibilities to improve the health of the population of Plymouth backed by a ring-fenced grant via Public Health England and the specialist public health team, led by the DPH. It is essential that such new responsibilities remain fully funded through a ring fenced grant. This would also allow for a continued focus on the promotion of health and wellbeing, moving towards a more preventative agenda which will contribute towards delaying the need for care and support.

2.3 This new public health role will also be complemented by the existing expertise within the council; the new statutory public health functions can be found in **Annexe B.**

3.0 How will Public Health help the Local Authority?

3.1 Public health professionals are accustomed to working at senior level in a range of national and local organisations, providing expert, objective and impartial advice to guide policy making, and overseeing implementation – an approach which should translate seamlessly to working at the heart of local government. Public Health will bring local authorities a range of skills and experience to complement existing strengths, and contribute to delivery both of their new public health responsibilities and other corporate priorities.

3.2 Public health professionals are used to working in partnership and leading across a range of different agencies from the public, private and voluntary sectors. Similarly they are used to liaising with other professionals and experts from a variety of disciplines and backgrounds, particularly within healthcare, to understand, interpret and apply technical material. This versatility is essential to effective delivery of public health, and could equally well be applied in support of other local authority functions.

3.3 By virtue of their professional accountability and expertise, public health professionals are able to communicate effectively and enjoy 'trusted status' among the public. Again this is crucial to effective delivery of public health, and could be harnessed in support of other local authority functions.

3.4 The new statutory **duty to improve health** presents local authorities with a range of opportunities: to develop new approaches to promoting health and well-being drawing on the local as well as the national evidence base; to exploit synergies across other areas of business; to better integrate all local public services; and to strengthen action at a community and neighbourhood level. Public health professionals can help in a number of ways to realise all of these.

- **Firstly by helping local authorities to understand their population**. Public health professionals will be able to work with existing intelligence resources to build a rich picture of the health and well-being needs and assets of local communities, and enable informed decisions about local priorities. They will be able to construct complex, evidence-based models of the potential impacts and costs of different options for improving health and well-being and enable informed decisions about the use of resources and disinvestment.
- **Secondly by shaping action**. Public health professionals will be able to contribute an expert perspective to support development of evidence-based and integrated strategies and services to improve health and well-being, working with local public service partners, businesses, the voluntary sector and communities themselves. This will enable local authorities to get the best value for money from the public health ring-fenced grant, to understand the impact of all of their decisions on health and to and optimise the impact of their full portfolio of services, as well as partner agencies and communities themselves on health and well-being.
- **Thirdly by mobilising communities**. Public health professionals will be able to support elected councillors and other local leaders to provide community leadership in relation to health for the populations they serve, to act as well informed and effective advocates on their behalf of their health, and to influence national and local policy development. Their advice will strengthen democratic accountability for health and enable councillors and officers to be well informed about health and health care when they engage with local communities.
- **Fourthly by ensuring accountability**. Public health professionals will be able to ensure that nationally mandated public health services and activities are appropriately tailored to local need whilst meeting the expectations of Public Health England. They will also be able to ensure that the impact of local strategies and services to improve health and well-being can be appropriately measured, including against those indicators which will form part of the Public Health Outcomes Framework.

- **Finally by reaping the rewards of success**. Health and well-being programmes done properly resonate positively with the public and are a good way to connect with local people. Public health professionals will be able to ensure that they are effective and well-received, and that local authorities are able to use this success to enhance their corporate reputation.

4.0 The Role of the Chief Officer for Public Health: the Director of Public Health.
The Department of Health published guidance (October 2012) which sets out the roles, responsibilities and context of the DPH. Part 1 of the guidance will be republished and updated in April 2013 under section 73A (7) of the NHS Act 2006 (inserted by section 30 of the Health and Social Care Act 2012) as guidance that local authorities must have regard to **(Annexe C)**.

4.1 The Director of Public Health will be the lead officer in the local authority for health, and a statutory Chief Officer. The DPH and their specialist public health team will support local political leadership in improving the health of communities and the population of Plymouth. The DPH, along with their specialist public health team, will champion health across the whole of the authority's business, promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed. How those statutory functions translate into everyday practice depends on a range factors that will be shaped by local needs and priorities for Plymouth and may change over time.

4.2 The DPH and their specialist public health team will be well placed to work alongside colleagues in the Council to tackle the wider determinants of health and to promote better health and wellbeing across the life-course, e.g. through early years services, education, culture, sports and leisure, spatial planning, transport, housing, economic development and regeneration. The DPH and their specialist public health team will also be involved with Council colleagues in promoting health-supporting behaviours across the full spectrum of interventions from health education and promotion in schools, workplaces and communities, to regulation for alcohol, tobacco, buildings and environmental protection. How the new statutory functions of public health translate into everyday practice depends on a range factors that will be shaped by local needs and priorities for Plymouth and may change over time.

4.3 Responsibilities of the Director of Public Health

- The DPH in Plymouth City Council will be the lead Officer for the new statutory public health responsibilities of the Council under the Health and Social Care Act 2012 and accompanying regulations and guidance **(Annexe D)**.
- The DPH's lead role for public health will enable the Council to significantly improve the health of the population, as measured by the Public Health Outcomes Framework.
- The DPH will support the Health and Wellbeing Board to discharge its responsibilities relating to the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.
- The DPH will have the lead role to build healthy public policy, to work with others to strengthen the community's ability to improve their own health and well-being and to inform and influence policy that will support a healthy local environment and culture.
- The DPH, and their specialist public health team, will have a lead role in the development of the Joint Strategic Needs Assessments and Joint Health and Wellbeing strategies and commission services accordingly in partnership with existing commissioning arrangements in the local authority.

- The DPH, and their specialist public health team, will have a lead role in the performance management and reporting of the Public Health Outcomes Framework **(Annexe E)**.
- The DPH and their specialist public health team will have a critical role in protecting the health of the population, both in terms of helping to prevent threats arising and in ensuring appropriate responses when things do go wrong.
- The DPH will provide public health guidance from the National Institute for Health and Clinical Excellence (NICE) to inform and influence local authority practice and will also draw upon evidence produced by the National School of Public Health Research.
- The DPH and their specialist public health team will participate in public health research and development activities for the benefit of Plymouth's population.
- The DPH will provide public healthcare advice (Core Offer) to the Clinical Commissioning Group.
- The DPH and their Specialist Public Health Team will liaise with public health teams in the Public Health England local units.

5.0 Local Transitional Arrangements

5.1 Human Resources

- The national position in respect of how the transfer of employees will be effected between the NHS ("sender organisation") and PCC ("receiver organisation") is that it should be undertaken in accordance with the requirements of the Transfer of Undertakings (Protection of Employment) Regulations 2006 often referred to as TUPE where this is appropriate. The transfer will be effected by way of Transfer Schemes or Orders and these will give explicit advice on the terms of the transfer. Plymouth City Council has confirmed that the requirements of the Cabinet Office Statement of Practice relating to Staff Transfers in the Public Sector will be given due regard during the transfer and this approach has also been confirmed by Devon and Torbay local authorities.
- Currently there is no confirmed final list of the roles and names of those transferring to PCC. This is now expected from the NHS around December 2012. The process of identifying and confirming the final destination of current NHS employees is currently on-going by NHS management and their HR departments. A recruitment protocol has been created with the intention of, for example, creating a flexible approach to recruitment options and avoiding the creation of on-going liabilities.
- As terms and conditions will transfer with employees details of these will need to be incorporated within the new payroll system and regular meetings are currently taking place with a payroll representative to ensure that systems are ready to effect a smooth transition.
- It has been agreed nationally between trade unions, LGA and NHS employers, the Department of Health, Department for Communities and Local Government and HM Treasury that NHS staff transferring to local authorities on 1st April 2013 will remain entitled to membership of the NHS Pension Scheme. Decisions on the provision of pensions for new starters and for staff who move between posts after 1 April 2013 are still the subject of further discussions. An update will be given in further reports.
- A joint communication plan has been developed to ensure that NHS Public Health and PCC employees are aware of the transfer and its implications. Part of the communication plan will include press management timescales.

- Lead representatives of Unison, Unite and GMB are regularly updated on progress in respect of the transfer and an invitation has been extended from the outset to the monthly workforce meeting in Newton Abbot so that joint discussion on various options can take place.

- Work has commenced on the induction programme that will be offered to all those who will transfer to Plymouth City Council on 1 April 2013. A detailed induction plan is also being scoped and an invitation offered to NHS employees likely to be transferring to contribute to this. Induction will also take place in respect of the co-location of health and PCC employees at Windsor House.

- The Faculty of Public Health requirements for on-going Continuing Professional Development that professionally qualified Public Health employees will require has been identified as a minimum of 50 CPD hours annually; those staff with clinical qualifications will have additional CPD requirements for clinical practice.

- Due diligence in respect of work force matters commences on 19 November 2012 with Devon County Council, Plymouth City Council and Torbay Council working together to identify any issues and concerns.

5.2 Finance

- As set out in Healthy Lives, Healthy People: Consultation on the funding and commissioning routes for public health from April 2013 public health services will be funded by a new public health budget via Public Health England, separate from the budget managed through the NHS Commissioning Board (NHS CB) for healthcare, as a ring-fenced grant. This will ensure that investment in public health is ring-fenced and protected.

- The total resource for all parts of the new health system for 2013 is £92 billion; of this £5.2 billion, or around 4% of total health spend, will be allocated to public health.

- Of the £5.2 billion expected to be allocated to public health £2.2 billion will be allocated to local authorities, £2.2 billion to the NHS CB, £220 million to Public Health England and £600 million to the Department of Health (DH).

- Two separate exercises have been conducted by the DH to determine the baseline ring-fenced grant for Upper Tier and Unitary Authorities public health spend; an exercise to identify Plymouth PCT public health spend for 2010-11 was undertaken in summer 2011 and a further DH review of 2011/12 actuals and 12/13 budget spend per PCT in 2012.

- The DH estimated calculation for Plymouth's PCT public health projected spend in 2012/13 was £10.713 million.

- The DH has developed an interim funding formula for public health via the Advisory Committee on Resource Allocation (ACRA); their interim recommendations are currently out for consultation.

- The ACRA interim recommendations projected an uplift of a ring-fenced grant allocation of £12.007 million for Plymouth; the final value however for 2013-14 will not be known until the end of December 2012.

- A health premium incentive (the element of non-mandated expenditure that is dependent upon the local authority making progress against certain public health indicators), will also be available however it is anticipated that the health premium incentive will not be a 'withheld sum' but more probably an added reward.

- The DH is planning to delay the first payments of the health premium until 2015-16, the third year of local authority responsibility for public health responsibilities.
- The final public health funding formula, developed by ACRA, along with the final public health grant allocations for 2013/14 will be published by the DH at the end of December 2012 at which point the level of funding will become clear. This does not prevent the consideration of where within the authority the Public Health Team is located as the cost of the service will have to be contained to the level of funding received.
- In the meantime financial 'due diligence' continues alongside building up potential shadow budget based on the PCT submissions and the current spending plans.
- The Department of Health has allocated £86,000 of public health transitional support funds to Plymouth City Council via the Primary Care Trust. This support is expected to contribute towards the transition costs for moving from one organisational form to another, including additional human resource capability, legal advice, estates (such as office moves and IT requirements) and project planning.

5.3 Commissioning

- From April 2013 the Local Authority will take on lead responsibility for commissioning public health services against its new responsibilities. Detailed mapping to identify which contracts are likely to transfer over to Plymouth City Council is on-going. To date, mapping has identified the following[1]:

Provider type	Approx number of contracts	Approximate total value	Examples of services
Voluntary and Community Sector	18	£3,095,352	Healthy lifestyles, drug and alcohol treatment, sexual health services
Primary Care Providers (GP's / Pharmacies)	12	£677,899	Smoking cessation, drug treatment, sexual health
Providers of NHS services (Plymouth Community Health Care Community Interest Company (CIC) / Plymouth NHS Hospitals Trust)	12	£5,000,001	Weight management, 5-19 services, sexual health services.

- Plymouth City Council is working with NHS Plymouth to identify which of these contracts will transfer to the responsibility of the Local Authority and the most appropriate mechanism for doing this.
- A number of transferring contracts will have clinical governance requirements not currently covered by local authority systems. Plymouth City Council is working together with NHS Plymouth to identify what needs to be in place to ensure all requirements are met by 1st April 2013.

[1] This does not currently include costs of staff expected to transfer to the Local Authority

5.4 Risk Management

A joint risk register has been developed and is monitored by the joint transition steering group. This can be found in **Annexe I**.

The NHS is due to issue the final draft of a model contract template by the end of December 2012 which will include indemnity provisions that cover the respective liabilities of the NHS and local authorities. At that stage the Council will be discussing the implications with its insurers to ensure that appropriate insurance protection is in place from 1st April 2013 to cover its new responsibilities.

6.0 Public Health Models Options Appraisal

6.1 The Public Health Transition Steering Group, co-chaired by Plymouth City Council and NHS Public Health Plymouth has undertaken a robust and detailed Options Appraisal of five potential organisational models of public health for the new Public Health responsibilities within the Plymouth City Council.

The five organisational models of public health assessed in the Options Appraisal[2] included:

I. A distinct Public Health Directorate in the local authority (often including additional local authority functions)

II. Public Health as part of the Chief Executive's Office function

III. Public Health as a distinct function within the People Directorate

IV. Public Health as a distinct function within the Place Directorate.

V. A 'distributed' model in which public health responsibilities and staff work across directorates or functions as a 'virtual team'.

6.2 These five options were informed by reviewing eight published case studies of good practice from Local Authorities that have integrated public health into their respective organisations. The eight case studies reviewed included: Coventry, Blackburn, Lincolnshire, Haringey, Salford, Wiltshire, Oxfordshire, and Kent local authorities.

6.3 A joint PCC and PCT Public Health workshop was held in August 2012 at which the strengths, weaknesses, threats and opportunities of the current local public health system for Plymouth were reviewed and the five public health models discussed.

6.4 The August 2012 workshop was followed-up with a detailed Options Appraisal of the five models and included wider involvement and discussions across NHS Public Health and PCC Teams; the findings of the Options Appraisal can be found in **Annexe F**.

6.5 All options were judged to have neutral financial impacts; however the delivery of new public health responsibilities is dependent on the publication of the public health ring-fenced grant and the funding formula; these are expected to be released by the Department of Health at the end of the calendar year.

[2] Following guidance from the Local Government Association and the Department of Health on broad categories for future public health delivery.

7.0 Public Health Models - Options Appraisal Findings

7.1 Option 1: Creating a Public Health Directorate. This is a very ambitious option and if it were adopted in its broadest sense it would have the greatest level of disruption to current PCC structures but could also deliver the greatest level of impact if public services were aligned.

- This option is a 'Strong Fit' for potential Public Health impact but a 'Weak Fit' for implementation and the significant structural change it would require to existing Council Directorates.

7.2 Option 2: Public Health within the Chief Executive's Office. This option potentially enables the Council to embrace Public Health with an ambitious vision as a corporate role; however this option could potentially limit public health to the current functions of the CEO Office.

- This option is a 'Good Fit' for potential Public Health impact and 'Fair Fit' for implementation but would still require organisational changes to the CEO Office function and structure.

7.3 Option 3: Public Health within the People Directorate. This option could work well for Plymouth City Council and public health if functions are organised within a suggested 'Office of the Director of Public Health'; the People Directorate already has strong and embedded links to Health, Joint Commissioning and reaching vulnerable populations as well as some of the wider determinants of health.

- This option is a 'Strong Fit' for potential Public Health impact for integrated health and social working and a 'Good Fit' for implementation if the 'Office of the Director of Public Health' is created within the People Directorate.

7.4 Option 4: Public Health within the Place Directorate. This option could work well for Plymouth City Council and public health if functions are organised within a suggested 'Office of the Director of Public Health'; there is a good fit between the current functions of Public Health and existing Directorate structures e.g. public protection services, transport, planning.

- This option is a 'Good Fit' for potential Public Health impact on the wider determinants of health and 'Good Fit' for implementation if the 'Office of the Director of Public Health' is created within the Place Directorate.

7.5 Option 5: A Distributed/Virtual Public Health Team. This is a high risk option for Plymouth City Council to take for delivering public health; there is a small Public health team which if dispersed into a virtual team will lose any impact and become diluted;

- This option is a 'Weak Fit' for potential Public Health impact and 'Weak Fit' for organisation implementation; it is therefore the least suitable option.

8.0 Public Health Model - Recommendations

8.1 Plymouth City Council's Corporate Plan (2012-15) sets the direction of travel for 'Open Plymouth' with a commitment to open government and greater access to and involvement in the decision making process. It is closely linked to the Co-operative Council concept and it will be important for Plymouth City Council's new public health function and responsibilities to be highly visible within the Council's structure and to be accessible to the people of Plymouth.

8.2 A highly visible public health function in Plymouth City Council could be delivered by having a distinct team through which all new public health responsibilities and duties for the Council would be discharged. The proposal is that this team be called 'Office of the Director of Public Health' as part of the People Directorate.

8.3 The ODPH would deliver its role for the health of the people in Plymouth by:

- Providing strategic leadership for improving health and well-being and working with partners to reduce the health inequalities that exist in and between neighbourhoods and communities.
- Ensuring that Local Public Health Intelligence data, analysis and evidence for the new public health functions across the Council is provided, i.e., for strategic leadership for health, developing health and wellbeing strategies and publishing Director of Public Health independent Annual Reports etc.
- Jointly identifying public health needs and using research and evidence of what works to improve the health of the whole population.
- Working with others to influence and address the social determinants of health.
- Working with colleagues to reduce the level of ill-health and reduce the number of deaths from preventable diseases.
- Advocating for the quality of life for all and ensure that the greatest improvement in quality of life is experienced by those who have the greatest public health needs.
- Protecting the whole population from hazards and threats to health arising from public health emergencies and being prepared and well equipped to respond to emerging threats to health.
- Ensuring the public receives the best value for money on public health by regularly reviewing the effectiveness of the ODPH Teams' business work-plan.
- Assuring that public health activity is safe, delivered to the highest standards and is led by a qualified and regulated public health workforce **(Annexe G)**.
- Being a Severn Deanery registered Public Health Training department and participating in the five year training programme for Speciality Registrars in Public Health.
- The National Guidance which informs the new public health responsibilities in local authorities can be found in **Annexe H.**

8.4 Based on current status of the transition, as outlined in section 4, it is recommended that public health responsibilities be transferred in shadow form from January 2013, in preparation of final transitional arrangements being in place by April 2013.

Annexe A: Glossary of Terms

AAC	Advisory Appointments Committee
ACRA	Advisory Committee on Resource Allocation
CEO	Chief Executives Office
CIC	Community Interest Company
CPD	Continuing Personal Development
DH	Department of Health
DPH	Director of Public Health
GMC	General Medical Council
GP	General Practitioner
HM Treasury	Her Majesty's Treasury
HPA	Health Protection Agency
HWBB	Health and Wellbeing Board
IT	Information Technology
LA	Local Authority
LGA	Local Government Association
NCMP	National Child Measurement Programme
NHS	National Health Service
NHS CB	National Health Service Commissioning Board
NICE	National Institute for Health and Clinical Excellence
ODPH	Office of the Director of Public Health
PCC	Plymouth City Council
PCT	Primary Care Trust
SW	South West
TB	Tuberculosis
TUPE	Transfer of Undertakings (Protection of Employment)

Annexe B: Statutory public health functions of local authorities under the Health and Social Care Act 2012

Pre-existing responsibilities

- Local Authorities (LA) will keep responsibility for their existing health protection functions, such as the Public Health (Control of Disease) Act 1984. (These do not form, part of the new statutory responsibilities of the DPH).

Health protection – Secretary of State responsibilities

- Section 11 of the Health and Social Care Act 2012 gives the Secretary of State the duty to take steps to protect the health of the people of England, and lists some examples of what those steps might include (based around the existing duties of the Health Protection Agency). Other sections transfer specific functions of the HPA to the Secretary of State (e.g. radiation protection and functions around biological substances).

Health improvement

- Section 12 gives each relevant LA a duty to take the steps it considers appropriate to improve (as distinct from the duty to protect) the health of the people in its area. This section also gives Secretary of State a power to take steps to improve the health of the people of England, and it gives examples of health improvement steps that either LAs or the Secretary of State could take.

Directors of public health

- Section 30 requires LAs, acting jointly with the Secretary of State to appoint a DPH. It gives that individual responsibility for the LA's new public health functions. This section also allows the Secretary of State to direct a LA to investigate the conduct of a DPH in relation to public health functions delegated from the Secretary of State, and to report back. A LA that wants to terminate the employment of a DPH must consult the Secretary of State before doing so.
- Under section 31 each DPH must produce (and their LA must publish) an independent annual report on the health of the local population.
- Schedule 5 of the Act amends the Local Government Act 1989 to add DsPH to a list of statutory chief officers.

Fluoridation

- Sections 35 - 37 set out new arrangements for consulting and making decisions on fluoridation schemes, which will become the responsibility of local authorities.

Other provisions

- Existing functions of PCTs in relation to dental public health (set out in regulations) will transfer to LAs (section 29).
- LAs will have a duty to co-operate with the prison service with a view to improving the exercise of functions in relation to securing and maintaining the health of prisoners (section 29).
- LAs will have a duty to co-operate with the police, the prison service and the probation service to assess the risk posed by violent or sexual offenders (section 31).

- Existing SoS responsibilities for the medical inspection and treatment and the weighing and measuring of school children are transferred to LAs (section 17).

Regulations

- Under section 18 the Secretary of State can use regulations to delegate his health protection duties to local authorities or to require LAs to undertake their health improvement duties in particular ways, and the DH has announced which services it intends to mandate.
- The DH is also proposing to make regulations setting out:
- when LAs can charge for activity under their new duties (section 50),
- the process for consultation by LAs on fluoridation of water supplies (sections 35 – 37),
- the sharing of data on births and deaths (sections 284 – 287),
- updates to the DsPH statutory responsibilities to match LAs' evolving public health role (e.g. acting as responsible authorities for licensing applications, under the Licensing Act 2003).

Guidance

- Under section 31 the Secretary of State can issue guidance that local authorities must have regard to ('statutory' guidance). Guidance can cover LAs' public health functions or the role and status of DsPH and other specialist public health staff.

Mandatory functions for local authorities

- The intention is to prescribe that all local authorities provide the following services to their local populations as part of their new public health responsibilities: child measurement programme, NHS health check, open access and confidential sexual health services, healthcare public health advice to NHS commissioners and steps to protect the health of their local populations.
- In practice, this will be arranged through Clause 14 of the Health and Social Care Act 2012, which inserts a new section of 6C of the NHS Act 2006 conferring powers to prescribe certain steps which local authorities must take.
- The first draft of the Regulations has been completed. Following legal checks and HA clearance, the Regulations will be laid in Parliament in November 2012. The planned coming into force date is 1st April 2013.

Health Protection

- On 1st September, 2012, Public Health Policy and Strategy Unit published a factsheet on health protection arrangements post April 2013 for local authorities. This document was developed in consultation with the Local Government Association, Health Protection Agency, the Faculty of Public Health, Association of Directors of Public Health and others. This document describes provisional arrangements for prevention and response to health protection incidents and outbreaks within the new public health system, focusing on those that do not require mobilisation of a multi- agency response under the Civil Contingencies Act 2004.
- This document also gives further details about the nature of the local authorities' planned new duty to protect the health of their populations, subject to regulations to be made under section 6C of the National Health Service Act 2006 ("NHS Act 2006") (as inserted by section 18 of the Health and

Social Care Act 2012) which will come into force in or before April 2013. This document is subject to further review in early 2013.

Annexe C: Directors of Public Health in Local Government

Directors of Public Health in Local Government

i) Roles, responsibilities and context

Prepared by the Public Health England Transition Team

Part 1 of this guidance will be republished and updated in April 2013 under section 73A(7) of the NHS Act 2006 (inserted by section 30 of the Health and Social Care Act 2012) as guidance that local authorities must have regard to.

1. Introduction

1.1 Public health practice made huge strides during the 20th century, transforming the living standards of millions and saving countless lives in the process. Yet real threats still linger and new ones emerge. Dealing with the avoidable mortality caused by, say, smoking or obesity as conclusively as cholera and typhoid were dealt with requires different ways of thinking and acting.

1.2 The 2010 white paper Healthy Lives, Healthy People set out an ambitious vision for public health in the 21st century, based on an innovative and dynamic approach to protecting and improving the health of everyone in England. The test that the white paper sets is clear – we will have succeeded only when we as a nation are living longer, healthier lives and have narrowed the persistent inequalities in health between rich and poor.

1.3 As the white paper proposed, and after a gap of almost 40 years, the Health and Social Care Act 2012 returned a leading public health role to local government. With it comes a sizeable proportion of the responsibility for rising to these challenges. In April 2013 unitary and upper tier authorities take over a raft of vital public health activity, ranging from cancer prevention and tackling obesity to drug misuse and sexual health services. Just as significantly, the reformed public health system gives local authorities an unprecedented opportunity to take a far more strategic role. They can now promote public health through the full range of their business and become an influential source of trusted advice for their populations, the local NHS and everyone whose activity might affect, or be affected by, the health of the people in their area.

1.4 Local government is ready, willing and able to take this on. To support it, every local authority with new public health responsibilities will employ a specialist director of public health (DPH) – appointed jointly with the Secretary of State for Health – who will be accountable for the delivery of their authority's duties. The post is an important and senior one. The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health.

1.5 Local authorities must take the action to improve public health that they decide is appropriate – it is not the job of central government to look over their shoulders and offer unnecessary advice.

Nevertheless, the statutory basis of the DPH role, its transfer to local government and the involvement of the Secretary of State mean that there is value in clear, informative guidance that establishes a shared understanding of how this vital component of the reformed system should work. This guidance is issued in that spirit.

1.6 It describes both the statutory and non-statutory elements of the DPH function, and sets out principles critical to their appointment, to delivery of an effective public health strategy and to other aspects of their relationship with their employer and the Secretary of State.

2. The role of the director of public health

2.1 The most fundamental duties of a DPH are set out in law and are described in the next section. How those statutory functions translate into everyday practice depends on a range factors that will be shaped by local needs and priorities from area to area and over time.

2.2 Nevertheless, there are some aspects of the role that define it in a more complete way than the legislation can, and that should be shared across the entire DPH community. All DsPH should:

- be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and concerns around access to health services
- know how to improve the population's health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that reduce inequalities in health
- provide the public with expert, objective advice on health matters
- be able to promote action across the life course, working together with local authority colleagues such as the director of children's services and the director of adult social services, and with NHS colleagues
- work though local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health
- work with local criminal justice partners and police and crime commissioners to promote safer communities
- work with wider civil society to engage local partners in fostering improved health and wellbeing.

2.3 Within their local authority, DsPH also need to be able to:

- be an active member of the health and wellbeing board, advising on and contributing to the development of joint strategic needs assessments and joint health and wellbeing strategies, and commission appropriate services accordingly
- take responsibility for the management of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money

- play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board
- contribute to and influence the work of NHS commissioners, ensuring a whole system approach across the public sector.

3. Statutory functions of the director of public health

3.1 A number of the DPH's specific responsibilities and duties arise directly from Acts of Parliament – mainly the NHS Act 2006 and the Health and Social Care Act 2012 – and related regulations. Some of these duties are closely defined but most allow for local discretion in how they are delivered. This section summarises and explains the main legal provisions in effect from April 2013.

3.2 In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the annual report on the health of the local population – the DPH has a duty to write a report, whereas the authority's duty is to publish it (section 73B(5) & (6) of the 2006 Act, inserted by section 31 of the 2012 Act).

3.3 Otherwise section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, gives the DPH responsibility for:

- all of their local authority's duties to take steps to improve public health
- any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations – these include services mandated by regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act
- exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health
- their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders
- such other public health functions as the Secretary of State specifies in regulations (more on this below).

3.4 As well as those core functions, the Acts and regulations give DsPH some more specific responsibilities from April 2013:

- through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department intends to confirm that DsPH will be responsible for their local authority's public health response as a responsible authority under the Licensing Act
- 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and
- 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act);
    - if the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1)

will also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended)

- DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

4. Other relevant statutory provisions

4.1 The 2012 Act makes a number of other provisions that take effect from April 2013 and are directly relevant to DsPH. DsPH are made statutory chief officers of their local authority, and therefore holders of politically restricted posts, by section 2(6)(zb) of the Local Government and Housing Act 1989, inserted by Schedule 5 of the 2012 Act.

4.2 Under section 73A of the 2006 Act, inserted by section 30 of the 2012 Act:

- DsPH must be appointed jointly by their local authority and the Secretary of State (in practice Public Health England), although their subsequent employment relationship is with the local authority exclusively. There is more detail below on how the joint appointment process should work, and further information on best practice will be available is set out in part 2 of this guidance if the Secretary of State believes that a DPH is not properly carrying out any Secretary of State function that has been delegated to the local authority s/he can direct the authority to review the DPH's performance, to consider taking particular steps, and to report back. This power does not extend to the DPH's performance of the local authority's own health improvement duties as local authority must consult the Secretary of State before dismissing its DPH. The authority may still suspend its DPH from duty (following its standard rules and procedures) and the Secretary of State cannot veto its final decision on dismissal. An authority proposing dismissal for any reason should contact Public Health England for advice on how to proceed with the consultation. Public Health England will normally provide the Secretary of State's formal response within a maximum of 28 days.

5. Corporate and professional accountability

5.1 The DPH is an officer of their local authority and shares the same kind of corporate duties and responsibilities as other senior staff. To discharge their responsibility to their authority and deliver real improvements in local health the DPH needs both an overview of the authority's activity and the necessary degree of influence over it.

5.2 This may or may not mean that the DPH is a standing member of their local authority's most senior corporate management team. That should be determined locally, not least because the scope of the DPH role can also vary locally – for instance, where it is agreed that a DPH's role will extend beyond its core statutory responsibilities.

5.3 However, it does mean that there should be direct accountability between the DPH and the local authority chief executive for the exercise of the local authority's public health responsibilities, and direct access to elected members.

5.4 DsPH should also have full access to the papers and other information that they need to inform and support their activity, and day to day responsibility for their authority's public health budget – although formal accountability will rest with the authority's accounting officer (usually the chief executive).

Professional accountability, regulation and registration

5.5 Medical and dental public health consultants are regulated by the General Medical Council or the General Dental Council. Nurse, health visitor and midwife public health consultants are regulated by the Nursing and Midwifery Council. All public health consultants can also register with the voluntary UK Public Health Register.

5.6 To assure themselves of the continuing competence of their DPH, local authorities should ensure that s/he:

- undertakes a Faculty of Public Health continuing professional development programme
- maintains a portfolio of training that demonstrates competence with all aspects of public health accepted by the UK Public Health Register.

Revalidation

5.7 Medical revalidation is the process by which licensed doctors, including medical DsPH, regularly demonstrate that their skills are up to date and that they are fit to practise. Responsible officers in Great Britain (see below) make fitness to practice recommendations to the General Medical Council in respect of individual doctors. The Nursing and Midwifery Council has an equivalent process for nursing revalidation, and the UK Public Health Register is also establishing a revalidation process for its members.

Professional appraisal and continuing professional development

5.8 Continuing professional development (CPD) is an essential feature of the revalidation process for public health specialists. The overall aim of CPD is to ensure that those who work in the field develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving the health of the population. Local authorities should consider how best to meet these aims in respect of their DPH.

5.9 CPD is a professional obligation for all public health professionals and protected time for CPD is a contractual entitlement for directors transferring into local government on medical and dental contracts. In order to comply with the Faculty of Public Health's minimum standards for CPD all Faculty members must either submit a satisfactory CPD return annually or have been formally exempted by the Faculty from this requirement.

5.10 The UK Public Health Register expects all its registrants to participate in CPD, preferably as part of a formal scheme such as those operated by the Faculty of Public Health, the Chartered Institute of Environmental Health or the General Pharmaceutical Council.

5.11 For medical consultants subject to the General Medical Council revalidation process there is a requirement for annual medical appraisal to be undertaken as an integral part of the revalidation process. Local authorities should reassure themselves that they are in a position to deliver this requirement.

The role of responsible officers in relation to the director of public health

5.12 Responsible officers help to evaluate doctors' fitness and monitor their conduct and performance. The role of the responsible officer is to support doctors in maintaining and improving the quality of care they deliver, and to protect patients in those cases where doctors fall below the high standards set for them. Responsible officers are licensed doctors themselves, and as such must have their own responsible officer.

5.13 The Responsible Officer Regulations came into force on 1 January 2011 and apply to medically qualified DsPH. The regulations designate those bodies that are required to nominate or appoint a responsible officer for the purposes of medical revalidation – this includes local authorities that employ medically qualified staff. For those DsPH who are not medically qualified, arrangements should be in place for supporting the individual's professional practice through appropriate networks. Similarly, alternative arrangements should be made for any medically qualified members of the public health team who work under an non-medically qualified DPH.

5.14 Proposals on the responsible officer role in relation to local authorities and public health have been consulted on. The consultation responses are now being considered and the outcome will be reflected in draft regulations that will be published shortly.

6. Appointing directors of public health

6.1 From 2013 the Secretary of State for Health (and therefore Public Health England, which acts on the Secretary of State's behalf) has two general duties that apply to the joint appointment process:

- to promote the comprehensive health service (section 1 of the NHS Act 2006, as amended by section 1 of the 2012 Act)
- to promote local autonomy so far as that is compatible with the interests of the comprehensive health service (section 1D of the 2006 Act, inserted by section 5 of the 2012 Act).

6.2 Local authorities undertaking public health duties conferred on them by the 2012 Act are part of the comprehensive health service. This means that the Secretary of State may not normally intervene in decisions about matters such as the role or position within local authorities of DsPH, but must intervene - and ultimately may refuse to agree a joint appointment - if s/he has reason to believe that anything about an authority's proposals for the appointment of a DPH would be detrimental to the interests of the local health service.

Requirements for director of public health appointments

6.3 Local authorities recruiting a DPH should:

- design a job description that includes specialist public health leadership and an appropriate span of responsibility for improving and protecting health, advising on health services and ensuring that the impact on health is considered in the development and implementation of all policies
- make every effort to agree the job description with the Faculty of Public Health and the Public Health England regional director, ensuring in particular that it covers all the necessary areas of professional and technical competence
- manage the recruitment and selection process and set up an advisory appointments committee to make recommendations on the appointment to the leader of the local authority.

6.4 The advisory appointments committee should be chaired by a lay member, such as an elected member of the local authority (the cabinet member of the health and wellbeing board, for example). It should also normally include:

- an external professional assessor, appointed after consultation with the Faculty of Public Health
- the chief executive or other head of paid service of the appointing local authority (or their nominated deputy)
- senior local NHS representation
- the Public Health England regional director, or another senior professionally qualified member of Public Health England acting on his or her behalf
- in the case of appointments to posts which have teaching or research commitments, a professional member nominated after consultation with the relevant university.

The role of the Secretary of State and Public Health England

6.5 The relationship of the Secretary of State and the local authority in the joint appointment process is one of equals. The role of the Secretary of State is to provide additional assurance of the DPH's competency. Public Health England will advise the Secretary of State on whether:

- the recruitment and selection processes were robust
- the local authority's preferred candidate has the necessary technical, professional and strategic leadership skills and experience to perform the role - proven by their specialist competence, qualifications and professional registration.

6.6 In order to provide this assurance for the Secretary of State, Public Health England will:

- agree with the local authority and the Faculty of Public Health a job description that fits with the responsibilities of the DPH and sets out the necessary technical and professional skills required
- offer advice in relation to the recruitment and selection process, including the appointment of Faculty of Public Health assessors
- participate in the local advisory appointment committee
- confirm to the local authority the Secretary of State's agreement to the appointment.

6.7 Public Health England regional directors will work with local authorities in any area where there is a DPH vacancy to ensure a robust and transparent appointment process is established and a timescale for recruitment and appointment agreed. This should be completed within three months of a post becoming vacant.

6.8 If the regional director has concerns about the process or their involvement in it, s/he will seek to resolve these through negotiation with the local authority. They will be able to draw upon advice and dispute resolution support if it is required. It is important that the interaction between the regional director and the local authority is based on dialogue, collaboration and agreement.

6.9 The local authority has the primary role in recruiting people who will be under contract to it. However, there are clear joint considerations in processes for appointing a DPH. If, at the end of this procedure, the Secretary of State is not satisfied that an appropriate recruitment process has taken place and that the local authority preferred candidate has the necessary skills for the role, s/he will write to the lead member and chief executive of the council setting out in full the reasons for not agreeing the appointment and proposing steps to resolve the situation.

Annexe D: The Public Health Responsibilities of the Office of the Director of Public Health from April 2013

The DPH will have new public health responsibilities which will complement the Councils existing services in relation to the following functions and services:

Mandatory Functions	Public Health Commissioning/Services
Comprehensive Sexual Health	From April 2013, Local Authorities will commission comprehensive sexual health services. This includes all aspects of sexual health provision **except:** - Abortion services, sterilisation and vasectomy which will be commissioned by Clinical Commissioning Groups although there will be a further consultation on the most appropriate commissioning route for these services; - Contraception which is currently provided as an additional service in the GP contract, which will continue to be provided via the GP contract; - HIV treatment, which will be the responsibility of the NHS Commissioning Board.
Health Protection	From April 2013, local authorities will be required through Regulations under new section 6C of the NHS Act to perform steps to protect the health of their local populations, in particular to ensure there are plans in place to protect the health of their populations from natural hazards, accidents, infectious diseases, terrorism and other health threats.
NHS Health Check Programme	From April 2013, local authorities will be required to deliver NHS Health Check assessments for eligible men and women (around 15 million people aged 40-74 in England), equivalent to 13,000 annual health checks in Plymouth.
Population healthcare advice to the NHS (Core Offer)	From April 2013, local authorities will be required through Regulations to provide population based public health advice to NHS commissioners on the commissioning of NHS services. The regulations provide a means to ensure that specialist public health advice is provided by each local authority. Clinical commissioning groups will require a range of information and intelligence support via both the population healthcare advice service based in local authorities and other commissioning support services.
The National Child Measurement Programme	The Department of Health currently issues annual operational guidance for local areas on delivery of the NCMP. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129001

In addition to the Mandated Public Health Responsibilities, Local Authorities will be responsible for commissioning or ensuring services are provided for:

Other Public Health Responsibilities	Public Health Commissioning/Services
Accidental injury prevention	Local initiatives such as falls prevention services
Alcohol misuse services	Alcohol misuse services, prevention and treatment
Behavioural and lifestyle campaigns	To prevent cancer and long-term conditions
Children's public health 5-19	Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people), including school nursing

Criminal Justice	Public health aspects of promotion of community safety, violence prevention and response
Dental public health	Epidemiology, dental screening and oral health improvement, including water fluoridation (subject to consultation)
Drug misuse services	Drug misuse services, prevention and treatment
Environmental risks	Local initiatives that reduce public health impacts of environmental risks
Health at work	Any local initiatives on workplace health
Nutrition	Any locally-led initiatives
Obesity programmes	Local programmes to prevent and address obesity, e.g. weight management services; community lifestyle services
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity; increasing levels of physical activity in the local population
Public mental health	Mental health promotion, mental illness prevention and suicide prevention
Reducing and preventing birth defects	Population level interventions to reduce and prevent birth defects (with Public Health England)
Reviewing public health funded & NHS delivered services	Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
Seasonal mortality	Local initiatives to reduce excess deaths as a result of seasonal mortality
Social Inclusion	Public health aspects of local initiatives to tackle social exclusion
Tobacco control and smoking cessation services	Local activity, including stop smoking services, prevention activity, enforcement and communications

At a glance - **Public Health Outcomes Framework**

Overview of outcomes and indicators

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness and or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty / disability or mental illness
- Sickness absence rate
- Killed and seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise / health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2 – 2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional well-being of looked after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adults (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check programme – by those eligible
- Self-reported well-being
- Falls and fall injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for TB
- Public sector organisations with board approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged 5
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Annexe F: Public Health Model Options Appraisal Summaries

Option 1: Creating a Public Health Directorate
Description / Characteristics
A distinct public health directorate in the local authority (often including additional local authority functions). This option could see a new Public Health Directorate created in addition to the existing Directorates for People, Place and Corporate Services. This could be just for the public health team transitioning or could extend to other teams currently located in PCC Directorates but linked to the responsibilities of the Director of Public Health, e.g. Environmental Health, emergency planning and resilience, licensing, trading standards, health and safety etc.
HR Features
• Chief Officer Status of DPH enabled. • Public Health team members retain clear lines of managerial and professional accountability through the DPH. This meets appraisal and revalidation requirements. • One directorate/office with clear, simple professional management and accountability enabling retention of distinct identity as Public Health. • Would increase the number of direct reports to the Chief Executive but provides direct line management arrangement between DPH to Chief Executive. • Would allow direct interface between public health and elected members, Chief Executive, • Directors and other Chief Officers. **Discrete Public Health Directorate consisting of existing team:** • Directorate would have initial size of approx 19 staff (based on potential transfers but excluding public health trainees and affiliated staff members). • The current size of smallest PCC Directorate is 1074.2 • Initial lift and shift relatively straightforward, minimal disruption initially; relatively cost neutral. **Discrete Public Health Directorate requiring transfer of staff from existing PCC areas:** • Would require consultation with staff and trade unions • Could highlight where there are synergies and potential savings if, for example, there is duplication of roles. • Aligns professionals (Emergency Planning, Public Protection) similar professional requirements in nature and subject.
Legal Features
• The Director of Public Health could be positioned within 'any' of the Corporate Directorate arrangements of Plymouth City Council. • The Director of Public Health should take responsibility for the management of the Councils new public health responsibilities with professional responsibility and accountability for their effectiveness, availability and value for money • Their role is that of a statutory chief officer with direct reporting and accountability to the Chief Executive and direct access to elected members. • They will need to have a highly visible public health role, and provide the public with objective advice on health matters as well as playing a lead role in the Councils health protections and public health improvement functions.

Objectives Fit	
• No conflict towards the delivery of the objectives. • Has the potential to enhance and further Council objectives. • Can influence from a Directorate perspective; influence across the whole organisation would need to engage fully with the dispersed leadership model of PCC.	
Timescale and achievability	
• Core Public Health Team could form a new Directorate by 1st April 2013. • Other services that are aligned could be 'bolted-on' after transfer; • However considering the scope of public health responsibilities this would be a **major piece of organisational development** work that would substantially change the longer term structure of the Council.	
Financial Features	
• Financial impacts assessed as neutral. • Achieving public health outcomes would have to be prioritised against the available ring fenced budget for public health. • Financial resources could be increased if the LA chooses to allocate more funds to Public Health activity.	
Risks specific to this option	**Mitigation**
• Minimal disruption to existing Directorates if a discrete Directorate is created; however this would be seen as separate function and inequity in team capacity. • Substantial disruption to the Council structure if a new Directorate that brings in services currently located in other Directorates. • A separate Directorate could be viewed as public health not being everyone's business.	• Would need clear agreed process for how other parts of the Council would work with Public Health Team and to utilize the dispersed leadership model in PCC.
Potential benefits	
• Would ensure Public Health retains a distinct identity. • The reach of public health in its broadest sense is enhanced in relation to being everyone's business. • This model provides a clear view of Public Health activity and responsibilities for the Council and would demonstrate the added value of integrating expertise. • Would give an indication of the importance of Public Health within the council priorities.	

Potential drawbacks

- As a stand-alone Directorate with the existing Public Health team it would be small in comparison to other Directorates, therefore will have an imbalance of Directorate sizes and budgets.
- If 'Public Health' is seen as a separate stand-alone Directorate there is the potential for reduced influence and impact over the wider Council functions that affect health and health inequalities.
- Duplication with other functions across the Council e.g. Joint Commissioning Team.
- Lessens scope for integration and join up e.g. delivery of the Core Offer, Emergency Planning, or joint commissioning.
- Replicates the current situation / maintains status quo rather than taking advantage of the opportunity to be more effective and efficient by working together.
- Would mean that Council structures would need to be changed adding a fourth Directorate to the agreed three.
- Disruption to existing Council Directorates if another re-organisation takes place.

Suitable if

- A major structural and cultural change in PCC is politically desired.

Additional Comments

- This is a very ambitious option and if it were adopted in its broadest sense it would have the greatest level of disruption to current PCC structures but could also deliver the greatest level of impact if public services were aligned.

Option 2: Public Health within the Chief Executive's Office

Description / Characteristics

A section of another directorate - Chief Executives Office. The Public Health Team could either be a clearly identified team within the Chief Executive's Office or subsume existing teams in Chief Executive's Office.

HR Features

- Chief Officer Status of DPH enabled.
- Would bring together a small Chief Executive Office, (47)3 i.e. led by a Head of Service and the Public Health Office (19).
- Creates a discrete public health team within the authority.
- Potential to increase number of direct reports to Chief Executive.
- Would allow direct interface between public health and elected members, Chief Executive, Directors and other Chief Officers.
- Public Health team members retain clear lines of managerial and professional accountability through the DPH. This meets appraisal and revalidation requirements.

- The Executive Office contains various functions which could be seen as "matching" with existing Public Health functions particularly those relating to business intelligence and civil/emergency planning so some synergy could be achieved.
- Would also be possible to see if there was duplication of roles at all levels and if so identify potential savings. If so and structural changes required, would need consultation with employees and trade unions.

Legal Features

- The Director of Public Health could be positioned within 'any' of the Corporate Directorate arrangements of Plymouth City Council.
- The Director of Public Health should take responsibility for the management of the Councils new public health responsibilities with professional responsibility and accountability for their effectiveness, availability and value for money.
- Their role is that of a statutory chief officer with direct reporting and accountability to the Chief Executive and direct access to elected members.
- They will need to have a highly visible public health role, and provide the public with objective advice on health matters as well as playing a lead role in the Councils health protections and public health improvement functions.

Objectives Fit

- Potential to embed Public Health in all areas of Council business.
- Ability to influence across whole Council.
- Allows influence across all determinants affecting health and wellbeing, as well as ability to link to other stakeholders.

Timescale and achievability

- Achievable by 1st April.
- Easy to move across as a team; structural changes may be required to CEO team.

Financial Features

- Financial impacts assessed as neutral.
- Achieving public health outcomes would have to be prioritised against the available ring fenced budget for public health.
- Financial resources could be increased if the LA chooses to allocate more funds to Public Health activity.

Risks specific to this option	Mitigation
• Potential disconnect to the 'People' and Place' Directorates which are the key delivery arms of the Authority. • The Public Health budget may be used for other purposes after the removal of the ring-fence.	• Would need clear agreed process for how other parts of the Council would work with Public Health Team and to utilize the dispersed leadership model in PCC.

Potential benefits

- Some fit between the current functions of Public Health and existing CEO structures e.g. emergency planning, intelligence / data analysis, needs assessment.
- Emergency Planning and Health Protection would be co-ordinated from the same place.
- It aligns public health with a Directorate that has a wide corporate brief.
- Public Health will be able to consolidate relationships with 'People', 'Place' and 'Corporate Services' to ensure Public Health is on the agenda of both Directorates.
- Would elevate the status of Public Health as a corporate issue.

Potential drawbacks

- Limiting the role of public health to the scope of the role of the Chief Executive's Office.
- Increases the size of the CEO Office which has been streamlined in previous structural changes.
- This doesn't take up the opportunity of joining up with other Council services, with a particular emphasis on service delivery e.g. commissioning, Environmental Health etc.
- CEO Office is not the primary Directorate that has the most interactions with health at strategic and operational levels.

Suitable if

- Created a distinct "Office of the Director of Public Health" within the wider directorate that retains responsibility for statutory and mandatory functions.
- The team could then establish partnering arrangements with teams in other directorates.

Additional Comments

This Option shows Public Health embracing the move to the Council with an ambitious vision as a corporate role.

Option 3: Public Health within the People Directorate

Description / Characteristics

Public Health as a section of the People Directorate; Public health team lift and shift into People Directorate. Public Health would be a clearly identified function within the People Directorate.

HR Features

- Chief Officer Status of DPH enabled.
- Line management reporting to the Director of People - increases line management reports from 4 to 5 for this Director.
- Would allow direct interface between public health and elected members, Chief Executive, Directors and other Chief Officers.
- There are a number of existing functions within People where synergy could be created - particularly around matters relating to health inequalities, housing, social care. These are likely to become clearer post transfer.
- Could be added as distinct department/office to existing management structure. This

would minimise disruption to existing departments who may currently be restructuring.

- If not wishing to be a "department" could be called "Office of Director of Public Health" (ODPH).
- If sited as stand-alone ODPH at transfer (lift and shift) would not create further changes in that directorate.

Legal Features

- The Director of Public Health could be positioned within 'any' of the Corporate Directorate arrangements of Plymouth City Council.
- The Director of Public Health should take responsibility for the management of the Councils new public health responsibilities with professional responsibility and accountability for their effectiveness, availability and value for money
- Their role is that of a statutory chief officer with direct reporting and accountability to the Chief Executive and direct access to elected members.
- They will need to have a highly visible public health role, and provide the public with objective advice on health matters as well as playing a lead role in the Councils health protections and public health improvement functions.

Objectives Fit

- Potential to embed Public Health in all areas of Council business.
- Ability to influence across whole Council.
- Legitimacy to influence 'Place' Directorate.
- Being in the People Directorate 'may' focus public health on that Directorate only.

Timescale and achievability

- The Public Health Team could go in the People Directorate as an 'Office of the Director of Public Health'.
- All achievable by 1st April.

Financial Features

- Financial impacts assessed as neutral.
- Achieving public health outcomes would have to be prioritised against the available ring fenced budget for public health.
- Financial resources could be increased if the LA chooses to allocate more funds to Public Health activity.

Risks specific to this option	**Mitigation**
• Potential for public health team to be internally focused on the work of the People Directorate, therefore not focusing on public health issues across the whole council.	• Would need clear agreed process for how other parts of the Council would work with Public Health Team and to utilize the dispersed leadership model in PCC.

• The Public Health budget may be used for other purposes after the removal of the ring-fence	

Potential benefits

- Director for People is the current health lead for the Council and ownership for this agenda exists for this Directorate.
- Strong fit between the current functions of Public Health and existing Directorate structures e.g. commissioning, social care, education.
- Potential to influence service areas / developments that impact on the wider determinants of health.
- People Directorate already has strong and embedded links to Health and is leading on integration and joint work with Health including formal arrangements i.e., section 75 agreements.
- Existing Portfolio Holder arrangements already in place.
- Good existing working relationships.
- Natural fit for activity influenced by the Health and Social Care Act.
- This option potentially has the greatest immediate impact upon communities and populations with the greatest need.

Potential drawbacks (link to functions criteria – see table 1.2)

- Public Health influence could be limited to the 'People' Directorate.
- Public Health may lose some focus on wider determinant of health although it is recognised the people directorate is already responsible for certain areas that tackle the wider determinants.

Suitable if

- Could create a distinct "Office of the Director of Public Health" within the wider directorate that retains responsibility for statutory and mandatory functions.
- The public health team could then establish partnering arrangements with teams in other directorates.

Additional Comments

This option could work well for PCC and public health if functions are organised within a suggested 'Office of the Director of Public Health'.

Option 4: Public Health within the Place Directorate

Description / Characteristics

Public Health as a section of the Place Directorate; Public health team lift and shift into Place Directorate. Public Health would be a clearly identified function within the Place Directorate.

HR Features

- Chief Officer Status of DPH enabled.

- Line management reporting to the Director of Place - increases line management reports from 4 to 5 for this Director.
- Would allow direct interface between public health and elected members, Chief Executive, Directors and other Chief Officers.
- There are a number of existing functions within Place where synergy could be created - particularly around matters relating to planning, environmental health and housing. These are likely to become clearer post transfer.
- Could be added as distinct department/office to existing management structure. This would minimise disruption to existing departments who may currently be restructuring.
- If not wishing to be a "department" could be called "Office of the Director of Public Health (ODPH"
- If sited as distinct ODPH at transfer (lift and shift) would not create further changes in that directorate.

Legal Features

- The Director of Public Health could be positioned within 'any' of the Corporate Directorate arrangements of Plymouth City Council.
- The Director of Public Health should take responsibility for the management of the Councils new public health responsibilities with professional responsibility and accountability for their effectiveness, availability and value for money
- Their role is that of a statutory chief officer with direct reporting and accountability to the Chief Executive and direct access to elected members.
- They will need to have a highly visible public health role, and provide the public with objective advice on health matters as well as playing a lead role in the Councils health protections and public health improvement functions.

Objectives Fit

- Potential to embed Public Health in all areas of Council business.
- Ability to influence across whole Council.
- Legitimacy to influence 'People' Directorate.
- Being in the Place Directorate 'may' focus public health on that Directorate only.

Timescale and achievability

- The Public Health Team could go in the Place Directorate as an 'Office of the Director of Public Health'.
- All achievable by 1st April 2013.

Financial Features

- Financial impacts assessed as neutral.
- Achieving public health outcomes would have to be prioritised against the available ring fenced budget for public health.
- Financial resources could be increased if the LA chooses to allocate more funds to Public

Health activity.	
Risks specific to this option	**Mitigation**
• Potential for public health team to be internally focused on the work of the Place Directorate, therefore not focusing on public health issues across the whole council. • The Public Health budget may be used for other purposes after the removal of the ring-fence	• Would need clear agreed process for how other parts of the Council would work with Public Health Team and to utilize the dispersed leadership model in PCC.
Potential benefits	
• Strong fit between the current functions of Public Health and existing Directorate structures e.g. public protection services, transport, planning. • Potential to influence service areas /developments that impact on the wider determinants of health. • Good existing working relationships • Natural fit for transport and health legislation.	
Potential drawbacks	
• Public Health influence could be limited to the 'Place' Directorate. • Public Health May lose some focus on wider determinant of health although it is recognised the people directorate is already responsible for certain areas that tackle the wider determinants.	
Suitable if	
• Could create a distinct "Office of the Director of Public Health" within the wider directorate that retains responsibility for statutory and mandatory functions. • The public health team could then establish partnering arrangements with teams in other directorates.	
Additional Comments	
This option could work well for PCC and public health if functions are organised within a suggested 'Office of the Director of Public Health'.	

Option 5: A Distributed/Virtual Public Health Team
Description / Characteristics
A "distributed" or "integrated" model in which Public Health responsibilities and staff work across Directorates or functions but maintain identity and focus through being a "virtual team" a "hub" or a "core and extended team". Overarching approach of this model is to have Public Health influence at senior and strategic levels and integration throughout all Council delivery functions. Specialist Public Health officers would work as distributed Public Health function across the Council with the creation of a virtual Public Health team approach.

HR Features
• Difficulty of siting and supporting a "virtual" Director of Public Health Office when team are dispersed. • Difficulty in maintaining identity and professional accountability as Public Health professionals. • There may be CPD, training and staff development issues if sited in a dispersed model. • Public health employees will be part of teams where work colleagues are on different terms and conditions. • Difficult to maintain overall Public Health skill set, but more positively will allow for "osmosis" of public health knowledge directly to PCC employees via closer working arrangements. • More complicated line management arrangements, particularly in terms of specialist reporting to DPH. • Would potentially highlight where there is duplication on tasks/roles earlier than other models.
Legal Features
• The Director of Public Health could be positioned within 'any' of the Corporate Directorate arrangements of Plymouth City Council. • The Director of Public Health should take responsibility for the management of the Councils new public health responsibilities with professional responsibility and accountability for their effectiveness, availability and value for money. • Their role is that of a statutory chief officer with direct reporting and accountability to the Chief Executive and direct access to elected members. • They will need to have a highly visible public health role, and provide the public with objective advice on health matters as well as playing a lead role in the Councils health protections and public health improvement functions.
Objectives Fit
• Potential to lose focus on key objectives when dispersed and there are other calls on public health capacity.
Timescale and achievability
• Difficult to put in place by 1st April. • Will require substantial staff consultation across the Council. • More time required to network back to other Public Health colleagues for specific expertise which may cause conflict of timescales and hold up pieces of work.
Financial Features
• Financial impacts assessed as neutral. • Achieving public health outcomes would have to be prioritised against the available ring fenced budget for public health. • Financial resources could be increased if the LA chooses to allocate more funds to Public

Health activity.

- Greater coordination of resources would be required to achieve outcomes within a dispersed model.

Risks specific to this option	Mitigation
• The Public Health budget may be used for other purposes after the removal of the ring-fence • The perceived and collective strength of a Public Health 'Team' will be reduced. • The ability to deliver the Core Offer could be compromised. • The authority of the DPH will be diluted in relation to the ability to achieve key Public Health performance targets. • Split team - reduction to resilience and loss of expertise. • Reduces flexibility of team to respond to sudden urgent needs. • Reduces ability to bring most appropriate expertise to pieces of work. • Professional isolation. • Not a big enough Public Health team for each Council team/function to have its own Public Health specialist attached to it.	• A lot of mitigation would be required and it would be time consuming to deal with all the challenges of this model.

Potential benefits

- In time, possible for Public Health to become everyone's business IF the Public Health team is not spread too thinly across the Council teams.

Potential drawbacks

- Fragmentation could lead to negative impact on performance.
- Setting up management arrangements of a virtual team.
- HR implications.
- Small resource and so influence could be diluted.
- Fragmentation of existing working relationships.
- The strength of the Public Health team will be reduced.
- The ability to deliver the Core Offer will be compromised.
- The Public Health team is too small to make this option work.

• The ability to influence the host team is diluted. • Doesn't allow skill mix of whole team to bring added value. • Not enough people to share around all the teams to give Public Health support.
Suitable if
• The Council environment is conducive to having a virtual Public Health Team.
Additional Comments
• This is a high risk option for a small team and is therefore the least suitable.

Annexe G: The Specialist Public Health team in the Office of the Director of Public Health (ODPH)

At local level the ODPH specialist public health team includes the Director of Public Health, Consultants in Public Health, Public Health Managers, Public Health Commissioners, Specialist Public Health Intelligence and the Senior Support Team.

There are ten key areas of competence that the whole public health team work across and hold expertise in:

i. Surveillance and assessment of population health
ii. Promoting and protecting the population's health and well-being
iii. Developing quality and risk within an evaluative culture
iv. Collaborative working for health
v. Developing health programmes and services to reduce inequalities
vi. Policy and strategy
vii. Strategic leadership for health
viii. Working with and for communities
ix. Research and development
x. Managing people and resources

The ODPH specialist public health team have high levels of skills and expertise in the above competencies and all senior staff members are professionally registered to practice accordingly.

Directors and Consultants in Public Health have a key role in health improvement, health protection and service improvement, including provision of expert public health advice, support to clinicians and NHS commissioners. Public Health Consultants bring a population perspective to service planning and care pathway development, often acting as the 'honest brokers' between primary and secondary care clinicians and as 'critical friends' to other commissioners.

Directors and Consultants in Public Health have a sound understanding and experience of the sciences of epidemiology, statistics, health economics, social sciences, management studies, ethics and law. They are also competent in a range of academic, research, management, leadership, advocacy and strategic skills. They are able to communicate effectively with the public – for example by promoting understanding of health risks. And they work effectively with other agencies and individuals, including the media, to improve population health and well-being.

Directors and Consultants in Public Health may come from medicine and other professional backgrounds. In order to be appointed as a Director or Consultant in Public Health an individual must be on the specialist Public Health Register, and they are appointed to their post through a formally constituted Advisory Appointments Committee (AAC), which includes an external assessor, provided by the Faculty of Public Health, part of the Royal College of Physicians.

There are two routes to specialist registration; the first is through a five year training programme, which includes completing a Masters' Degree, and undertaking rotating placements in public health settings. In order to enter the training scheme, applicants must either have competed medical training or have a good first degree in a subject relevant to public health together with at least three years post-degree work experience in a relevant area, such as social science or a health professional qualification, such as nursing.

The training curriculum is devised and overseen through the Faculty of Public Health (soon to be the Royal College of Public Health), which is the standard setting body for public health. In order to demonstrate their ability to practice effectively, trainees must achieve over 100 competencies throughout their training and pass both written and practical skill examinations. On completion of training, successful candidates must be registered with a regulatory body. Those with a medical background must have full GMC registration and be on the GMC specialist register. Those with a non-medical background must be registered with the UK Public Health Register.

The second route to specialist registration is through retrospective portfolio, whereby those who have extensive experience and knowledge of public health (including a Masters' Degree) demonstrate achievement of all competencies through submitting evidence against each of over 100 standards.

Directors and Consultants in Public Health who are medically qualified are employed on the NHS consultant contract and are part of the NHS consultant body, with equivalent status and pay. Those Directors and Consultants in Public Health from backgrounds other than medicine are employed on senior NHS payscales: Directors on the Very Senior Manager scale, equivalent to other NHS Directors, and Consultants at the top of the Agenda for Change scale at a level with terms and conditions similar to the NHS consultants.

All Directors and Consultants have a professional requirement for Annual Appraisal and continuing professional development which is organised through the Faculty and includes the requirement for an annual return to the Faculty demonstrating that they remain competent and up to date in order to continue their practice. Many have responsibilities for teaching public health at undergraduate and postgraduate levels and for training of medical and public health trainees.

Public Health specialist's professional competencies

All Consultants in Public Health require a professional registration to practice and will have demonstrated competence against a set of professional standards.

Consultants in Public Health will have achieved a high level of competence in the following nine key areas of public health:

i. **Surveillance and assessment of the population's health and well-being**. This includes the qualitative and quantitative assessment of the population's health, including managing, analysing, interpreting and communicating information that relates to the determinants and status of health and well-being. Integral to this is the assessment of the population needs and its relationship to effective actions.
ii. **Assessing the evidence of effectiveness of health and healthcare interventions, programmes and services**. This includes the critical assessment of evidence relating to the effectiveness and cost-effectiveness of public health interventions, programmes and services including screening. It concerns the application of these skills to practice through planning, audit and evaluation.
iii. **Policy and strategy development and implementation**. This includes developing strategies and policies, and assessing their impact on health.
iv. **Strategic leadership and collaborative working for health**. This includes leading teams and individuals, building alliances, developing capacity and capability, working in partnership with other practitioners and agencies, and using them effectively to improve health and well-being.

v. **Health improvement**. This focuses on promoting the health of populations by influencing lifestyle and socio-economic, physical and cultural environment and health education for populations, communities and individuals.
vi. **Health protection.** This includes prevention of the transmission of communicable disease, including through immunisation and vaccination; management of outbreaks and incidents; infection control; risk assessment; and environmental hazard identification.
vii. **Health and social service quality**. This includes commissioning, clinical governance, quality improvement, patient safety, equity of service provision, and prioritisation of health and social care services.
viii. **Public health intelligence**. This focuses on the systems needed for organisations to base policy and practice on sound intelligence, including surveillance; performance management; and cost-effectiveness analysis.
ix. **Academic public health**. This includes the teaching of and research into public health.

Public Health Practitioners in the ODPH also have a range of professional competencies and qualifications, from a variety of disciplines, such as nursing, sports science, information sciences, business management etc. The ODPH public health team ensures that any public health programme or change is based on good evidence, is acceptable, and involves the most appropriate people to really make a difference and, most importantly, will reduce inequalities in health. The ODPH public health team is also concerned about what determines local people's health and well-being and the part that everyone plays in this.

The ODPH has a small and efficient Senior Support Team providing the day-to-day administrative, organisational and governance support functions for the ODPH and ensuring the smooth operation of the ODPH. The Senior Support Team are also fully trained 'Loggists' and are on standby call to provide key administrative support functions as part the emergency preparedness response for the Local Health Resilience Forum.

Specialty Training for Public Health: the ODPH is a Training Centre for the South West Public Health Specialty Training Programme which is organised by the Severn Deanery on behalf of the whole SW region. It provides a combination of academic training, service experience and skills based training in public health.

Annexe H: National Guidance on Public Health in Local Authorities (as at October 2012).

Public Health HR Concordat: November 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131186.pdf

Public Health in Local Government (factsheets): December 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf

Public Health England's Operating Model (factsheets): December 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131892.pdf

Public Health in Local Government: Public health advice to NHS Commissioners: December 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131902.pdf

Public Health Transition Planning Support for Primary Care Trusts and Local Authorities: January 2012
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132179.pdf

Public health workforce issues - Local government transition guidance: January 2012
http://www.local.gov.uk/c/document_library/get_file?uuid=624422f8-5207-457d-9487-19172beb548a&groupId=10161

Public Health Outcomes Framework: January 2012
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

Baseline spending estimates for the new NHS and Public Health Commissioning Architecture: February 2012
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132540.pdf

Healthy Lives, Healthy People: Towards a workforce strategy for the public health system: March 2012
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133705.pdf

Guidance to local authorities and NHS on the appointment of a Director of Public Health during the transition period up to 1st April 2013: April 2012
http://www.fph.org.uk/uploads/FPH%20guidance%20to%20LAs%20-%20FINAL.pdf

Guidance to local authorities on the appointment senior public health consultants during the transition period up to 1st April 2013: April 2012
http://www.fph.org.uk/uploads/Guidance%20to%20LAs%20on%20appointment%20of%20CPH%20-%20Aug2012.doc

Guidance to support the transfer of public health functions from PCTs to local authorities: June 2012
http://www.dh.gov.uk/health/2012/06/public-health-functions/

Public health advice service for clinical commissioning groups: July 2012

http://www.dh.gov.uk/health/2012/06/public-health-advice-to-ccgs/

Resource pack for local health resilience partnerships: July 2012
http://www.dh.gov.uk/health/2012/07/resilience-partnerships/

Consultation on joint strategic needs assessments and joint health and wellbeing strategy guidance: July 2012
http://www.dh.gov.uk/health/2012/07/consultation-jsna/

NICE Public health briefings for local government: July 2012
http://www.nice.org.uk/localgovernment/PublicHealthBriefingsForLocalGovernment.jsp

Joint letter (from CMO and LGA Chief Executive) to local authorities, alerting them to the national guidance on 'filling of posts in receiving organisations': August 2012
http://www.local.gov.uk/c/document_library/get_file?uuid=6b3bafc4-60fa-4771-b40b-09731883daba&groupId=10171

Health Protection in Local Government: August 2012
http://www.dh.gov.uk/health/2012/08/health-protection-guidance/

Health intelligence requirements for local authorities: September 2012
http://www.dh.gov.uk/health/2012/09/health-intelligence/

Statutory and non-statutory guidance on the role, responsibility and context of the DPH, including post 1st April 2013 appointments guidance: October 2012
http://www.dh.gov.uk/health/2012/10/public-director/

Annexe I

Risk No:	Function	Potential Risk *Description of risk should be high-level potential risks that are unlikely to be fully resolved and require on-going control*	Risk Assessment Impact (1 to 5)	Raw Score Likeli-hood (1 to 5)	Red (15-25), Amber (5-12) Green (below 4)	Brief description of action plan to be taken or reference action plan	Residual Risk Owner / Leads	Red (15-25), Amber (5-12) Green (below 4)	Trend ▼ Worse ▲ Better ► stable	Date Risk identified	Review Date	Review Notes
1	Finance	Insufficient money in ring fenced PH budget to fulfil all local authority PH responsibilities	4	5	**16**	Commissioning and financial mapping is be consistently reviewed. Due diligence summary position to be produced on budget, outturn and variation against potential public health return values. Joint working between sender and receiver finance teams to establish the most accurate current spend and budget values.	SA / JW	12	▲ better	01-Sep-12	07/11/2012	
2	Performance	Performance will deteriorate during transition	4	4	**16**	Regular performance monitoring mechanisms to be maintained. Key performance indicators will be ragged and published through the PH Business Performance Report.	JW / KS / CM	12	▲ better	01-Sep-12	07/11/2012	

3	Commissioning	Insufficient resources available to commission full range of services needed	4	4	**16**	Mapping of current spend to understand present liabilities. Ensure contracts give flexibility to terminate if necessary. Identification of potential areas of decommissioning activity	JW / KS / CM	12	▲ Better	01-Sep-12	07/11/2012	
4	Workforce	Key staff will leave during transition	4	5	**20**	Ensure the right processes and policies are in place to ensure business continuity if staff leave.	BS / SD	12	▲ Better	01-Sep-12	07/11/2012	Recruitment protocol agreed with Cluster for vacant posts as they arise
5	Patient safety & Quality	Patient safety and quality risk will increase due to fragmentation of PH functions across a number of organisations	4	5	**20**	Unclear lines of accountability needs to be worked through, dependant on structures not yet in place.	DL	20	▼ worse	01-Sep-12	07/11/2012	
6	Health Protection	Health protection risk will increase due to fragmentation of PH functions across a number of organisations	5	5	**25**	Workshop is being planned to work through these issues	DL	25	▼ worse	01-Sep-12	07/11/2012	
		Test arrangements for the role of public health in emergency planning, in particular the	4	5	**20**	The key milestone of October is having to slip due to confirmation of the PH model. A scenario-based resource pack containing a 'menu' of items for use by Local Authorities and their partners to provide a level of assurance to	NV/SS	12	▲ Better	01-Sep-12	07/11/2012	Agreement to run desk-top resilience exercise on publication of agreed model - likely to be December

		role of the DPH and LA based public health - due end Oct:				all that the new EPRR structures and functions are well understood, workable and fit for purpose at local level, is under development by the Department of Health and will be issued early in September (likely to be published via the LGA website). This will help local areas meet this end of October NHS Operating Framework milestone. Date needs to slip to January 2013.						2012
7	Corporate	No clear operating model agreed for PH within local authority, CCG, NHSNCB, PHE	5	5	**25**	Robust and detailed options appraisal completed. Draft paper for CEO and portfolio Holder produced. Paper being presented to CMT in November and Cabinet in December for final sign-off.	CS / KE	5	▲ better	01-Sep-12	07/11/2012	Draft paper for integrating public health into Council produced - final model recommendation made.
8	Legal	Insufficient clarity on clinical risk negligence and its impact on LA insurance liabilities	4	5	**20**	Existing staff and systems to be transferred. Build strong clinical governance into contracts. Utilise existing LA good practice on contract management. Ensure Legal and procurement are aware of issues and working as part of the transition. Learn from other areas.	JW / MH	16	▲ better	01-Sep-12	07/11/2012	
9	IM&T	Proposed methods of accessing systems and datasets post-transition may not work. Information sharing protocols may	4	3	**12**	The proposed methods of accessing systems and datasets are being tested in September/October 2012. NHS Devon's Head of Public Health Intelligence is drafting a data sharing protocol to cover the whole of Devon. If this can be agreed, then there should be continuation of access to	RN	8	▲ better	01-Sep-12	07/11/2012	Devonwide IM&T meeting has now occurred to look at addressing the common issues and to identify the solutions. A

		not be agreed at all or on time.				data and systems post-transition.						IM&T action is plan now in place and is a part of the wider Intelligence transition Plan
10	Comms	Communication issues will emerge if a plan is not implemented by sender and receiver organisations	5	4	**20**	Development of agreed coordinated communication plan is now required that reaches the wider public that provides the key messages	CS / KE	8	▲ better	01-Sep-12	07/11/2012	Draft Comms plan now agreed, clear actions from respective organisations identifie.
11	Core Offer	The draft core offer may not be agreed by (1) the city council, or (2) the CCG	4	3	**12**	The draft core offer is being discussed with Plymouth's Public Health portfolio holder and the Director for People on 14th September. This will highlight any amendments that might need to be made in order for the Core Offer to be acceptable to Plymouth City Council. Once similar processes have been carried out across Devon, the final core offer can be agreed and the accompanying work-plan developed and agreed between the relevant parties.	RN/KS	8	▲ better	01-Sep-12	07/11/2012	Each local authority will sign the MOU with CCG's and work collaboratively for each year with a named lead.
12	Accommodation	No confirmation of future accommodation for public health	4	3	**12**	Future accommodation could possibly be Windsor House, Civic or the Public Dispensary dependant on the agreed PH model. Notice has been given on the Dispensary this may prove to cause an issue if future accommodation is not confirmed it will have	KT/CT	6	▲ better	01-Sep-12	07/11/2012	N3 network yet to be resolved

						implications on other areas on the risk register such as, IM&T as sufficient networking would need to be arranged which may have financial implications and could affect timescales for the transition.							
13	Business Continuity	Business continuity needs to be maintained throughout pre and post transition	5	4	**20**	Business continuity for public health needs to be aligned with PCC	SS/ JW	20	► stable	17th Oct	07/11/2012		