PUBLIC HEALTH DEVELOPMENT IN THREE SOUTH-EAST HAMPSHIRE LOCAL AUTHORITIES

A REPORT TO NHS EDUCATION SOUTH CENTRAL

JUNE 2008

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Joanna Chapman-Andrews
ACKNOWLEDGEMENTS

Thanks are due to all our interviewees who gave their time and thoughtful contributions to this work, the South-East Hampshire Area Public Health Liaison Board which adopted the project into their programme, and to Kathryn Rowles and Noreen Kickham, Area Directors of Public Health for East Hampshire who gave helpful advice on the report.

Rhiannon Walters MSc FFPH
Specialist in Public Health

Rhiannon Walters is an experienced public health specialist with skills in research methods and epidemiology. She specialises in health policy, and the evaluation of complex multi-sectoral interventions. She worked as information officer at the Faculty of Public Health Medicine from 1989 to 1996, worked for London Health Economics Consortium to 1999, specialising in public health and health promotion projects, and has worked independently since 1999. She is a registered public health specialist. Before moving to public health she worked in local government at strategic level. She designed and conducted a similar project in London boroughs as part of the London Public Health Workforce Development project.

Joanna Chapman-Andrews, MSc, FRSH, MFPH
Head of Public Health Development Programmes, NESC

Joanna Chapman-Andrews has been working for the NHS for almost 20 years in the speciality of public health. During the last eight years this has been as the lead for Public Health education, training and development; the role now covers the NHS South Central Strategic Health Authority area. The work encompasses developing the strategic direction of the development of the PH practitioner and wider workforce, commissioning and ensuring provision of training and education programmes at all levels both with the NHS and with health partner organisations, working closely with the development of public health specialists.
Table 3: Number of posts in Gosport by service and CMO public health workforce category

Table 4: Number of posts in Havant by service and CMO public health workforce category
CHAPTER 1  BACKGROUND

Public health is “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”. It involves a wide range of organisations, and the NHS is not equipped, alone, to improve the health of populations and reduce inequalities. Local authorities are key local partners, and this was recognised by two successive Chief Medical Officers in their project to strengthen the public health function (‘CMO’s project’). This report describes a local initiative to apply the CMO’s project in Fareham, Gosport and Havant, three boroughs in south-east Hampshire. It is intended to support those organisations, with the involvement of their local primary care trust, in developing as public health organisations, by identifying their public health workforce.

1.1 Aims and objectives of the project

This project aimed to:

- develop the existing partnership and improve the effectiveness of the partnership in achieving its objectives in physical activity, obesity and older people’s independence and wellbeing;
- strengthen the public health 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 public health across the organisations.

This would enable identification of the boroughs’ development needs and ultimately provide a training programme for them, related to whatever training and development already exists within the organisations or their partner agencies, or that they can already access.

1.2 Activities of the project

The project worked to:

- establish which services in the local authorities and their associated partner organisations (including the voluntary and community sector) employed staff who work on health-related issues and could be considered to be public health practitioners and “key influencers” in the wider workforce (based on the CMO’s classification and previous similar work in London, Box 1 and Box 2);
- 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 each authority, who were well informed about staff numbers and roles. A list of interviewees is given at Appendix 1. Documents used to structure the meeting are given at Appendix 2 (an instrument used to identify members of the public health workforce) and Appendix 3 (a topic guide used by the
The project was conducted by Rhiannon Walters between November 2007 and April 2008.

1.3 What is the public health 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).

Box 1: Public Health Categories from the CMO's project to strengthen the public health function

- “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)²

These definitions preceded the setting up of the UK Voluntary Register of Public Health Specialists, 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 wider public health workforce is broad, containing most of those contributing to public health in any sector, and two subdivisions were developed (Box 2).
Box 2: Public Health Categories from the CMO's project to strengthen the public health function

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key health influencers</td>
<td>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</td>
</tr>
<tr>
<td>Experts</td>
<td>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</td>
</tr>
</tbody>
</table>

(From Report of the Chief Medical Officer's project to strengthen the public health function in England 1998)

Appendix 2 shows the algorithm for determining who is in which category of the public health workforce, based on the CMO's project definitions, which was used for this project.

1.4 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 is being planned for the autumn. This is being 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 is 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.

1.5 Structure of this report

- Chapter 2 describes the authorities, the public health function of the local primary care trust, and the local population.

- Chapter 3 gives a profile of the public health workforce in the three authorities.

- Chapter 4 describes the extent and type of work contributing to public health that the authorities now undertake.

- Chapter 5 explores the potential for further development of the organisations as public health organisations.
• Chapter 6 makes recommendations for the authorities, NSC and the primary care trust public health department.
CHAPTER 2  FAREHAM, GOSPORT AND HAVANT

This chapter sets out the roles and the organisation of the three authorities involved in the project and some of their collaboration with local agencies including the primary care trust. It also describes how the primary care trust is organised to engage with the local authorities on public health matters.

2.1 Borough council functions

District councils including the three borough councils, Fareham, Gosport and Havant are responsible for:

- Local planning
- Housing
- Local roads
- Building regulation
- Environmental health
- Refuse collection
- Recreation
- Cultural matters

These functions include nearly all local public services, apart from education social services and major highways. 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 are expected to achieve 3% efficiency savings during the current year 2008/09.

2.2 Contribution to public health

Two kinds of activity contribute to public health which can be characterised as ‘mainstream’ and ‘ad hoc’.

2.2.1 ‘Mainstream’ activities contributing to public health

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

Social and economic factors are strong determinants of health and wellbeing and local government services such as 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 outcomes of these mainstream activities, but none the less they make an important contribution.

2.2.2 ‘Ad hoc’ activities contributing to public health

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.

2.2.3 Organisational structure differences between project boroughs

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.

Which services are contracted out has an impact on the workforce, and the following are major differences.

2.2.3.1 Fareham
Fareham retains both its housing stock and its directly-employed cleansing, recycling and refuse service, and is the largest employer of the three authorities.

2.2.3.2 Gosport
Gosport has retained its housing stock, but contracts out its cleansing, recycling and refuse collection.

2.2.3.3 Havant
Havant has transferred 100% of its housing stock to registered social landlords. The function of housing allocation is retained in the authority within a service which also deals with business regeneration and community regeneration. It employs its cleansing, recycling and refuse collection operatives directly.

2.3 Hampshire PCT
Hampshire Primary Care Trust (PCT) has a public health leadership role across Hampshire, including Fareham, Gosport and Havant. The organisations responsible for the health of these populations have changed several times in the years from 1997 preceding the start of this project, and these changes have had some impact on continuity and priorities for health improvement programme delivery.

• From 1997, England’s 100 health authorities were given clear responsibility for the health of local populations, and each had a director of public health
• Between 2002 and 2004, responsibility for public health was transferred from health authorities to 302 primary care trusts (PCTs) operating at a more local level, coterminous with local authorities as far as possible. Joint appointments of directors of public health with local authorities were encouraged.
• In 2005 a planned reduction in the number of PCTs was announced, and in 2006 the number of PCTs was reduced to 152, with 7 PCTs including Fareham and Gosport PCT, and East Hampshire PCT (covering Havant) merging to form Hampshire PCT, the largest in the country.

Within the public health directorate, there is a small team responsible for both the strategic leadership and commissioning of health improvement programmes at both county and locality level. At area level there is an area director of public health (covering Fareham, Gosport and Havant Borough Councils) who provides input to the Local Strategic Partnerships in each local authority and acts as the lead for health and wellbeing programmes. This is supported by a small county wide team of PCT health improvement managers.

In line with government policy, Hampshire PCT public health services focus on commissioning programmes through a range of providers. Their public health function is now a smaller but more refined resource than its predecessor PCTs, containing a reservoir of public health expertise. It invests focused resources in areas of poor health indicators, where it is able to be proactive, while resource limits mean some routine activities engaged in by earlier authorities must be scrutinised rigorously for value added. As well as the health
improvement function most familiar to local authorities, public health also commissions programmes on immunisation and vaccination, screening and health protection and provides public health input to the commissioning of health services.

2.3.1 Public health local partnership – the Area Public Health Liaison Board

The three authorities work together at member and officer level on public health issues, through an Area Public Health Liaison Board which includes Hampshire PCT. The board has identified priorities to address jointly – physical activity, obesity and older people’s independence and wellbeing.

2.4 Populations of project boroughs

Information on the health of the three boroughs is available from health profiles produced by the Department of Health.7

2.4.1 Fareham

In Fareham, life expectancy is increasing and is higher than the England and regional average. Homelessness is higher than the national average, at 13.2% of households on the housing list being homeless in 2004/05. None of its 15 wards are among the most deprived two-fifths of areas in England.

2.4.2 Gosport

In Gosport, life expectancy is increasing but is close to the England and below the regional average. Homelessness is higher than the national average, at 14.1% of households on the housing list being homeless in 2004/05. None of its 17 wards are among the most deprived fifth of areas in England, but four include populations in the most deprived two fifths.

2.4.3 Havant

In Havant, life expectancy is increasing and is higher than the England and regional average. Homelessness is close to the national average. Four of its 14 wards are among the most deprived fifth of areas in England and a further four contain populations in the most deprived two fifths.

2.5 Key points from this chapter

- These boroughs provide most important local services, apart from education, social services and highways.
- Some mainstream functions contribute to public health without being labelled as public health, and there are some local government activities explicitly intended to improve health. These activities tend to be more ad hoc, and have less secure funding.
- The three authorities have different internal organisations and not all own their housing stock or employ the labour force in cleansing, refuse and recycling.
- There is an Area Public Health Liaison Board, bringing together the three local authorities and Hampshire PCT, with a shared action plan prioritising obesity, physical activity and older people’s wellbeing.
- The health of Fareham and Havant’s population is generally better than average for England, while Gosport’s is close to the England average, and worse than the regional average. There are areas of deprivation within Gosport and Havant.
This chapter gives data on how the workforce is distributed between the CMO’s categories in each of the boroughs in the project, and illustrates how the criteria were applied. It explores how differences in organisation of the three boroughs affect the profile of the public health workforce. 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 public health workforce, and if so, in which category they belong. At the start of each borough section, a couple of illustrations show how the classifications set out in Box 1 and Box 2 and the criteria in Appendix 2 have been applied.

3.1 Number of posts by public health workforce category and borough

Five hundred and sixty-eight members of the public health workforce were identified in these three authorities (Table 1). Seventy-nine percent (440 of 559) of the public health workforce was in the wider public health workforce, but outside the special sub-categories, “key public health influencer” and “technical expert” (see Section 1.3 in Chapter 1). This proportion is lower than that found in London unitary authorities in 2001, because these authorities do not include the large education and social services which include many members of the public health workforce.

Table 1: Number of posts by CMO public health workforce category and borough

<table>
<thead>
<tr>
<th>Category</th>
<th>Fareham</th>
<th>Gosport</th>
<th>Havant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Influencer</td>
<td>14</td>
<td>16</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td>Technical expert</td>
<td>5</td>
<td>14</td>
<td>14</td>
<td>33</td>
</tr>
<tr>
<td>Wider Public Health*</td>
<td>160</td>
<td>93</td>
<td>192</td>
<td>445</td>
</tr>
<tr>
<td>Practitioner</td>
<td>5</td>
<td>14</td>
<td>20</td>
<td>39</td>
</tr>
<tr>
<td>Specialist (CMO definition)</td>
<td>3</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>187</td>
<td>141</td>
<td>240</td>
<td>568</td>
</tr>
<tr>
<td><strong>Percentage of total workforce</strong></td>
<td>33.3</td>
<td>33.8</td>
<td>53.8</td>
<td>41.3</td>
</tr>
</tbody>
</table>

* includes recycling & refuse and cleansing operatives in Fareham and Havant

The employees in the public health workforce made up a third to just over a half of the total workforce in each authority. The higher proportion in Havant could be accounted for by having interviewed the most senior officer in every service, and therefore having an opportunity to review the entire workforce as potential members of the public health workforce.

The findings by borough below illustrate how different organisations of work could lead to different profiles for organisations serving the same functions. However, two categories, “key public health influencer” and “public health specialist” by the CMO’s project definition, were closely equivalent in every borough.
Box 3: Key public health influencers and public health specialists by the CMO’s definition

The **Chief Executive** and senior managers in all three authorities control resources which can have a profound impact on population health, as do certain elected members, including Executive Members in Fareham, Board Chairmen in Gosport and Portfolio Holders in Havant. All these roles were classed as key public health influencers.

Senior environmental health officers working at strategic level (very few in each authority) 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. They were classed as **public health specialists**.

3.2 Fareham

Box 4: Fareham – examples of public health technical experts and members of the wider public health workforce

The environmental health officers in Fareham focusing on air pollution contaminated land and noise control were classed as **public health technical experts** (who do work which is vital to public health but who normally view development as an activity which lies within their own professional discipline only).

Fareham’s community football development officer develops football opportunities with women, girls and people with disabilities. This post is not full time, and funding will cease in 2012. It was classed as being in the **wider public health workforce**, because of its potential to further health improvement.

Table 2: Number of posts in Fareham by service and CMO public health workforce category

<table>
<thead>
<tr>
<th>Service</th>
<th>Key Influencer</th>
<th>Technical expert</th>
<th>Wider Public Health</th>
<th>Practitioner</th>
<th>Specialist (CMO definition)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive's Department</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Customer Services</td>
<td>1</td>
<td>118</td>
<td>119</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning and Transport</td>
<td>2</td>
<td>7</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulatory Services</td>
<td></td>
<td>5</td>
<td>31</td>
<td>5</td>
<td>3</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Elected Members</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>5</strong></td>
<td><strong>160</strong></td>
<td><strong>5</strong></td>
<td><strong>3</strong></td>
<td><strong>187</strong></td>
</tr>
</tbody>
</table>

3.2.1 Chief Executive’s Department

This department included the performance and improvement unit, with members of the wider public health workforce supporting partnerships, and working on social inclusion and target setting across the organisation.
3.2.2 Customer Services

Fareham’s customer services include strategic housing, leisure and community services, and street-scene (recycling and refuse, cleansing and ground maintenance), and members of the wider public health workforce were found in all these services. The street-scene staff are directly employed, and cleansing and recycling/refuse operatives were included in the wider public health workforce. Leisure and community managed health projects, although no worker had sufficient public health content to be defined as a public health practitioner.

3.2.3 Planning and Transport

Planning and transport included a team focusing on strategic planning, addressing issues such as green space, health service and transport needs in new developments, included in the wider public health workforce.

3.2.4 Regulatory Services

Regulatory services include environmental health, where Fareham’s five public health practitioners and three public health specialists (by the CMO’s criteria) were employed. Environmental health officers and technical officers focussing on pollution were classed as “technical expert”. Members of the wider public health workforce in this service included staff working on licensing, pest control, community safety and emergency planning.

3.3 Gosport

Box 5: Gosport – examples of public health practitioners and members of the wider public health workforce

| Most of Gosport’s environmental health officers and environmental health technicians (apart from 4 working at strategic level) were classed as public health practitioners, because they work hands on with communities and use specialised knowledge and skills in public health. They were involved at operational level in dealing with commercial food hygiene and pollution control |
| Gosport’s Sheltered Housing Scheme Managers undertake needs and risk assessment to ensure that programmes meet individual need. They provide activities for housing scheme residents including physical activity and personal protection. They ensure that the environment is safe, and are also working on a telecare project outside the sheltered schemes. There is a move towards less directly provided sheltered accommodation and more support in community settings. These managers were classed as members of the wider public health workforce because of their work in furthering health improvement. |
Table 3: Number of posts in Gosport by service and CMO public health workforce category

<table>
<thead>
<tr>
<th>Service</th>
<th>Key Influencer</th>
<th>Technical expert</th>
<th>Wider Public Health</th>
<th>Practitioner</th>
<th>Specialist (CMO definition)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive's Department</td>
<td>1</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Development Services</td>
<td>1</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Environmental Services</td>
<td>1</td>
<td>17</td>
<td>14</td>
<td>4</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Housing</td>
<td>1</td>
<td>54</td>
<td></td>
<td></td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>Leisure and Cultural Services</td>
<td>1</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Elected Members</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>14</strong></td>
<td><strong>93</strong></td>
<td><strong>14</strong></td>
<td><strong>4</strong></td>
<td><strong>141</strong></td>
</tr>
</tbody>
</table>

3.3.1 Chief Executive's Department

The community safety function reports through the Chief Executive’s department in Gosport, and includes several members of the public health workforce delivering or commissioning voluntary and community sector projects related to inclusion. The department also hosts the economic prosperity unit which contributes to the public health workforce.

3.3.2 Development Services

Planners and the traffic management team in the development services were classed as public health technical experts.

3.3.3 Environmental Services

This service contains Gosport’s public health practitioners and specialists (by the CMO’s criteria), in the environmental health service. Street scene, including refuse, recycling, cleansing and grounds maintenance, employs members of the wider public health workforce, but refuse, recycling and cleansing are contracted out, affecting the total size of the public health workforce in this authority relative to neighbouring authorities.

3.3.4 Housing

Gosport has retained its housing stock, and this service contains the bulk of its wider public health workforce.

3.3.5 Leisure and Cultural Services

This service included a range of staff supporting physical activity and childcare who are in Gosport’s wider public health workforce.

3.4 Havant

Box 6: Havant – examples of public health practitioners and members of the wider public health workforce

Havant’s Community Regeneration Team Leader is responsible for several projects within Community Regeneration, including projects with people aged over 50 involving physical activity, dance and smoking cessation. This post was
classed as a **public health practitioner** because it involved working directly with groups and communities with health improvement as a major objective.

**Havant Customer Services Centre Team** resolve 85% of queries to the council by phone, letter and email with no further contact with other council officers. Their direct contact with the local community on issues critical to their wellbeing such as housing noise and fly-tipping means they have an impact on health which makes them members of the **wider public health workforce**.

### Table 4: Number of posts in Havant by service and CMO public health workforce category

<table>
<thead>
<tr>
<th>Service</th>
<th>Key Influencer</th>
<th>Technical expert</th>
<th>Wider Public Health Practitioner</th>
<th>Specialist (CMO definition)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Services</td>
<td>132</td>
<td>15</td>
<td>2</td>
<td>149</td>
<td></td>
</tr>
<tr>
<td>Customer and Support Services</td>
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<td>3</td>
<td>21</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Development and Technical Services</td>
<td>1</td>
<td>8</td>
<td>26</td>
<td>35</td>
<td></td>
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<tr>
<td>Development</td>
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<td>9</td>
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<td>Regeneration</td>
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<td>Elected Members</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>14</strong></td>
<td><strong>192</strong></td>
<td><strong>20</strong></td>
<td><strong>240</strong></td>
</tr>
</tbody>
</table>

### 3.4.1 Environmental Services

Environmental services employed more than half of Havant’s public health workforce. Most of Havant’s public health practitioners, and all its public health specialists by the CMO’s definition were in this service, and it also employed the recycling, refuse and cleansing operatives which made up the largest group in the wider public health workforce.

### 3.4.2 Customer and Support Services

Customer and support services included members of the building maintenance team who were classified as technical experts, and also the customer service centre staff who acted as first point of contact with the public, and were classified as wider public health workforce.

### 3.4.3 Development and Technical Services

The largest group of Havant’s technical experts was found in the Development and Technical Services, and it also contributed to the wider public health workforce through planners and managers.

### 3.4.4 Organisational Development

Members of the wider public health workforce in this service focused on partnership and equalities, and it also included a technical expert responsible for maintaining a representative panel of the local population and obtaining feedback on key issues.
3.4.5 Regeneration

Regeneration covered community regeneration, business regeneration and housing, and all areas contributed to the public health workforce, including technical experts within the housing service. There had been a 100% stock transfer to registered social landlords, but the borough retained responsibility for allocation and decent home standards. Practitioners were found in community regeneration where there were health and sports development projects.

3.5 Key points from this chapter

- A third to a half of the workforces of these authorities were included in the public health 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 senior environmental health officers working at strategic level and practitioners were either in environmental health roles or in community development or leisure projects with a health focus.
- The remaining categories, public health technical experts and members of the wider public health workforce, who made up the majority of the public health workforce, were found in all services.
- The way functions were carried out was organised differently in each borough, and these differences had implications for the profile of the public health workforce in each borough.
CHAPTER 4  LOCAL AUTHORITIES AS PUBLIC HEALTH ORGANISATIONS

This chapter describes the extent and type of work contributing to public health that the authorities now undertake, and their level of development as public health organisations, including partnership with the NHS. 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 public health activities;
- a shared understanding of public health across the organisation;
- partnership with the NHS to build a shared understanding across the health economy.

4.1 Public health activities

Chapter 2 identified two types of public health activity within local authorities:

- ‘mainstream’ activities forming part of authorities’ statutory functions and funded from mainstream sources;
- ‘ad hoc’ activities, generally explicitly labelled as health activities, often funded from short-term funding.

4.1.1 Mainstream activities

Discussion of the local authorities’ housing, regulatory, street scene and other mainstream functions revealed a good understanding of their public health impact in all authorities. Examples were:

- in housing, the provision of appropriate housing for vulnerable groups and addressing fuel poverty;
- in regulatory services, ensuring that private sector rented housing was safe.

In most cases these functions were carried out without health partnership, or measurement of their health outcomes.

Environmental health was an exception. The service has a common history with NHS public health, and until 1974 hosted the medical officer of health, the forerunner of the director of public health role now within the NHS. Until more recently it was also the home of health education or health promotion in most authorities, and the shift of this work was mentioned with regret by at least one environmental health interviewee. The service has responsibilities for infection control and sometimes emergency planning. These functions involve liaison with the Health Protection Agency, a public health organisation which is no longer organisationally part of the NHS, but works in close partnership with it. Environmental health is also responsible for implementation of ‘smokefree’ legislation, with potential for tobacco control partnerships.

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 general, mainstream public health activities were established, stable and likely to continue into the future, but did not (with some exceptions) involve partnership across the health economy, or a day-to-day awareness of their health impact.

4.1.2 Ad hoc activities

Examples of ad hoc activities included:

- health development projects within the leisure and community service in customer services in Fareham;
- a thematic review (one of several conducted within Fareham) of ‘safe, healthy borough’ led by environmental health, looking at activities across all services and making recommendations;
- commissioning and direct provision of projects with young people at risk of offending through the community safety unit in the chief executive’s department in Gosport;
- play workers, a sizeable childhood obesity project, and an older people’s health project in the community regeneration service in Havant.

Informants reported that many of these had been cut back in the past, and some present activities were under threat. The short-term and insecure status of the projects, and their scattered location in different services according to organisational variations and funding opportunities, however, meant that it could be hard to sustain a developed public health workforce within an organisation. There was a lack of organisation-wide shared understanding of the elements of the organisations’ contributions to public health, found to varying degrees in all three boroughs. This was illustrated, in two of the boroughs, by a lack of awareness of the Area Public Health Liaison Board and its priorities (described in Chapter 2). However, in Fareham and Gosport, consideration was being given to bringing all officers addressing inclusion under the community safety function (in Fareham in Regulatory Services and in Gosport in a unit in the Chief Executive’s department). This and similar developments would facilitate growth of organisations as public health organisations.

4.2 Partnership with the NHS

Ad hoc activities were often linked through partnership to health improvement work of the PCT.

Several informants would like to deliver more services on behalf of the NHS, particularly communicating public health messages. The saw their advantages for this work as:

- good access to local populations, for examples through tenant newsletters, shopping centre stalls or seafront activities;
- good understanding of the local population;
- experience of delivering public interest messages.

In some cases, but not inevitably, they would want to recover the marginal cost of these activities.

They had not found the NHS well set up to use their well-established communication channels, and two informants contrasted the NHS unfavourably with the police in this respect.

There were other negative experiences of the NHS, including the lack of continuity of contact (for example in Crime and Disorder Partnerships). There was some lack of clarity about how the NHS was organised and funding allocated within it. Some of these views and misunderstandings can be attributed to NHS reorganisations described in Section 2.3 in Chapter 2, and some support in navigation around the PCT, and understanding its current scope, may be needed.
4.3 Key points from this chapter

- Informants were aware that many mainstream activities have public health impact but the authority did not necessarily track health outcomes of these activities. There was no strong incentive to partnership with the NHS for these activities.
- Exceptions were:
  - environmental health, which had a shared history with NHS public health;
  - planning where the potential for Section 106 contributions from developers could be enhanced with input from the health services, and increasing partnership was sought.
- Ad hoc health-related activity was found in community development and in leisure services, and generally there was some partnership with other sectors on these activities.
- Many ad hoc activities were vulnerable. Informants reported that more had been done in the past, and there were plans to cut back on some existing activities. Their dispersed and insecure nature made it harder to develop the public health workforce within an organisation.
- Informants saw themselves as well-placed to increase the health impact of mainstream activities, and to add further ad hoc activities, because of their good contact with and understanding of the local population.
- In some cases, they would need external funding to cover the additional marginal cost of engaging in some additional public health activities.
- The NHS public health function and its priorities were not always well understood, with recent NHS reorganisations contributing to these difficulties.
CHAPTER 5 SCOPE FOR PUBLIC HEALTH DEVELOPMENT

This chapter reports on current public health development activities, and explores the potential for further development of the organisations as public health organisations. Key informants were asked about these topics in a semi-structured interview, and the topic guide used is given at Appendix 3.

5.1 Current public-health related training and development

Key informants were asked about what training relevant to public health they were already undertaking. Examples included:

- environmental health officers attending Health Protection Agency seminars, for example one covering radiation emergencies and the public health implications of the recent floods;
- environmental health officers attending courses provided by NHS Education South Central;
- partnership development training:
  - in Havant there was a series of seminars for local strategic partnership members, supported from national funds
  - Fareham’s officer supporting the local strategic partnership was attending a 3-day course offered Hampshire-wide, by Progress through Partnership
- planning officers across Hampshire had been invited to a seminar on 14 March 2008 on planning for primary health care services, run by the PCT (through the Primary Health Care and Practice-based Commissioning directorate), with strong public health input setting the context for the day.

5.2 Perceived need for public health development

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

- seminars for elected members and senior officers on public health concepts, their relevance to public health and the contribution of local authorities to public health;
- seminars or away days on areas of joint interest such as tobacco control or older people’s housing, to identify actions to achieve shared priorities, which also deepened partnership and improved understanding of each others’ roles.
  - Such a workshop had been held on 14 March 2008, in Fareham, on strategy development for older people’s housing. The opportunities to meet partners had been much appreciated.
  - A Havant informant saw opportunities for such a workshop or seminar on tobacco control
5.3 Training and development processes

Informants were asked about how training and development needs were identified and met, to gain an understanding of how public health workforce development could be incorporated. All three authorities identified training needs in the annual appraisal, and aligned those training needs to the authority’s priorities and budget capacity, in a process which could take 18 months from the expression of needs to receipt of training.

Those in structured professions, sometimes with continuing professional development requirements, such as planning and environmental health, received seminar programmes at six-weekly or monthly intervals. A programme for planners, commissioned by the sub-regional alliance Partnership for Urban South Hampshire (PUSH) and subsidised from New Growth Point funding, was particularly appreciated.

There was limited evidence of training collaboration with third sector partners. A wide range of staff received health and safety and equalities training, provided either internally or externally. Training for recycling and refuse operatives was provided in at least one authority by the South Downs College of Further Education trainers on the vehicle during the round, to minimise the impact on the workforce’s “task and finish” work pattern. One authority mentioned working towards the Equality Standard for Local Government.

5.4 Recruitment and retention

Retention was high in most services in all authorities. However, recruitment and retention were difficult in some services, particularly in middle grades in services such as housing, planning and building control where there was competition from the private sector. This was exacerbated by the high cost of housing, particularly in Fareham and Havant, and by competition from neighbouring authorities. Authorities responded by funding training, and in some cases presenting penalties for departure within a given period after training is complete.

It was usually possible to release employees for prioritised training, although it was sometimes acknowledged that this involved those trained, and their colleagues, working long hours.

5.5 Key points from this chapter

- Few key informants saw scope or need for development of the local authorities’ public health workforces.

- Those who did see such a need suggested:
  - seminars on public health for key informants;
  - joint workshops for partners in delivering shared policies such as older people’s wellbeing and tobacco control.

- Training and development was structured, and identified by individual need and business priorities. There could sometimes be up to 18 months’ delay between a need being identified and training being delivered.

- There were some barriers of resources which sometimes made delivery of training difficult, but generally, identified training needs were met.
CHAPTER 6 RECOMMENDATIONS

The following recommendations arise from this work’.

**Workforce development**

1. **Key influencer seminars on public health leading to further development as public health organisations**

2. **Priority setting and action planning away days (occasional and mainstream activities)**

**Developing local authorities as public health organisations**

3. **Strengthened leadership for public health in local authorities**

4. **Development of improved communication between the local authorities and the PCT public health department**

### 6.1 Workforce development

1. **Key influencer seminars on public health leading to further development as public health organisations**

There was some demand within the local authorities for seminars on public health for elected members and senior managers, and such seminars could build the leadership advised in recommendation 3. Mainstream services which contribute to public health are best engaged with through key influencers.

**It is recommended:**

- that seminars be held for key influencers on public health, covering:
  - what is public health
  - examples of local authorities’ contribution to public health, such as findings on the health impact of social capital and green space
  - how does the NHS work
  - principles of health impact assessment
  - partnership drivers
  - workshop to identify scope for making explicit the public health impact of activity, including, for example, development of health outcome measurement of mainstream activity
  - scope for further development as public health organisations, including for example joint funding and secondments between the local authorities and the PCT.

2. **Priority setting and action planning away days (occasional and mainstream activities)**

There was evident demand for this type of event within the authorities, and appreciation of those that had been held. Such events would reveal scope for joint working and deepen the understanding in each of the agencies of the strengths of the other in meeting shared objectives in related policy priority areas such as tobacco control and older people’s independence and wellbeing.
It is recommended:

- that priority setting and action planning away days be held on the priority areas for the Area Public Health Liaison Board (physical activity, obesity, and older people's independence and wellbeing) and possibly also for tobacco control. These sessions should involve a wide range of partners - for example older people's health and physical activity takes in safer communities, stronger communities, and good public transport. Events should cover:
  - activity mapping and understanding each others' roles
  - partnership development and influencing without authority
  - scope for further joint activities
  - development of shared outcome measures.

6.2 Developing local authorities as public health organisations

3. Strengthened leadership for public health in local authorities

This project found that much ad hoc health related authority was funded by short-term funding, under threat from other priorities, and dispersed across the organisation according to funding opportunities. Under these circumstances it is hard to retain within the organisation a skilled public health workforce, or to make links between ad hoc and mainstream activities.

It is recommended:

- that an elected member of each of the three authorities take overall leadership for health matters across the borough.
- that a member of the senior management team in each authority with existing health-related responsibilities such as environmental health or community development, maintain an overview of health related activities across the authority and lead on cross-organisation matters such as health workforce development. This arrangement would not replace existing line management arrangements.

These individuals would be appropriate people to attend key influencer training proposed in recommendation 2, or to participate in the NHS Education South Central leadership programme referred to in Section 1.4, Chapter 1. For Hampshire PCT, there is an opportunity now to make the connections identified through this project to the opportunities that will be provided for local public health workforce development by means of the public health development leads referred to in that section.

4. Development of improved communication between the local authorities and the PCT public health department

It was evident from the findings of this project that the perception of the PCT’s public health department was influential in local authorities’ attitude to participation in health activities. The project found that the some local authority interviewees were sometimes unclear as to how the PCT worked and in the past joint working had not always gone to plan (Chapter 4 Section 4.2). The authorities were interested in more collaboration with the PCT but these negative perceptions formed a barrier to partnership. They may be accounted for by past re-organisations of the NHS, and to difficulties in protecting NHS funding for health improvement from the demands of the hospital sector, but addressing these perceptions so far as possible will improve local partnership and help the local authorities to clarify their own role in public health in relation to the PCT’s role. Measures such as reciprocal secondments between local authority and PCT staff, and joint training could contribute to this.

It is recommended:
• that the PCT communicate its revised structure and priorities to key contributors to public health in the local authorities, so that the organisations can further cultivate relationships based on where there is added value for both organisations, and critical contributions to shared priorities.

• that NESC support the PCT to commission development activities in recommendations 1 and 2, so that the PCT remains the authorities’ main point of contact for this initiative.
APPENDIX 1: INTERVIEWEES

**Fareham**
Garry White, Director of Regulatory Services  
Linda Jewell, Head of Planning Policy and Development  
Tony Mundy, Economic Development Manager  
Mark Bowler, Head of Leisure and Community  
Andrew Fiske, Head of Strategic Housing  
Alan Higgins, Acting Head of Street Scene Services  
Phil Rayner, Head of Performance and Improvement  
Alistair Tait, Community Partnerships Officer

**Gosport**
David Martin, Leisure and Cultural Services Manager  
Lynda Dine, Head of Economic Prosperity  
Jamie O'Reilly, Head of Community Safety  
Chris Payne, Head of Planning Policy  
Charles Harman, Head of Housing Operational Services  
Dave Jago, Environmental Services Manager  
Dave Palmer, Head of Environmental Health  
Stevyn Ricketts, Head of Streetscene

**Havant**
Claire Hughes, Community Regeneration Manager  
Nicki Conyard, Community Regeneration Team Leader  
Joy Okwuadigbo, Head of Regeneration Services  
David Bridges, Head of Customer and Support Services  
Tim Slater, Head of Organisational Development  
Colin Rowland, Head of Environmental Services  
Jackie Batchelor, Head of Development and Technical Services

**Hampshire PCT**
Noreen Kickham, Area Director of Public Health  
Kathryn Rowles, Area Director of Public Health
APPENDIX 2: WHO IS IN THE PUBLIC HEALTH WORKFORCE?

From Walters et al 2002

START

Work contributes to maintaining or improving the health of communities?

Yes → PH WORKFORCE

No → NOT PH WORKFORCE

PH WORKFORCE

Health improvement is major objective of post?

Yes → Postholder public health trained?

No → Works with populations or communities?

Yes → Mostly works hands on with patients and community members?

No → Involves a substantial proportion of disease prevention/health education with patients or communities?

Yes → Involves significant responsibilities for defined community/patch?

No → Postholder has gained transferable public health skills through experience?

Yes → Postholder public health trained?

No → Applies public health skills for strategic change?

Yes → Remit has profound influence on public health?

No → Specialist not classed as public health whose development is within own discipline?

Yes → WIDER PH KEY INFLUENCER

No → WIDER PH TECHNICAL

WIDER PH

WIDER PH KEY

WIDER PH OTHER

PH PRACTITIONER
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 public health, local authority role in public health, 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 public health 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


