PORTSMOUTH CITY COUNCIL – HEALTH IMPROVEMENT ORGANISATION

A REPORT TO NHS EDUCATION SOUTH CENTRAL

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SUMMARY

Local authorities have obligations to promote health and wellbeing of their populations. Increasingly, they are encouraged by policy to collaborate with NHS primary care trusts on achievement of objectives. Comprehensive Area Assessments and Local Area Agreements reflect that progress in many areas of population wellbeing can only be achieved by sectors in partnership. About 15% of the National Indicator Set indicators are relevant to health and wellbeing, and health improvement supports prevention and early intervention that makes the ‘personalisation’ agenda in social care possible.

As one of their programmes to develop practitioners and the wider workforce, NHS Education South Central worked with Portsmouth City Council to map the public health workforce to support development to strengthen the health improvement function.

The project found that at least 57% of the council’s workforce was engaged in work which contributed to the health of Portsmouth’s population, including at least 43 members of staff, across several services, who had health improvement as a substantial part of their role. The council had strengths in a strategic commitment to health improvement and to learning development, a management structure which seemed to improve collaboration across services and strong partnership with other agencies across Portsmouth and in south Hampshire. Its unusual Health Improvement and Development Service brings together several health improvement and preventive services normally dispersed among several parts of most local authorities, allowing an exceptionally focused approach to health improvement. Portsmouth has been awarded Healthy Town status, a great achievement for the city council and its partners which could be a focus for further development around an understanding of health improvement.

The project also identified some development needs, some of which the council was already addressing, and recommendations were made for further action. Health improvement action could be enhanced by raising awareness within the organisation of the contribution of its services to health, and by resolving some unintended consequences of its innovative health improvement services about the location of expertise and leadership, and the responsibility for action, within the council and across public service agencies in Portsmouth. The large health improvement workforce identified by the project would benefit from initiatives to improve capacity and capability.

Portsmouth City Council is an authority with a strong commitment to health improvement, and the potential to improve its impact through focused action to develop as a health improvement organisation.
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CHAPTER 1 BACKGROUND

1.1 Aims and objectives of the project

Increasingly, local government and the NHS are encouraged by policy to collaborate on achievement of objectives, through Comprehensive Area Assessments, Local Area Agreements, and about 15% of the National Indicator Set being indicators relevant to health and wellbeing. This reflects that progress in many areas of population wellbeing can only be achieved by sectors in partnership. Health improvement, and reducing health inequalities is achieved not only by activities labelled as ‘health improvement’, but also by mainstream services such as housing, education, social services, planning and environmental health.

NHS Education South Central funded work with Portsmouth City Council to map the health improvement workforce, with a view to supporting development to strengthen the health improvement function, as a contribution to the work of Portsmouth Local Strategic Partnership.

The aims of the project were to:

- strengthen the health improvement function by identifying which services contribute to it
- establish the likely available workforce resource over the next 3 to 5 years;
- establish where there are knowledge and skill gaps;
- raise awareness of health improvement across the organisation.

1.2 Activities of the project

The project worked to:

- establish which services in the City Council employed staff who work on health-related issues and could be considered to be health improvement practitioners and “key influencers” in the wider workforce;
- with those people, understand the content of jobs within their service in order to decide whether they should be counted as part of the wider public health workforce, and if so their development needs;
- identify data sources which would enable those jobs to be counted;
- collect data on numbers of jobs;
- collect information on barriers and facilitating factors to training and development, including any recruitment or retention difficulties.

The project worked with senior key informants in relevant services in the council, who were well informed about staff numbers and roles. The consultant had access to a full list of job titles of council employees by service, and estimated membership of the health improvement workforce in services where no interview was conducted. A list of interviewees is given at Appendix 1. Interviewees headed services likely to include members of the health improvement workforce, apart from children and young people, safeguarding, learning and achievement and schools. Documents used to structure the meeting are given at Appendix 2 (an instrument used to identify members of the health improvement workforce) and Appendix 3 (a topic guide used by the researcher for the semi-structured interview). Experience from
other areas showed that this process in itself develops the understanding of health improvement within organisations.¹

The project was conducted by Rhiannon Walters between October and December 2008. It was sponsored within the council by the Head of the Health Improvement and Development Service, who secured the support of the strategic directors for the project.

1.3 What is health improvement?

Health improvement is the intended outcome of activities in three areas:

- life circumstances – addressing social and economic determinants of health such as employment, housing, environment and social inequalities;
- lifestyles – making healthier choices easier and supporting individuals to change behaviours which threaten their health;
- priority health issues – improving services and access to services relating to high priority health issues, including diseases, risk factors and population groups at high risk.*

Often ‘health improvement’ is also used to describe those activities themselves, or even the people or elements of an organisation that carry them out.

‘Public health’ is a closely related term. Most simply it refers to the health of whole populations (as opposed to the health of individuals) but has come to mean a body of knowledge and a set of activities – “the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals.”² Like health improvement, public health can be taken to refer to people or units of an organisation that hold that body of knowledge and carry out those activities. When used like this, it is generally taken to refer to the health sector, which makes it an unhelpful term in a local government context. ‘Health improvement’ is the preferred term in this report.

However it does help to remember the considerable overlap between the terms because it gives access to valuable resources to support organisational and workforce development. In particular, the Chief Medical Officer’s project to strengthen the public health function (‘CMO’s project’³⁴ gives a useful way of identifying members of the health improvement workforce and thinking about their development needs.

1.4 What is the health improvement workforce?

The CMO’s project initiated the training and development of the public health workforce using set of categories inclusive of a wide range of jobs and organisations going well beyond the NHS to the voluntary and private sectors and particularly to local authorities (Box 1).

* This description of health improvement is based on one that supports multi-agency health improvement work in Scotland (Working together for a Healthier Scotland 1998).
“Most professionals, including managers in the NHS, local authorities and elsewhere eg teachers, would benefit from a better basic understanding of public health. Knowledge of how to gain access to more specialist input would be useful to strengthen their role in furthering health improvement goals in their daily work, a role they may not have recognised as public health” (wider public health workforce).

“A smaller group of ‘hands on’ public health practitioners spend a substantial part of their working practice furthering health by working with communities and groups. They need more specialised knowledge and skills in their respective fields. This group includes public health nurses, health promotion specialists, health visitors, community development workers and environmental health officers.

“A still smaller group are public health specialists who come from a variety of professional backgrounds and experience and need a core of knowledge, skills and experience. This core is in urgent need of definition so that generic public health specialists can be fully acknowledged for their contribution. This group includes professionals from backgrounds such as the social sciences, statistics, environmental health, medicine, nursing, health promotion and dental public health. The knowledge, skills and experience needed include the ability to manage strategic change in organisations, to work in management teams and leadership of public health initiatives, as well as more technical areas.”

(From The CMO’s project to strengthen the public health function: report of emerging findings 1998)³

These definitions preceded the setting up of the UK Public Health Register,⁵ for which more stringent criteria for the term “public health specialist” were developed. There is scope therefore for some confusion about the term, and in this document, where “specialist” by the broader definition is used, reference is always made to the CMO’s project. The CMO’s project identifies development needs in relationship to the level and content of a post-holder’s responsibilities for improving the health of populations while the UK Public Health Register ensures that the public is protected through maintenance of standards among those who hold responsibility at those levels. The value to this project of the CMO’s definitions is its identification of development needs.

The wider health improvement workforce is broad, containing most of those contributing to health improvement in any sector, and two subdivisions were developed (Box 2).

“Key health influencers, such as trust and health authority chief executives, or leaders of local authorities, or those in senior positions in education, such as head teachers, whose remit has such a profound impact on population health that their continuing understanding on public health should be specially nurtured”

Experts, such as those with specialised knowledge of radiation, or soil science, or virology, whose work is vital to public health but who normally view development as an activity which lies within their own professional discipline only” (public health technical experts)

(From Report of the Chief Medical Officer’s project to strengthen the public health function in England 1998)³
Appendix 2 shows the algorithm used in this project for determining who is in which category of the health improvement workforce, based on the CMO’s project definitions.

1.5 Unitary authorities and health improvement

1.5.1 Unitary council functions
Unitary councils such as Portsmouth City Council are responsible for:

- education
- housing
- planning applications
- strategic planning
- transport planning
- passenger transport
- highways
- social services
- libraries
- leisure & recreation
- waste collection
- waste disposal
- environmental health
- revenue collection

Sometimes some of these functions will be carried out by one authority on behalf of several others in a region or sub-region. About 56% of local government funding comes directly from government (revenue support grant and various targeted programmes), and the rest from council tax (25%) and redistributed commercial rates (20%). The government funding, and redistribution of commercial rates, allow adjustment for population need. All local authorities were expected to achieve 3% efficiency savings during each year from 2008/09 to 2010/11 under the 2007 Comprehensive Spending Review, and Portsmouth City Council has committed itself to further savings above this requirement.

1.5.2 Local authorities’ contribution to health improvement
Two kinds of activity in local authorities across England contribute to health improvement which can be characterised as ‘mainstream’ and ‘ad hoc’.

1.5.2.1 ‘Mainstream’ activities contributing to health improvement
Some activities which are mainstream-funded and usually statutory contribute to the health of the population, without carrying a health ‘label’.

Environmental health addresses transmission of infectious disease and environmental pollution, and so has a direct impact on health.

Social and economic factors are strong determinants of health and wellbeing and local government services such as education, regeneration, social services, housing and planning can have a direct impact. Community cohesion or ‘social capital’ has an independent impact on health and wellbeing. Services such as cleansing, refuse and recycling contribute to how positive people feel about their area, in addition to their impact on infection control.

Health outcomes are not the primary stated outcomes of these mainstream activities, but none the less they make an important contribution.
1.5.2.2 ‘Ad hoc’ activities contributing to health improvement
Some activities are explicitly labelled as health-related. Apart from environmental health services, these tend not to be mainstream-funded, but often involve partnership. They are often found within community development or leisure services.

1.6 Context of the project
This project forms part of a Public Health Development programme within the NHS Education South Central Public Health Development function across the South Central NHS Strategic Health Authority.

The Public Health Development Programme encompasses a range of education, training and development opportunities for increasing the public health knowledge, skill and competence of people working in public health and wellbeing across sectors and at all levels of the workforce who have or would like to have public health as part of their role.

Working across sectors and at all levels of the workforce this includes two programmes which are particularly relevant to this project:

- An innovative programme to develop key influencers and leaders from all sectors to enhance their strategic leadership of partnerships for health and well-being, and their abilities to deliver transformational change to services to improve the health and well-being of their communities. A high level multi-agency programme began in the autumn of 2008. This was offered to strategic leaders and key influencers, such as Local Strategic Partnership members, councillors, directors of service within local authorities and the voluntary sector, for example. It was planned in conjunction with national and local partners and uniquely combines and offers development in the three areas of health improvement, quality and service improvement as well as personal leadership skills.

- A Public Health Development Leads group of public health practitioners, who are nominated by and work on behalf of PCT Directors of Public Health, and take the lead on identifying and development of the local public health workforce.

1.7 Structure of this report
- Chapter 2 describes the health of the local population authority, and the agencies, Portsmouth City Council and Portsmouth Primary Care Trust, with responsibility for health improvement.

- Chapter 3 describes the extent and type of work contributing to health improvement that the City Council now undertakes, sometimes in partnership, and workforce and organisational development relevant to health improvement.

- Chapter 4 gives a profile of the health improvement workforce in the City Council.

- Chapter 5 draws conclusions from the findings.

- Chapter 6 makes recommendations for the City Council, the Primary Care Trust and NHS South Central.
1.8 Key points from Chapter 1

- This project aimed to strengthen Portsmouth City Council as a health improvement organisation, as part of the Public Health Development programme of NHS Education South Central.

- A major activity of the project was mapping of the council’s workforce engaged in health improvement activity, using definitions developed for the ‘CMO’s project’.

- The term ‘health improvement’ is preferred to ‘public health’ for this project, but the two terms are closely related.

- Unitary authorities such as Portsmouth City Council engage in a range of activities funded from mainstream and more short term funding streams which contribute to health improvement.
CHAPTER 2    PORTSMOUTH

This chapter describes the health of Portsmouth’s population. It then sets out the organisation of Portsmouth City Council and some of its collaboration with local agencies including the primary care trust. It also describes how the primary care trust is organised to engage with the council on health improvement matters.

2.1 Health of Portsmouth’s population

Information on the health of Portsmouth’s population is available from health profiles produced by the Department of Health.8

Portsmouth’s life expectancy and mortality rates are worse than the average for England. As in the rest of the country, mortality rates for men and women have been improving in recent years but Portsmouth’s mortality rates remain above the national rates. Homelessness is higher than the national average, with 6.5 of every 1,000 households being homeless in 2005/06 compared to 4.1 in the whole of England, a significant difference. Five of Portsmouth’s 14 wards include areas that are among the most deprived fifth of areas in England. There are inequalities in health within Portsmouth. Life expectancy is 8 years shorter for men and 4 years shorter for women in the most deprived fifth of areas in the city compared to the least deprived fifth.

2.2 Portsmouth City Council

2.2.1 Organisational structure of Portsmouth City Council

How local authorities are organised varies:

- in the way they structure governance by elected members;
- in the management structure for employed officers;
- in how functions are deployed between different services;
- in what functions are delivered directly, and what is delivered by other organisations contracted to the council.

Portsmouth’s governance structure involves portfolio-holding members, and the portfolio-holders for health, and communities and families are both engaged in the health improvement role of the council. It has recently introduced an unusual matrix management structure, where 24 heads of service report to five strategic directors in clusters which may not on first inspection have obvious functional connection. It is hoped that this will bring the benefit of increasing the level of operational responsibility taken by service heads while freeing strategic directors to be genuinely strategic, and of facilitating a wider network of cross-service working than might be expected with more conventional groupings of services.

Portsmouth owns its housing stock, and has a priority for more affordable homes. Recycling and waste collection are contracted out, and there is a consortium of three authorities (Portsmouth, Southampton and Hampshire) responsible for waste disposal, with Hampshire having the main operational responsibility. It has an unusual Health Improvement and Development Service which commissions and provides services, and contributes strategic advice, across the organisation and the city.
2.2.2 Performance

Portsmouth was judged in by the Audit Commission as ‘improving adequately’ and was awarded 3 stars (of 5) in 2007.\(^9\) The Commission conducted a Corporate Assessment in 2008, when it was judged as performing well. The council was urged to address the following areas:

- management and delivery of its equality and diversity strategy;
- a strategic approach to the needs of people aged over 50;
- development of the capacity and capability of elected members;
- development of a programme of modernisation, paying particular attention to workforce development.\(^10\)

The Joint Area Review of services for children within Portsmouth conducted in 2008 commended the strength of partnership in the area, and singled out for praise the strength of the teenage pregnancy service. Portsmouth’s partnership scored “good” in most areas. There was concern about the level of recruitment of social workers.\(^11\)

2.3 Portsmouth Primary Care Trust

Portsmouth Primary Care Trust (PCT) has a public health leadership role in Portsmouth. As a unitary authority with a coterminous PCT Portsmouth has been spared some of the changes in public health leadership experienced by two-tiered authorities, where PCTs have been restructured. The coterminosity facilitates partnership. The Director of Public Health has been jointly appointed by both agencies, under an informal arrangement from 2002, and recorded by a Memorandum of Understanding in August 2006. He holds the job title of “Director of Health and Wellbeing” within the council. He is engaged with the council’s work at strategic level, but does not have a portfolio of services as the strategic directors do, and does not appear on the council’s organisation chart at strategic director level.

2.4 Key points from Chapter 2

- The health of Portsmouth’s population is poorer than England and regional averages, and there are considerable social and health inequalities within Portsmouth.
- The Council has a new matrix management structure which, it is hoped, will give considerable operational autonomy to heads of service while allowing the five strategic directors to focus on strategic work.
- The PCT is coterminous with the City Council, and the director of public health is jointly appointed by both agencies.
CHAPTER 3  PORTSMOUTH CITY COUNCIL AS A HEALTH IMPROVEMENT ORGANISATION

This chapter describes the extent and type of work contributing to health improvement that Portsmouth City Council now undertakes, and its level of development as a health improvement organisation, including partnership with the NHS. It also reports on current organisational and workforce development activities which could be supportive to health improvement, and some factors which support or impede development. Key informants were asked about these topics in a semi-structured interview, and the topic guide used is given at Appendix 3.

It was assumed that three factors contributed to such development:

- continuity of health improvement activities;
- a shared understanding of health improvement across the organisation;
- partnership with the NHS to build a shared understanding across the health economy.

3.1 Strategic focus on health improvement

3.1.1 City Council strategic focus

There appeared to be a commitment to a health improvement role for the City Council among both elected members and strategic directors. This commitment was demonstrated by the existence of a free-standing health improvement service, the Health Improvement and Development Service (HIDS). This service was formed to deliver the health improvement and disease and injury prevention functions of four previous services, and serves both as a provider to the PCT and a commissioner from the private and voluntary and community sectors. The existence of strategic commitment to health improvement was supported by accounts from interviewees inside and outside the City Council.

3.1.2 Strategic partnership

The Local Strategic Partnership (LSP) is chaired by the Director of Public Health. The LSP’s Health and Social Wellbeing Partnership Board, and its subgroups on for example obesity, alcohol and smoking are reported by interviewees from both the council and the PCT to work well together.

The LSP developed the Local Area Agreement¹² which prioritised four ‘flagship issues’ – obesity, violence, employability of young people, and innovation and enterprise – the first three of which have direct health improvement relevance. The process of data collation and consultation which led to the agreement was reported to have been a good one, and work is now in progress on delivering the agreement. A similar process is now under way for the joint strategic needs assessment, a newer joint statutory requirement which is potentially supportive to future local area agreement cycles.

The location of the city’s main health promotion provider, HIDS, in the City Council, increases the level of shared responsibility for health improvement. However there could be a lack of clarity and conflicting perceptions between the PCT and the City Council about the location of health improvement expertise and leadership, with the Council perceiving a lack of understanding within the PCT about the skills and qualifications within HIDS. This resulted in a need for the Health Improvement and Development Service to make a much stronger case for its ability to deliver or commission services required by the PCT. An illustration of
this was that the PCT, now working under the ‘World Class Commissioning’ framework, needed strong assurances about the quality of contracted services. The HIDS staff had strengths in competencies such as partnership working, community involvement and management and some, more health-related competencies such as health needs assessment, evidence of effective interventions, behaviour change and community development.

However, there was a recognised gap and lack of resource around health intelligence, although some HIDS staff were participating in practitioner learning sets and undertook the recent health impact assessment training. Having recognised the PCT’s position, a process of recording and mapping qualifications across the service was now going to be consistently addressed through the appraisal and the personal development planning process. There was a strong drive to support staff to go forward for registration as a public health practitioner and one member of staff was already engaged in the public health practitioner training scheme.

The City has been awarded Healthy Town status as part of the government Change4Life programme to increase opportunities for physical activity and healthy eating, through the efforts of the council supported by the PCT.

3.2 Health improvement activities

Chapter 1 identified two types of health improvement activity within local authorities:

- ‘mainstream’ activities forming part of the council’s statutory functions and funded from mainstream sources;
- ‘ad hoc’ activities, generally explicitly labelled as health activities, often funded from short-term funding or an opportunistic combination of mainstream and ad-hoc funding.

Portsmouth’s unusual Health Improvement and Development Service (HIDS) cuts across these categories. Cross-service collaboration seemed to be facilitated by the council’s matrix structure, and compared to many authorities there seemed to be high awareness of the related activities in other services within Portsmouth City Council.

3.2.1 Mainstream activities

Discussion of the City Council’s housing, regulatory, social care and other mainstream functions revealed a good understanding of their health improvement impact. Examples were:

- in Community Housing, the provision of appropriate housing for vulnerable groups and ensuring that private sector rented housing was safe;
- in Environment and Public Protection, control of under-age tobacco and alcohol sales by an innovative responsive service model for trading standards which made use of monitoring by volunteers; food inspection, infectious disease response; and environmental protection covering pollution, noises and smells;
- in Community Safety, addressing anti-social behaviour;
- in Adult Services, leading provision for older people and those adults eligible for “supporting people” funding with a combination of commissioning, direct in-house provision and brief interventions to promote independence;
- in Planning, building control, including ensuring safety and disabled access of private housing; leading development of the local development framework; and dealing with and enforcing planning decisions in line with planning priorities.
In most cases these functions were carried out without health partnership. The council and PCT had had a health and social care outcomes monitoring group which was no longer operational, and generally no reference to measurement of their health outcomes was made when these activities were discussed.

Planning or development has become a growing area for possible public health action because of the potential of Section 106 contributions. Given adequate evidence of benefit, developers can be required to provide health facilities, open space, or other facilities with an impact on health and wellbeing. The scope of this provision of the Town and Country Planning Act was a stimulus to partnership with the PCT although not necessarily with public health.

In summary, mainstream health improvement activities were established, stable and likely to continue into the future, but, in common with many other local authorities, did not (with some exceptions) involve partnership across the health economy, or evaluation by their health impact.

### 3.2.2 Ad hoc activities

Examples of ad hoc activities, funded mainly through short-term or ‘soft’ money, included:

- in environment and public protection, the “Big Draw” event in October 2008 at the John Pound leisure centre, featuring live mapping of cycle routes by cyclists carrying GPS trackers;
- the domestic violence and hate crime unit in Community Safety, drawing on a mixture of mainstream and short-term funding; this service also runs a youth offending project, mainly on soft money, working with whole families, and addressing social factors such as health and education;
- some of the work of the Health Improvement and Development Service, funded from a combination of mainstream and short-term services (see below);
- in audit and performance improvement, the corporate strategy team supports multi-agency work including the local strategic partnership (LSP) and also leads on the climate change strategy.

The level of activity suggested that the council was active in seeking opportunities and funding for this kind of work.

### 3.2.3 Health Improvement and Development Service

HIDS has a strategic role within the council and across the City. It commissions prevention and early intervention services on behalf of adult social care and targeted services for children and young people, and leads on issues such as carers’ support services and teenage pregnancy, as well as providing health improvement services directly. It attracts a large amount of external funding into the council. The PCT provides 8.5% of its overall base budget. An example of the flexibility of the funding mix of this service is an adolescent health initiative, initiated by HIDS on two years’ soft money and continued through mainstream funding by the PCT.

### 3.2.4 Multi-agency partnership activity

Portsmouth City Council interviewees reported strong working both across services within the council, and between agencies across the city, compared to other areas, and interviewees from the PCT agreed with this conclusion. Collaboration for development on health issues, within the council and across the other agencies responsible for Portsmouth’s population, is supported by a number of factors. The level of coterminosity between agencies, the single tier of local authority, the joint appointment of the Director of Public
Health and the compact peninsula which contains the city are likely to contribute. The location of a health promotion provider within the local authority is also a support to collaboration between the PCT and the City Council.

Looking to the future, the most important example of cross-agency working will be the Healthy Town, for which the city has been awarded £3 millions of government funds to be matched by local resources. These funds were competed for, and the application had to make a convincing case for local agencies’ imaginative approach to improving the health of the people of Portsmouth and their ability to deliver to a demanding timescale.

Other examples of cross-agency working include:

- the Substance Misuse Panel, involving the City Council, the Police, the PCT and other local agencies;
- the setting up joint commissioning unit for care services between the council and the PCT, with a joint board and pooled funds;
- various partnership arrangements with the voluntary, community and independent sectors, including the involvement of voluntary and community organisations in the delivery of health improvement activities, and the delivery of most commissioned social care services by the independent sector;
- a responsive, intelligence based model used in trading standards which includes community volunteers (who have opportunities for training, and are termed “the Edge”) among its intelligence resources.

3.3 Workforce and organisational development for health improvement

3.3.1 Training and development processes

Portsmouth City Council has a regular system for one-to-one meetings with managers, and annual appraisals, where employees can identify personal training needs. Resources for training were not comparable to those in the NHS, but several services had been able to use planned salary underspends to enhance their training budgets.

Equipping employees to meet statutory requirements is prioritised. Disciplines such as planning and environmental health which are governed by external standard-setting bodies tend to have continuing professional development requirements, and also to have good value training opportunities through these bodies. Beyond these, there is little formal tailoring of training provision to business planning, and the content of training is led by individually identified requests. In part this is a response to the retention difficulties that arise from Portsmouth’s below-market pay rates (paragraph 3.3.2) – meeting training requests is a way of indicating that employees are valued. However, all training, whether internally or externally sourced, is processed through a central point, and the mechanism exists for a more corporate approach. Work was beginning on a new learning and development strategy, exploring the potential of the greater proportion of training and development spending that did not contribute directly to delivery of statutory functions and which was at present unevaluated.

There was a good level of joint workforce training and development relevant to health improvement, including:

- an integrated employment and skills pilot across the Portsmouth and Urban South Hampshire (PUSH) sub-regional partnership;
- joint training between HIDS and the voluntary sector.
• a training package on hidden violence within the Community Safety Service which is provided to other agencies;

• the award of funding for an Advancement Network Prototype, which will bring together advice services to help individuals to advance in work and in life. Delivery of the service through hubs where staff from a wide range of services (potentially including health services) are co-located will provide targeted support to address specific barriers to getting into and on in work. Issues such as child care, further training and skills, personal or life style complications and financial matters are just some of the subjects that the 'Advancement Experts' would provide assistance in resolving;

• several services were taking advantage of a series of 2-day health impact assessment training courses provided by NHS Education South Central, using as worked examples the council’s active transport and obesity strategies. As a result of the training the planning service’s policy team was already undertaking joint work with the Health Improvement and Development Service on the linkage between planning and health agendas; for example, designing cycling and walking into new housing developments.

• several staff from Portsmouth City Council and its partner organisations are attending NHS Education South Central’s Leading Improvement for Health and Wellbeing Programme (see section 1.6 in Chapter 1).

• thought was being given in some services to recommissioning health impact assessment type of training from council resources.

• A member of HIDS staff was preparing for registration as a public health practitioner, and it was expected that more staff would follow.

Several of these activities offer opportunities to build systematically into Portsmouth City Council’s training and development the skills it needs to develop as a health improving organisation fit to excel as a Healthy Town, as does the new strategic approach to learning.

3.3.2 Recruitment and retention

Portsmouth City Council, like other local authorities, struggles to recruit qualified staff with skills which are nationally scarce, particularly social work, planning and environmental health. These difficulties are exacerbated by the proximity of other authorities competing for staff with scarce skills, and, particularly in Portsmouth, by lower rates of pay.

The authority uses a number of strategies to deal with recruitment difficulties. Where there is scope, in planning and those services using environmental health expertise, the authority recruits untrained candidates with aptitude and trains within the authority (‘growing its own’). It also recruits from abroad and in some cases offers help with housing.

Considering its uncompetitive pay rates, Portsmouth City Council does well in retention in many services. Portsmouth was believed to be an area where people liked to live, and the City Council provides some services with reputations for leading edge practice, including its domestic violence service.
3.4 Key points from Chapter 3

- Portsmouth’s local strategic partnership is reported to be effective, and to have developed a local area agreement with strong local commitment.

- Interviewees were aware of the health improvement impact of mainstream activities but most did not involve partnership and there was little evaluation of their health impact.

- There were many ad hoc health improvement activities, including many involving inter-agency partnerships suggesting that the council was active in seeking opportunities and funding for this work.

- The City Council has good local strategic and operational partnerships, and engages in some joint training with other organisations relevant to health improvement.

- The City Council is embarking on a strategic approach to learning and development.

- Like most local authorities the council has difficulties in recruiting and retaining staff in some services, including some such as social work and planning which are important to health improvement.
CHAPTER 4  PROFILE OF THE HEALTH IMPROVEMENT WORKFORCE

This chapter gives data on how the workforce is distributed between the CMO’s categories, and illustrates how the criteria were applied. Appendix 2 gives a flow chart which includes criteria based on content of jobs, training and the level at which people work to determine whether they are in the health improvement workforce, and if so, in which category they belong. Illustrations show how the classifications set out in Box 1 and Box 2 in Chapter 1, and the criteria in Appendix 2, have been applied.

4.1 Number of posts by health improvement workforce category

5262 members of the health improvement workforce were identified in Portsmouth City Council (Table 1). Ninety-eight percent (5180 of 5262) of the health improvement workforce was in the wider health improvement workforce, but outside the special sub-categories, “key public health influencer” and “technical expert” (see Section 1.3 in Chapter 1). These numbers are underestimates, because services investigated excluded some judged not likely to include members of the health improvement workforce.

Table 1: Number of posts by CMO health improvement workforce category

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Influencer</td>
</tr>
<tr>
<td>Technical expert</td>
</tr>
<tr>
<td>Wider Public Health</td>
</tr>
<tr>
<td>Practitioner (CMO definition)*</td>
</tr>
<tr>
<td>Specialist (CMO definition)*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td><strong>Percentage of total workforce</strong></td>
</tr>
</tbody>
</table>

Number of employees at end September 2008. Includes elected members, agency and unpaid staff. Does not include vacancies.

* The CMO’s definitions are based on learning and development needs. The UKPHR standards, based on the need for public protection, are now more widely used. See Chapter 1.

The employees in the public health workforce made up 57 per cent of the workforce, based on interviews with eight services, and examination of job titles in all remaining services.

Table 2 gives the distribution of the health improvement workforce by CMO’s classification and service.
Table 2: Number of posts in Portsmouth City Council by service and CMO health improvement workforce category

<table>
<thead>
<tr>
<th>Service</th>
<th>Key Influencer</th>
<th>Technical expert</th>
<th>Wider Health Improvement</th>
<th>Practitioner (CMO definition)‡</th>
<th>Specialist (CMO definition)‡</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Social Care</td>
<td></td>
<td></td>
<td>724</td>
<td></td>
<td></td>
<td>724</td>
</tr>
<tr>
<td>Audit &amp; Performance Improvement</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Chief Execs</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Children and Young People</td>
<td></td>
<td></td>
<td>157</td>
<td></td>
<td></td>
<td>157</td>
</tr>
<tr>
<td>Community Housing Services</td>
<td></td>
<td></td>
<td>61</td>
<td>5</td>
<td></td>
<td>66</td>
</tr>
<tr>
<td>Community Learning</td>
<td></td>
<td></td>
<td>99</td>
<td></td>
<td></td>
<td>99</td>
</tr>
<tr>
<td>Community Safety</td>
<td></td>
<td></td>
<td>109</td>
<td>4</td>
<td></td>
<td>113</td>
</tr>
<tr>
<td>Culture</td>
<td></td>
<td></td>
<td>119</td>
<td></td>
<td></td>
<td>119</td>
</tr>
<tr>
<td>Democratic &amp; Community Engagement*</td>
<td>9</td>
<td></td>
<td>37</td>
<td></td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>Environment and Public Protection Service</td>
<td>24</td>
<td>29</td>
<td>8</td>
<td>1</td>
<td></td>
<td>62</td>
</tr>
<tr>
<td>Health Improvement &amp; Development</td>
<td></td>
<td></td>
<td>43</td>
<td>15</td>
<td>7</td>
<td>65</td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td></td>
<td>114</td>
<td>3</td>
<td></td>
<td>117</td>
</tr>
<tr>
<td>Learning &amp; Achievement</td>
<td></td>
<td></td>
<td>54</td>
<td></td>
<td></td>
<td>54</td>
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<tr>
<td>Planning Services</td>
<td></td>
<td></td>
<td>36</td>
<td></td>
<td></td>
<td>36</td>
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<tr>
<td>Regeneration &amp; Business</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Revenues &amp; Benefits</td>
<td></td>
<td></td>
<td>102</td>
<td></td>
<td></td>
<td>102</td>
</tr>
<tr>
<td>Safeguarding</td>
<td></td>
<td></td>
<td>241</td>
<td></td>
<td></td>
<td>241</td>
</tr>
<tr>
<td>Schools†</td>
<td></td>
<td></td>
<td>3220</td>
<td></td>
<td></td>
<td>3220</td>
</tr>
<tr>
<td>Transport &amp; Street Management</td>
<td></td>
<td></td>
<td>17</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15</td>
<td>24</td>
<td>5180</td>
<td>35</td>
<td>8</td>
<td>5262</td>
</tr>
</tbody>
</table>

* Includes elected members
† Includes “Building Schools for the Future” project
‡ The CMO’s definitions are based on learning and development needs. The UKPHR standards, based on the need for public protection, are now more widely used. See Chapter 1.
Members of the wider health improvement workforce were found in nearly every setting, and made up a majority of the workforce of several services. The extent of their contribution varied greatly, and illustrations are given in Box 3. Box 4 illustrates the work of public health practitioners and health technical experts by the CMO’s classification. Key health influencers were restricted to a few settings – the strategic directors in the Chief Executive’s service, and some elected members in the Democratic and Community Engagement Service. Public health specialists by the CMO’s classification were found only in the Environment and Public Protection, and Health Improvement and Development Services (Box 5).

Box 3: Examples of members of the wider health improvement workforce

<table>
<thead>
<tr>
<th>Members of the wider health improvement workforce do work which contributes to improving or maintaining the health of communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff in the <strong>Corporate Strategy Unit</strong> in the <strong>Audit and Performance Improvement Service</strong> develop corporate strategy, provide the statistical information for assessing population wellbeing, and support local strategic partnership.</td>
</tr>
<tr>
<td>The <strong>Community Safety Service</strong> includes the <strong>Community Wardens</strong> who work with partners to improve community safety, for example giving evidence in prosecutions relating to crack houses, so that community members need not risk doing so.</td>
</tr>
<tr>
<td>All roles involving hands-on work with <strong>children</strong>, in <strong>early years, schools and youth settings</strong>, address important determinants of health.</td>
</tr>
</tbody>
</table>

Box 4: Examples of health technical experts and public health practitioners

| Public health practitioners work hands on with communities using specialised health-related knowledge and skills. The **Community Housing Service** employs environmental health officers and technicians who deal with housing standards in the private rented sector, addressing health and safety, and housing conditions such as damp. In the **Community Safety Service**, the **Alcohol Intervention Team** provides screening and brief interventions and receives referrals from health and criminal justice services. |
| Health technical experts work in specialised fields do work is vital to public health but who normally view development as an activity which lies within their own professional discipline only. All the technical experts identified in Portsmouth City Council work in the **Environment and Public Protection Service**, in areas such as environmental protection and contaminated land, pest control and trading standards. |
The Chief Executive and strategic directors control resources which can have a profound impact on population health, as do elected members who are Cabinet Members. These roles were classed as key health influencers.

Senior environmental health officers working at strategic level have a core of knowledge, skills and experience which includes the ability to manage strategic change in organisations, to work in management teams and leadership of public health initiatives, as well as more technical areas of regulation of commercial food handling, pollution and pest control, health and safety and emergency planning. Senior managers within the Health Improvement and Development Service develop health improvement at strategic level, and have appropriate expertise to equip them for that work. They were classed as public health specialists by the CMO's project definitions.

4.2 Key points from Chapter 4

- More than half (57%) of the workforce Portsmouth City Council was included in the health improvement workforce.

- Some workforce categories were found in a limited range of roles. Key public health influencers were found in a small set of senior roles, all public health specialists by the CMO's definition were working at strategic level in Environment and Public Protection and Health Improvement and Development, and practitioners were either in environmental health roles or in community development or leisure projects with a health focus.

- Members of the wider health improvement workforce, who made up the majority of the health improvement workforce, were found in almost all services.
CHAPTER 5  CONCLUSIONS

This chapter summarises conclusions from the findings of the project.

5.1 Strengths of Portsmouth City Council as a health improvement organisation

Portsmouth City Council had a number of strengths as a health improvement organisation.

- There was a strong commitment to health improvement at strategic level.
- The Health Improvement and Development Service brought together several health improvement and preventive services normally dispersed among several parts of most local authorities, allowing an exceptionally focused approach to health improvement. The service is taking a systematic approach to developing the health improvement capability of its staff.
- The unusual matrix structure was supportive of collaboration across different council services and there was evidence that this collaboration was actually happening.
- There was good collaboration between agencies, supported by:
  - coterminosity between the PCT and the City Council;
  - organisational continuity in the PCT, while neighbouring PCTs had been reorganised;
  - the compact peninsula on which the city was located.
Both the Audit Commission’s Corporate Assessment\(^{10}\) and the Joint Area Review of children’s services\(^{11}\) praised the strength of partnership in Portsmouth.
- Portsmouth City Council was working on a strategy to develop the council as a learning organisation, which was likely to be supportive of further development as a health improvement organisation.
- The award of Healthy Town status was a great achievement for the City Council and its partners, and could be a focus for development. At their best, initiatives such as Healthy Town provide national and international showcases for good practice.

5.2 Need for development

There were findings which suggested that development was still necessary.

- The considerable level of mainstream funded, usually statutorily required activity which resulted in improved health for Portsmouth’s population seemed to be conducted, to a large extent, without strong focus on its health benefits or links to other health-related activity. This was being addressed, in some services, by health impact assessment training. It may have been an unintended consequence of the presence of the Health Improvement and Development Service, which could be seen within the council as the home of all health improvement activity.
- Despite the contribution of mainstream and ad hoc services to health, some interviewees assumed that population health was mainly the responsibility of the health services.
- An unintended consequence of both the PCT and the City Council learning to work with the innovative Health Improvement and Development Service was a lack of clarity and conflicting perceptions about the location of health improvement expertise and
leadership. The Health Improvement and Development Services staff had strengths in many generic competencies important to health improvement but lacked formal qualifications which gave evidence of competencies which might be expected in an equivalent NHS provider.

- The Council had capacity problems, exacerbated by its uncompetitive pay rates. For example the Joint Area Review of children’s services raised a concern about recruitment of social workers. These problems reduce the flexibility needed to respond to health needs.

5.2.1 Perceived need for workforce and organisational development for health improvement

When key informants were asked what kinds of development for health improvement would be useful, many informants saw no scope for development of the workforce in this area, given competing pressures on their time and resources. Those who did see a need identified development activities that were closely linked to action. Types mentioned included:

- working with population-based data – technical aspects of needs assessment such as choosing the right population;
- building an evidence base – literature searching and critical appraisal.

There was also an expressed need for better capacity for high level policy analysis and horizon scanning, a capacity which would support a strategic approach to health improvement.
CHAPTER 6 RECOMMENDATIONS

The following recommendations arise from this work:

<table>
<thead>
<tr>
<th>Development through the Health Improvement Development Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Annual workshops organised by the Health Improvement and Development Service for key health influencers on leadership for health improvement.</td>
</tr>
<tr>
<td>2. Taking opportunities to build ownership of health issues across the council’s services through cross-organisation initiatives.</td>
</tr>
<tr>
<td>3. A joint evaluation by the city council and PCT of health improvement across Portsmouth</td>
</tr>
<tr>
<td>4. Building quality in health improvement through Healthy Town</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building capacity and capability in the Portsmouth health economy for health improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Building capacity and capability through partnership within the City Council and across the health economy</td>
</tr>
<tr>
<td>6. Expanding capacity for policy analysis and horizon scanning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing the workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. A programmed plan of development for Health Improvement Development Service staff</td>
</tr>
<tr>
<td>8. Building evidence and data skills</td>
</tr>
</tbody>
</table>

6.1 Development through the Health Improvement Development Service

The Health Improvement and Development Service is a great asset to the Portsmouth health economy, but there are unintended consequences from the presence of this service, including a lack of ownership of health issues in other parts of the council, and a lack of clarity about the location of health improvement leadership and expertise across the city.

1. Annual workshops organised by the Health Improvement and Development Service for key health influencers on leadership for health improvement

It is recommended:

- That a half-day themed workshop on leadership for health improvement be provided annually for key health influencers (council members, strategic directors of service), to raise awareness of the impact of a wide range of council services on health.
  - The events should be facilitated by the Health Improvement and Development Service.
  - They should involve some input from leaders in local authorities outside Portsmouth.
  - The theme should change annually according to the council’s priorities.
2. **Taking opportunities to build ownership of health issues across the council’s services through cross-organisation initiatives**

It is recommended:

- That cross-council initiatives relevant to health improvement or workforce or organisational development, such as the Advancement Network Prototype, the new strategic approach to learning within the council, and the Health Town be used as opportunities to raise awareness of the contribution of most of the council’s services to improving the health of Portsmouth’s population.

3. **A joint evaluation by the city council and PCT of health improvement across Portsmouth**

It is recommended:

- That the PCT and the Health Improvement Development Service jointly commission an evaluation of the impacts (positive and negative, planned and unintended) of the structure and governance of their health improvement arrangements on the capacity of the health economy to address health improvement, committing themselves to disseminating the findings, and to developing and implementing an action plan to address any emerging issues. It is hoped that this evaluation will clarify issues of the location of leadership and expertise.

4. **Building quality in health improvement action through Healthy Town**

It is recommended:

- That the Health Improvement and Development Service take the opportunity of Healthy Town status to share with those nationally who do what they do, at practitioner and specialist level, and among the wider workforce, particularly those who were preparing for practitioner and specialist roles. The service should be seeking to develop initiatives to increase opportunities for physical activity and healthy eating which provide models of good practice in using the evidence base and quality standards.

6.2 **Building capacity and capability in the Portsmouth health economy for health improvement**

The Council has difficulty in recruiting and retaining, particularly in some skills important to delivering mainstream services with health impact including environmental health, planning and social work. This pressure can limit flexibility, but partnership can help share resources and promote innovation. When resources are stretched, it is important to protect and even expand the capacity to think strategically and creatively.

5. **Building capacity and capability through partnership within the City Council and across the health economy**

It is recommended:

- That the council actively explore opportunities to enhance the health impact of mainstream activities through partnerships within and outside the council, including collaboration with neighbouring authorities.
• That good use is made of the learning and development of several individuals within the council and its partner organisations who attended the Leading Improvement for Health and Wellbeing Programme.

6. Expanding capacity for policy analysis and horizon scanning

It is recommended:
• That the council consider expanding the resources needed to analyse policy and maintain awareness of national developments. These resources will sustain the capacity to think strategically about addressing determinants of health and social inequality, and help the council to provide evidence of the contribution of its mainstream and ad hoc health related services to health improvement.

6.3 Developing the workforce

7. A programmed plan of development for Health Improvement

Development Service staff

HIDS was planning a consistent process of recording and mapping qualifications across the service through the appraisal and the personal development planning process, and development through the public health practitioner training scheme.

It is recommended:
• That a programmed plan for development of health improvement competencies be put in place and implemented for HIDS staff.

8. Building evidence and data skills

Interviewees reported that improving the skills to interpret, critically analyse and present data, and to build an evidence base for action for health improvement would help advocacy for these projects in an environment where resources were limited.

It is recommended:
• That training in skills to interpret, critically analyse and present data, and to build an evidence base for action for health improvement and addressing the determinants of inequalities in health be offered to research officers, policy officers, and holders of posts with similar functions, in all Council services with health impact.
APPENDIX 1: INTERVIEWEES

Portsmouth County Council
Alan Cufley, Head of Service, Community Housing
Rachael Dalby, Head of Service, Community Safety
Paul Hunt, Head of Service, Public Protection
Paddy May, Corporate Strategy Manager, Audit and Performance Improvement Service
John Slater, Head of Service, Planning
Kathy Wadsworth, Strategic Director
Susie Waller, Head of Service, Health Improvement and Development Service
Rob Watt, Head of Service, Adult Social Care
Kay White, Head of Service, Human Resources

Portsmouth PCT
Paul Edmondson-Jones, Director of Public Health
Joanne Newton, Senior Public Health Development Manager

Distribution
Portsmouth City Council Strategic Directors’ Board
Portsmouth Local Strategic Partnership Health and Social Wellbeing Partnership Board
APPENDIX 2: WHO IS IN THE HEALTH IMPROVEMENT WORKFORCE?

START

- Work contributes to maintaining or improving the health of communities?

  - No → NOT HI WORKFORCE
  - Yes → HI WORKFORCE

  - HI WORKFORCE

    - Health improvement is major objective of post?
      - No → WIDER PH
      - Yes → HI WORKFORCE

      - HI WORKFORCE

        - Postholder public health trained?
          - No → WIDER PH
          - Yes → HI WORKFORCE

          - HI WORKFORCE

            - Postholder has gained transferable public health skills through experience?
              - No → WIDER PH
              - Yes → HI WORKFORCE

              - HI WORKFORCE

                - Works with populations or communities?
                  - No → WIDER PH
                  - Yes → HI WORKFORCE

                  - HI WORKFORCE

                    - Applies public health skills for strategic change?
                      - No → WIDER PH
                      - Yes → HI WORKFORCE

                      - HI WORKFORCE

                        - Remit has profound influence on public health?
                          - No → WIDER PH
                          - Yes → HEALTH KEY INFLUENCER

                          - HEALTH KEY INFLUENCER

                            - Specialist not classed as public health whose development is within own discipline?
                              - No → HEALTH TECHNICAL
                              - Yes → WIDER PH OTHER

                            - HEALTH TECHNICAL

                              - Work involves a substantial proportion of disease prevention/health education with patients or communities?
                                - No → WIDER PH
                                - Yes → HI/PH PRACTITIONER

                                - HI/PH PRACTITIONER

                                  - Work involves significant responsibility for defined community/patch?
                                    - No → WIDER PH
                                    - Yes → HI/PH PRACTITIONER

                                    - HI/PH PRACTITIONER

                                      - Mostly works hands on with patients and community members?
                                        - No → WIDER PH
                                        - Yes → HI/PH PRACTITIONER

                                        - HI/PH PRACTITIONER

                                          - Health improvement is major objective of post?
                                            - No → WIDER PH
                                            - Yes → HI/PH PRACTITIONER

                                            - HI/PH PRACTITIONER

                                              - Work contributes to maintaining or improving the health of communities?
                                                - No → WIDER PH
                                                - Yes → HI/PH PRACTITIONER

                                                - HI/PH PRACTITIONER

                                                  - Adapted from Walters et al 2002

- Walters, Chapman-Andrews

- Portsmouth Health Improvement Organisation
APPENDIX 3: SEMI-STRUCTURED INTERVIEW TOPIC GUIDE

Meetings with key informants took the form of an exchange of information and understanding, with the researcher both informing and learning from informants. Questions were not scripted but all meetings had the following structure.

Preamble
- Summary of definition of health improvement, local authority role in health improvement, importance of partnership, need for mutual understanding between local authorities and NHS public health
- The project – objectives, funding, outputs, timescale
- Outline of the structure of the interview

Understanding of key informant’s service
- Key informant asked about the functions and structure of their service
- Identification of health improvement action within the service
  - Which activities explicitly improve or maintain health
  - Which activities have an impact on underlying determinants of health
  - How were public health actions of both types funded (mainstream, short term, extent of funding)
  - Did they involve partnership with other agencies

Identification of public health roles
- Posts contributing to public health identified using the flow-chart (Appendix 2).
- Data on numbers, and whether posts were full- or part-time, filled or vacant and any time-limits to funding collected on a pro-forma

Barriers and facilitating factors to public health action and public health development
- Exploration of labour market – recruitment, retention, professional structures
- Exploration of operation of local partnership
- Explanation by key informant of current process for identifying and meeting training and development needs
- Identification of public-health-related training
- Key informant’s views on existing public health training and development needs
REFERENCES


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