Report for the Health Scrutiny Committee
Nottingham City Council
30 July 2014

Public Health function within
Nottingham City
Nov 2012 – March 2014

1. Report Purpose

This report summarises the progress made by the new Public Health (PH) function within Nottingham City between November 2012 and March 2014.

2. Background

The current PH function in Nottingham City started on 1 November 2012, when the Director of Public Health (DPH) for Nottinghamshire County was asked to take on the DPH role for Nottingham City. Since then, the working arrangements between the city and county teams have much improved, with a much more efficient deployment of staff across important PH areas. This has coincided with a move to integrate the PH teams within the city council, and ensure the PH grant is used as effectively as possible

A summary of the main changes to the NHS and the incorporation of the PH function within local authorities can be found in Appendix A.

Also a summary of the role of the Director of Public Health can be found in Appendix B.

3. Key issues for the Public health function

a) ***Ensure a robust assessment of population health need.*** This is an ongoing process but a summary of the key health needs for Nottingham City is enclosed in Appendix C. The main points are:

I. Health in summary

II. The health of people in Nottingham is generally worse than the England average. Deprivation is higher than average and about 35.2% (19,100) children live in poverty.

III. Life expectancy for both men and women is lower than the England average.

IV. Living longer

V. Life expectancy is 9.2 years lower for men and 8.7 years lower for women in the most deprived areas of Nottingham than in the least deprived areas.

VI. Child health

VII. In Year 6, 21.7% (536) of children are classified as obese, worse than the average for England.

VIII. The rate of alcohol-specific hospital stays among those under18 was 32.1*, better than the average for England. This represents 20 stays per year.

IX. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

X. Adult health

XI. In 2012, 21.7% of adults are classified as obese.

XII. The rate of alcohol related harm hospital stays was 878*, worse than the average for England. This represents 2,205 stays per year.

XIII. The rate of self-harm hospital stays was 204.2*, worse than the average for England. This represents 703 stays per year.

XIV. The rate of smoking related deaths was 358*, worse than the average for England. This represents 422 deaths per year. Estimated levels of adult smoking are worse than the England average.

XV. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are worse than average.

*per 100,000 population

b) ***Transition of staff into the local authority***. This occurred on 1 April 2013. Further work is needed on developing the PH workforce. This is currently ongoing. A number of key elements of this process include:

I. **Reducing duplication wherever possible** in responsibilities between Consultants in the County and City

II. Ensuring the **senior PH teams** across both organisations act as strategic leaders for all the different PH areas

III. Ensuring that elected members receive timely and professional advice about use of the **PH ring fenced grant**, including developing plans to ensure the grant is spent in ways which maximise the opportunities for investment to promote the health and wellbeing of the population

c) Ensure continued understanding of the PH function by **elected members and officers** within the council; this would involve further briefings seminars etc. One of the issues to emphasise is the integration of the PH Consultants across the different directorates of the organisation to act as key link staff members as follows:

City	Development	Jo Copping
	Communities	Alison Challenger
	Resources	TBC
	Children and Adults	Lynne McNiven
		Jo Copping

d) Development and implementation of the **PH business plan** from April 2014 and integration of it into the council's strategic plans. This work is currently ongoing but an important part of the integration process. Part of this process will include developing more radical proposals in relation to Tobacco and Obesity, public health enemies numbers one and two. It is proposed that there is a **full council debate** on these two topics during 2014, both to raise the issues with elected members but also with the public. These could coincide the publication of the DPH Annual Report planned for Sept/Oct 2014.

e) Lead the process for identifying **efficiencies within the PH budget in 20015/16, 20016/17 and 20017/18**, and the **realignment** of this resource within the overall city council's expenditure plans (please see Appendix D for more details).

f) Continue to ensure a strong **PH function within the CCG** and review the Memorandum of Understanding (MOU) to continue from March 2014. This review has been done with any changes being implemented from now onwards.

g) Continue to support and develop the **Health and Wellbeing Board** to ensure they are robust and fit for purpose. Again this work is ongoing with a PH paper presented to each meeting whenever possible. A particular focus needs to be the translation of the strategic plans into action plans, as part of the routine council business.

h) Ensure the safe transfer of the **Commissioning responsibility for Health visiting and the Family Nurse partnership**, from NHS England to the local authority from October 2015. This will enable a greater degree of flexibility in the use of overall resources for children and young people, including resources for school nursing, health schools, children's centres etc

11 Summary

This report has summarised the progress made by the new Public Health (PH) function across Nottingham City in the first year of its operation between November 2012 and March 2014, and has made recommendations for further development and integration of the PH function in the future.

Chris Kenny
Director of Public Health
Nottinghamshire County and Nottingham City
July 2014

Appendix A – summary of key changes to the NHS and incorporation of the PH function within local authorities during 2013/14

1 Changes to the NHS

The Health and Social Care Act 2012 laid down the legal framework for a number of changes within the NHS:

- Abolition of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs)
- Creation of Clinical Commissioning Groups (CCGs)
- Creation of NHS England (NHSE)
- Creation of Public Health England (PHE)
- Responsibility for health and wellbeing, including the public health function, moving to unitary and upper tier local authorities
- Creation of Health and Wellbeing Boards (HWBBs) to develop and oversee the local health and wellbeing agenda

2 Summary of the PH function

Locally the PH staff are currently leading the PH agenda under 3 headings:

- **Health improvement**, including a number of PH policy areas such as tobacco, obesity, substance misuse, sexual health, children's health age 5-19, oral health, mental health, workplace health, health inequalities
- **Health protection**, including community infection control, screening, vaccination and immunisation programmes, health emergency planning
- **Health services**, including giving PH advice and support to the CCG to ensure services are commissioned based on population need

3 PH ring fenced grant

In addition, Nottingham City Council has received a PH grant to commission services to help achieve outcomes within the new PH outcomes framework (see below). This expenditure includes:

- PH staff including pay and non pay
- Priority areas (PH support to local NHS commissioners, health emergency planning, health checks, child measurement programme, sexual health)
- Other areas (eg tobacco, obesity, drug or alcohol misuse, school nursing, oral health, cancer prevention, community safety)

For Nottingham City the figures are £27.1m in 2013/14 rising to £27.9m in 2014/15. There is no confirmation that the grant will remain ring fenced beyond 2015/16. The proportion of the grant spent on different items is as follows:

Drug and alcohol services	35%
Sexual Health	20%
School nursing	7%
Tobacco	7%
Obesity	7%
Health checks	2%
PH leadership / support for CCGs	10%
Other	12%

4 Public Health Outcomes Frameworks

The performance of the new health and wellbeing system will be measured through a new Public Health Outcomes Framework (PHOF). This is one of a suite of frameworks[1] through which the Government intends to ensure accountability and transparency.

[1] Public Health Outcomes Framework 2013-16, Adult Social Care Outcomes Framework 2013/14 and NHS Outcomes Framework 2013/14.

Councils and Health and Wellbeing Boards will be expected to improve their performance against the measures in the PHOF through addressing the health needs of their local population. These are set out in the Joint Strategic Needs Assessment (JSNA) then prioritised and tackled through their Health and Wellbeing Strategy. While local authorities are expected to drive improvements themselves, the Government intends to link performance on some elements of the PHOF and the Health Premium. Only limited information on the Health Premium has been released, so it is not exactly clear how this would work. The premium is not expected to begin until at least April 2015.

5 Key points regarding the local PH function

a) 2 PH Departments 1 Director of Public health

The 2 PH departments across Nottinghamshire County and Nottingham City are managed separately, but by the same joint DPH, and they now work much more closely together. In particular:

- There are now a number of managerial responsibilities which span the 2 departments (eg health emergency planning) and working arrangements are now much more efficient within the PH senior team.
- "Public Health Nottingham City" is now routine to describe the way in which the PH function is available locally, not only to the local authority but also to the CCG, and other local stakeholders.
- There have been 3 meetings of all the PH staff. December 2012, July 2013, and December 2013, all of which have focused on team development, integration within the local authority, and use of the PH grant.

b) Other key aspects include:

- **Communication** – both PH teams now have a single PH communications service hosted by Nottinghamshire County Council but jointly funded by the City and County PH grants; this allows both organisations to half their financial contribution to this issue but still have a very strong cohesive communications service
- **PH Information teams** – these are working together to ensure an efficient use of PH analyst time and expertise
- **Matrix working** has become the norm, with flexible line management arrangements to ensure efficient deployment of specialist skilled staff.
- Work has also taken place to harmonise titles of staff. All general PH staff on A4C Bands 5-7 are **Public Health Managers**, and most of those on Bands 8abc are **Senior Public Health Managers**. All staff directly accountable to the Director of Public Health (DPH) in the City are a Consultant in PH.

c) Integration within LA structures

This is progressing well. Key points include:

- Consultants have been allocated to different corporate directorates to try and ensure PH skills are used to best effect within the council as a whole.
- PH outcomes are slowly being incorporated into the council's strategic plans
- Support functions such as finance Information Technology (IT) and Human Resources (HR) have been very helpful in the integration process
- The interface with procurement is crucial and progressing well generally; more joint working between procurement teams across county and city is needed to really see the benefits of joint PH working
- PH teams are integral to developing plans for the council to achieve financial balance over the next 3 years

- Engagement with elected members is improving all the time; in the City portfolio holder briefings are working well.

d) Nottingham City specific developments:

- Commissioning staff – now fully integrated with the Early Intervention (EI) teams within Nottingham City Council; however, there are still commissioning staff within the Crime and Disorder Partnership (CDP) who procure drug and alcohol services on behalf of the DPH, who would be better sited within the EI team too, to ensure maximum efficiency in the use of the PH Grant
- Business support – secretarial staff are now fully embedded within the business support infrastructure of the council
- Health promotion team – this is no longer a separate team and staff are integrated within the main PH teams
- Knowledge and Resources team – options are currently being actively pursued as to how to integrate this function into the mainstream city council knowledge management services

e) Resources

The whole of both PH teams across the county and city are committed to becoming as efficient as possible, and to contributing to the corporate financial needs of both organisations. Key points include:

- In the city, efficiencies within the staff budget will yield about £300k savings in 2014/15; in addition staff are working towards achieving savings of £8m over the 4 years 2013/14 – 2016/17 as part of the councils financial recovery plans
- Although PH staff will work in a flexible way for the benefit of both organisations, the PH grant will remain separate and different allocations to PH services will be made reflecting the separate statutory status of each organisation
- A significant part of the PH grant is being realigned against a variety of council priority areas; please see Appendix D for details

6 Health and Wellbeing Board

This has now been in existence for a couple of years although only in a statutory form since April 2013. It is extensively supported by the PH team, and will continue to do so, to ensure a well functioning Board into the future.

7 Memorandum of Understanding (MOU) with NHS Nottingham City Clinical Commissioning Groups (CCG)

Support for local NHS commissioners is a mandatory PH function to be provided by the local authority. This has been in place since April 2013, and is working well. The process was reviewed in March 2014, with some minor revisions coming into effect from April 2014.

8 Business Plan

The PH business plan is used to guide the work of the department. It is being integrated into the mainstream LA business plan as part of the overall integration process.

9 Director of Public Health (DPH) role

The latest guidance on the roles and responsibilities for Directors of Public Health has recently been issued by the Department of Health (DH) and is included as Appendix B. Locally the DPH has been appointed as a Chief Officer within Nottinghamshire County Council, and there is a contract with Nottingham City Council to provide a DPH role there. In the City although not a member of staff, the DPH has been given equivalent powers and responsibilities of a corporate director. He is currently attending both county and city corporate leadership teams (CLTs) on

a Tuesday morning. As far as possible, he is trying to ensure the various policy groups that he chairs are either joint ones (eg Health Protection, Local Health Resilience Partnership, sexual health steering group) or ones that are about to become joint. He is providing a DPH service to both authorities for 5 days per week ie there is no artificial 2/3 day split.

Appendix B – Department of Health Guidance on the role of the Director of Public Health October 2013

Please see separate Department of Health Document

Appendix C Health profile for Nottingham City July 2014

Appendix D
PH Grant realignment 2014/15

Introduction
From April 2013 the statutory duties of upper tier local authorities have included improving the health of their populations as defined within the Health and Social Care Act 2012. Upper tier local authorities have been allocated an annual public health grant to help discharge these duties. The mandatory areas of public health spend are sexual health: contraception/STI testing and treatment, NHS Health Check Programme, Health Protection, National Child Measurement Programme and Public Health Advice.

Local Authorities have discretion to spend their public health grant on other activities to improve the health and wellbeing, reducing health inequalities and restoring or protecting health of their population. This should be informed by the priorities set out in the Joint Strategic Needs Assessment, Joint Health and Wellbeing Strategy and other local strategies. This can include action to tackle the wider determinants of health as set out in the Public Health Outcomes Framework.

Nottingham City Public Health Grant Expenditure
The Public Health Grant for Nottingham City Council is £27.1m in 2013/14 and £27.8m in 2014/15. The City Council has undertaken a strategic review of the inherited public health expenditure in 2013/14. This has reviewed the distribution of the inherited expenditure, the contribution of City Council services and functions to the Public Health Outcomes Framework; and where public health grant expenditure should be invested in city council services for the greatest health impact.

From 2014/15 the City Council aims to have reinvested £5.3M of the public health grant into existing council funded services. This will release £5.3M from the city council's services to contribute to the council's corporate savings programme. An additional, £1.59m additional reinvestment is planned by 2016/17.

The budgeted expenditure for 2014/15 is outlined below. Further detail of the planned reinvestment is in appendix 2.

Planned Public Health Expenditure 2014/15

PUBLIC HEALTH	**2014/15 £m**
Staff & Non Pay Costs	2.564
Nutrition, Physical Activity and obesity	2.674
Prevention & Early Intervention	3.329
Tobacco Control & Stop Smoking	1.342
Sexual Health	4.625
Drugs & Alcohol	9.628
Children 5-19/School Health	3.548
TOTAL	**27.71**

Appendix 1 – Proposed Saving by Public Health Priority

Public Health Priority	2014/15 £m	Where and how proposed saving are being made
Savings brought forward from 2013/14	(1.722)	
Staffing Efficiencies	(0.200)	Disestablished Posts.
Nutrition & Physical Activity	(0.444)	Efficiencies in Public Health Nutrition contract Efficiencies in men's weight management contract Decommissioning of child weight management to reinvestment proportion in new school health model Efficiencies in Breastfeeding Peer Support contract Decommissioning adult cycle training and funding through non-recurrent monies Decommissioning of Active Families Programme Efficiencies in adult physical activity referral contract
Prevention, Early Intervention and Infection control	(0.677)	Efficiencies in dental health contract Efficiencies in NHS Healthcheck IT software Efficiencies in Domestic Violence Nurse Specialist Decommissioning of Third Sector Health and Wellbeing Forum support Efficiencies in infection control
Tobacco Control & Stop Smoking Services	(0.287)	Efficiencies in stop smoking contract Decommissioning of smoke free homes Decommissioning of Young Peoples Peer mentoring Decommissioning of stop smoking enhanced service in pharmacies
Sexual Health Services	(0.787)	Decommissioning sexual health health promotion Efficiencies in CASH and Chlamydia screening office contract Ending TSC: CQUIN
Drugs & Alcohol	(1.140)	
Children 5-19/School Health	(0.043)	Efficiencies in School Health contract
TOTAL	**(5.300)**	

Appendix 2 – Proposed reinvestment into council services

Process

- Council services that contribute to the Public Health Outcomes Framework Indicators and are funded by the council recurrently were identified.
- These services were assessed against a public health prioritisation framework.
- Funding has been proposed towards services assessed as having the greatest potential public health contribution.
- The proposals have had extensive discussion with council Directors.
- Agreements are in place between Public Health and council Directorates to ensure that the funding enables a greater emphasis on health improvement and health inequalities within the council.

Service Proposed for a contribution from the Public Health grant

Service Name	Service Description	Public Health Service Categorisation	PHOF indicator service contributes to	Local Strategy
Befriending Service – Family Befriending	Provides parenting information, engagement and support to families with additional needs in relation to their parenting.	Children 5-19	1.4 First time entrants to youth justice system 2.23 Self reported well-being	Health and Wellbeing Strategy-Priority Families Nottingham Plan - antisocial behaviour
Education Link Workers	Education Link Workers within Compass Young People's Drug Service who to follow up drug incidents in schools and providing support to the young people.	Substance misuse (Youth Services)	2.15 Successful completion of drug treatment	Children's Plan
Teenage Pregnancy and Early Intervention Specialist	Coordination of the Teenage Pregnancy and Aspirations strategy and action plan.	Sexual Health (advice prevention and promotion) Children 5-19	2.4 Under 18 conceptions 3.4 Chlamydia diagnosis	Nottingham Plan-teenage conceptions
Healthy Schools: SRE post	Provides Sexual Health and relationship support to schools as part of the local Healthy Schools Programmes	Sexual Health (advice prevention and promotion) Children 5-19	2.4 Under 18 conceptions 3.4 Chlamydia diagnosis	Nottingham Plan-teenage conceptions

Drug Aware Healthy Schools Team	Drug awareness work in schools	Substance misuse (Drug Misuse)	2.15 Successful completion of drug treatment	Children's Plan
18 Children's Centres	Health improvement and wellbeing support and intervention to children and families.	Children 5-19	2.1 Low birth weight of term babies 2.2 Breastfeeding 2.3 Smoking status at time of delivery 2.5 Child development at 2-2.5 years	Nottingham Plan - Early years Child development
Youth and Play Services	Provision of play services to children and youth engagement	Children 5-19	1.4 First Time Entrants to the Youth Justice System	Nottingham Plan - child obesity antisocial behaviour
Independent Living Support Service	To provide housing related support to vulnerable people at risk of homelessness - this includes those just exiting homelessness	Miscellaneous (Social Exclusion)	1.15 Statutory homelessness	Vulnerable Adults Plan
Physical Activity, Sport and PE Strategy Manager	Coordination of a programme of school physical activity across the city	Physical Activity	2.4 Excess weight in 4-5 & 10-11 year olds	Nottingham Plan - child obesity
Outdoor and Adventurous Activities	Provision of outdoor and adventurous activities to children and young people	Physical Activity	2.4 Excess weight in 4-5 & 10-11 year olds	Nottingham Plan - child obesity
Health and Wellbeing Team	Health & Wellbeing Manager	Public Health Structure Costs		
Asylum Seeker Officer	Work with families in relation to finding funding and relevant support.	Miscellaneous (Social Exclusion)	1.18 social isolation	Vulnerable Adults Plan

Trading Standards Tobacco and Alcohol enforcement	Work to tackle the provision of illicit and counterfeit alcohol & tobacco and underage sales .	TobaccoSubstance misuse (alcohol)	2.9. Smoking prevalence – 15 year olds 2.14 Smoking prevalence – adults (over 18s)2.18 Alcohol-related admissions to hospital	Nottingham Plan Tobacco and Alcohol
Sports Development Team	Work to increase participation in sport and active recreation with different groups	Obesity Physical Activity	2.6 Excess weight in 4-5 year olds 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults	Nottingham Plan Child obesity, Adult obesity, Physical Activity
Books on Prescription	Scheme delivered with the NHS and is aimed at people with anxiety and depression and builds on best practice - combining expert endorsed self-help reading and health information alongside mood-boosting creative material recommended by readers.	Miscellaneous (Public mental health)	2.23 Self Reporting Wellbeing	Nottingham Plan - mental wellbeing
Bookstart coordination and resources	Bookstart is run in partnership with Health Visitors. Health Visitors use book packs to teach interaction with very young children.	Miscellaneous (Public mental health)	1.2 school readiness	Nottingham Plan - Early years Child development
Leisure Centres	Provision of facilities and programmed activities at 10 Centres.	Physical Activity	2.6 Excess weight in 4-5 year olds 2.12 Excess weight in adults 2.13 Proportion of physically active and	Nottingham Plan Child obesity, Adult obesity, Physical Activity

			inactive adults	
Park Ranger Team	Outdoor activities such as health walks and orienteering programme. Proactive site based community engagement, events and activities.	Physical Activity	2.6 Excess weight in 4-5 year olds 2.13 Proportion of physically active and inactive adults 2.23 Self reported wellbeing	Nottingham Plan Child obesity, Adult obesity, Physical Activity
Prevention Adaptations Schemes (PADS)	Falls and injuries in the over 65s. Installation of minor preventative adaptations	Miscellaneous (Accident Prevention)	2.24 Injuries due to falls in older People	Vulnerable adults Plan
Nottingham Futures	Funded by the City and County councils identifies and supports NEETs and pre 16 who are identified as being at risk of NEET.	Miscellaneous (other Public Health)	1.5 16-18 year olds not in education, employment or training	Nottingham Plan - increase the city's employment rate
GIS Team, Data and Information Team	GIS Team, Data and Information Team			
Nottm & Notts Refugee Forum	Provides welfare rights to refugees	Miscellaneous (Public Mental Health/Social Exclusion)	2.23 Self-reported well-being1.18 social isolation	Vulnerable Adults PlanCouncil Plan -lessen impact of economic recession
Nottm & District Citizen Advice Bureau	Provides broad range of welfare rights services	Miscellaneous (Public Mental Health)	2.23 Self-reported well-being	Council Plan -lessen impact of economic recession
Internal welfare rights service	Provision of benefit and debt advice with a view to maximising incomes and reducing debt to 5049 per annum.	Miscellaneous (Public Mental Health)	1,17 Fuel Poverty	Council Plan -lessen impact of economic recession

Notts Deaf Society	Provides welfare rights to Deaf citizens	Miscellaneous (Public Mental Health/Social Exclusion)	2.23 Self-reported well-being 1.18 social isolation	Vulnerable Adults Plan Council Plan -lessen impact of economic recession

Department of Health

Directors of Public Health in Local Government

Roles, Responsibilities and Context

October 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Directors of Public Health in Local Government

Roles, Responsibilities and Context

Prepared by the Public Health Policy and Strategy Unit, Department of Health

This guidance is published under section 73A(7) of the NHS Act 2006 as guidance that local authorities must have regard to.

Contents

1. Introduction

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

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

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

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

1.5 Local authorities must take the action that they decide is appropriate to improve the health of the people in their areas – it is not the job of central government to look over their shoulders and offer unnecessary advice. Nevertheless, the statutory basis of the DPH role, its transfer to local government and the involvement of the Secretary of State mean that there is value in clear, informative guidance that establishes a shared understanding of how this vital component of the reformed system should work. This statutory guidance is issued in that spirit.

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

2. The role of the director of public health

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

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

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

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

- be an active member of the health and wellbeing board, advising on and contributing to the development of Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, and commission appropriate services accordingly;
- take responsibility for the management of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money;
- play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board; and

- contribute to and influence the work of NHS commissioners, helping to lead a whole system approach across the public sector.

3. Statutory functions of the director of public health

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

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

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

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

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

- through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department has confirmed that DsPH are responsible for their local authority's public health response as a responsible authority under the Licensing Act 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act);

- if the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1) also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended); and
- DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

4. Other relevant statutory provisions

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

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

- DsPH must be appointed jointly by their local authority and the Secretary of State (in practice Public Health England), although their subsequent employment relationship is with the local authority exclusively. There is more detail below on how the joint appointment process should work, and further information on best practice is published by Public Health England;

- if the Secretary of State believes that a DPH is not properly carrying out any Secretary of State function that has been delegated to the local authority s/he can direct the authority to review the DPH's performance, to consider taking particular steps, and to report back. This power does not extend to the DPH's performance of the local authority's own health improvement duties; and

- a local authority must consult the Secretary of State before dismissing its DPH. The authority may still suspend its DPH from duty (following its standard rules and procedures) and the Secretary of State cannot veto its final decision on dismissal. An authority proposing dismissal for any reason should contact Public Health England for advice on how to proceed with the consultation. PHE will normally provide the Secretary of State's formal response within a maximum of 28 days.

5. Corporate and professional accountability

Corporate accountability

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

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

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

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

Professional accountability

Regulation and registration

5.5 Medical and dental public health consultants are registered with - and regulated by - the General Medical Council or the General Dental Council. They, and other public health consultants, can also register with the voluntary UK Public Health Register. PHE will not regard an applicant for a DPH post as suitable unless s/he has the appropriate registration with the GMC, the GDC or the UKPHR.

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

- undertakes a continuing professional development (CPD) programme that meets the requirements of the Faculty of Public Health or other equivalent professional body;
- maintains a programme of personal professional development to ensure competence in professional delivery. This programme should include all training and development needs identified by both management and professional appraisal processes; and
- undertakes appropriate annual professional appraisal in order to ensure revalidation and fitness to practise.

5.7 The Government has announced its intention to extend statutory regulation to public health consultants with backgrounds other than medical or dental through the Health and Care Professions Council and expects this to be in place in 2015. The HCPC will consult on the standards and criteria it will use for the new statutory register. Prior to the

establishment of the new register, public health specialists with backgrounds other than medical or dental are expected to adhere to the standards set by the UKPHR.

Revalidation

5.8 Medical revalidation is the process by which all licensed doctors, including DsPH with medical qualifications, are required to demonstrate to the General Medical Council (GMC) that their skills are up to date and that they are fit to practise in order to retain their license to practise. The GMC publishes guidance on the revalidation process.

5.9 PHE acts as the designated body for revalidation, where appropriate, for all doctors for whom it is the employing organisation and for those holding honorary contracts with PHE. PHE also acts as the designated body for doctors employed by local government organisations. Equivalent arrangements for revalidation are likely to be agreed for all public health consultants with backgrounds other than in medicine, including dental public health consultants.

The role of responsible officers

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

5.11 The Responsible Officer Regulations came into force on 1 January 2011 and apply to medically qualified DsPH. The regulations designate those bodies that are required to nominate or appoint a responsible officer for the purposes of medical revalidation – this includes local authorities that employ medically qualified staff. PHE provides the responsible officer for all doctors in local government.

5.12 The responsible officer:

- makes recommendations to the GMC about the fitness to practise of doctors;
- assures the quality of professional appraisers;
- ensures that recommendations are informed by clinical governance information provided by the employing organisation, and other key stakeholders, where appropriate; and
- provides support and advice to employers and appraisers where performance concerns have been identified, in liaison with GMC, GDC and UKPHR when appropriate.

Professional appraisal and continuing professional development

5.13 Local authorities should reassure themselves that all public health professionals are in a position to participate in professional appraisal and that those with suitable experience and training are enabled to appraise others in the public health system.

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

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

5.16 The UK Public Health Register expects all its registrants to participate in CPD, preferably as part of a formal scheme operated by a professional body.

5.17 Personal development plans should include recommendations made as a result of both management and professional appraisal. This ensures that CPD activities are suitably aligned to the needs of the employing body, and the professional development requirements of the individual.

6. Appointing directors of public health

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

- to promote the comprehensive health service (section 1 of the NHS Act 2006, as amended by section 1 of the 2012 Act); and

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

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

Requirements for directors of public health appointments

6.3 Local authorities recruiting a DPH should:

- design a job description that includes specialist public health leadership and an appropriate span of responsibility for improving and protecting health, advising on health services and ensuring that the impact on health is considered in the development and implementation of all policies;

- make every effort to agree the job description with the Faculty of Public Health and the PHE regional director, ensuring in particular that it covers all the necessary areas of professional and technical competence; and

- manage the recruitment and selection process and set up an advisory appointments committee to make recommendations on the appointment to the leader of the local authority.

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

- an external professional assessor, appointed after consultation with the Faculty of Public Health;

- the chief executive or other head of paid service of the appointing local authority (or their nominated deputy);

- senior local NHS representation;

- the PHE regional director, or another senior professionally qualified member of PHE acting on his or her behalf; and

- in the case of appointments to posts which have teaching or research commitments, a professional member nominated after consultation with the relevant university.

The role of the Secretary of State and Public Health England

6.5 The relationship of the Secretary of State and the local authority in the joint appointment process is one of equals. The role of the Secretary of State is to provide additional assurance of the DPH's competency. This means that PHE, acting on behalf of the Secretary of State, should be involved in all stages of the process. PHE will advise the Secretary of State on whether:

- the recruitment and selection processes were robust; and

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

6.6 In order to provide this assurance for the Secretary of State, PHE will:

- agree with the local authority and the Faculty of Public Health a job description that fits with the responsibilities of the DPH and sets out the necessary technical and professional skills required;

- offer advice in relation to the recruitment and selection process, including the appointment of Faculty of Public Health assessors;

- participate in the local advisory appointment committee;

- confirm to the local authority the Secretary of State's agreement to the appointment.

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

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

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

Public Health England

Nottingham

Unitary Authority

This profile was produced on 8 July 2014

Health Profile 2014

Health in summary
The health of people in Nottingham is generally worse than the England average. Deprivation is higher than average and about 35.2% (19,100) children live in poverty. Life expectancy for both men and women is lower than the England average.

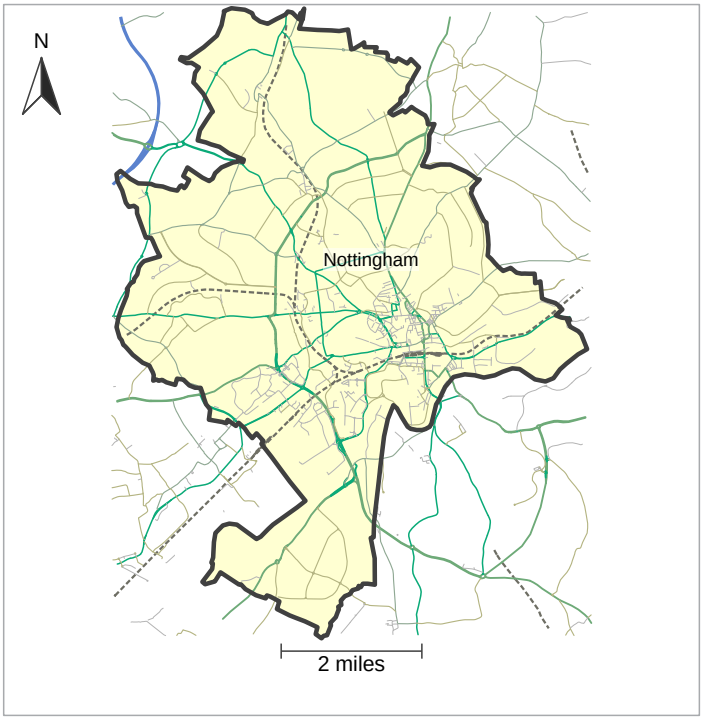
Living longer
Life expectancy is 9.2 years lower for men and 8.7 years lower for women in the most deprived areas of Nottingham than in the least deprived areas.

Child health
In Year 6, 21.7% (536) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 32.1*, better than the average for England. This represents 20 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 21.7% of adults are classified as obese. The rate of alcohol related harm hospital stays was 878*, worse than the average for England. This represents 2,205 stays per year. The rate of self-harm hospital stays was 204.2*, worse than the average for England. This represents 703 stays per year. The rate of smoking related deaths was 358*, worse than the average for England. This represents 422 deaths per year. Estimated levels of adult smoking are worse than the England average. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are worse than average.

Local priorities
For more information, including locally agreed priorities see www.nottinghamcity.gov.uk

* rate per 100,000 population



Population: 309,000
Mid-2012 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Nottingham. It is designed to help local government and health services understand their community's needs, so that they can work to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info
or scan this Quick Response code: for more profiles, more information and interactive maps and tools.

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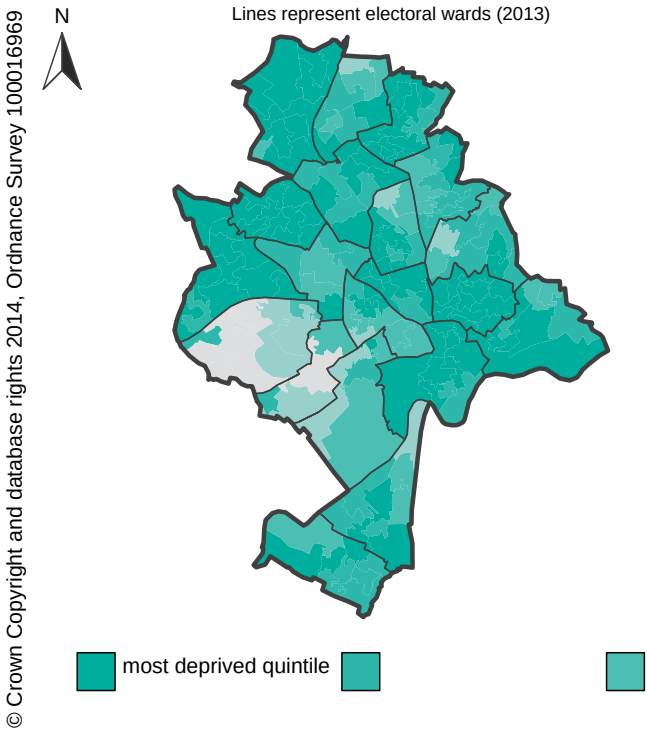
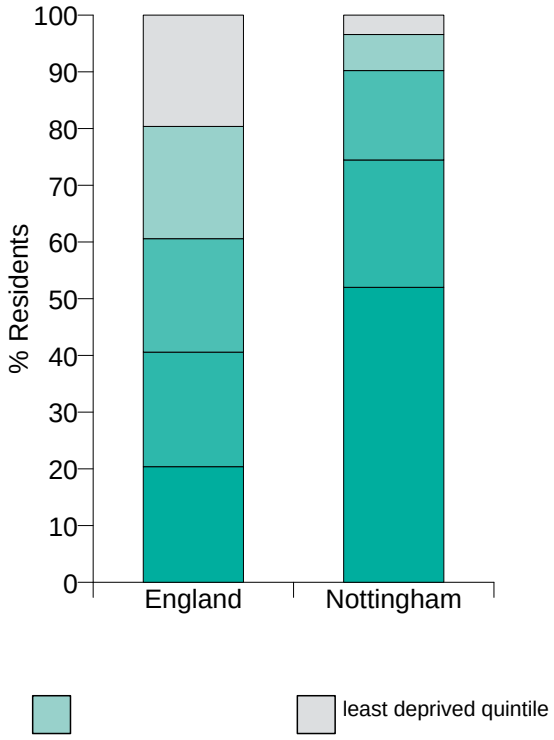
Deprivation: a national view

The map shows differences in deprivation levels in this area based on national quintiles (fifths) of the Index of Multiple Deprivation 2010 by Lower Super Output Area. The darkest coloured areas are some of the most deprived areas in England.



This chart shows the percentage of the population in England and this area who live in each of these quintiles.

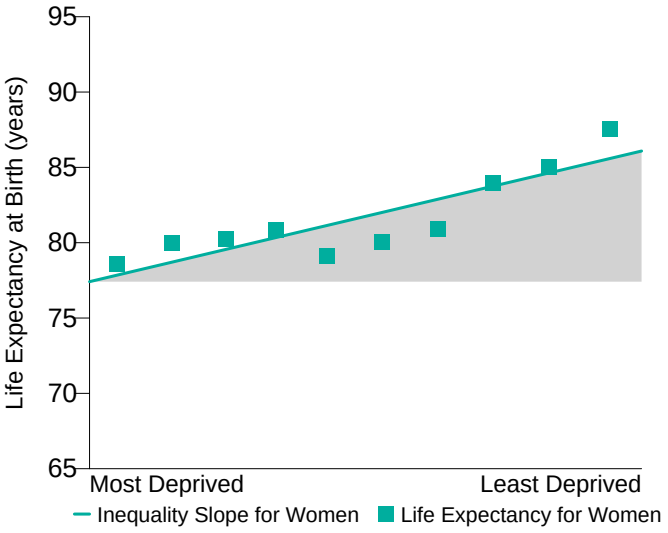


Life Expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2010-2012. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life Expectancy Gap for Men: 9.2 years

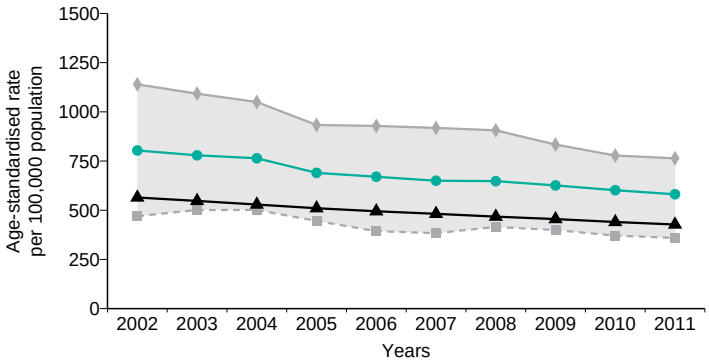
Life Expectancy Gap for Women: 8.7 years



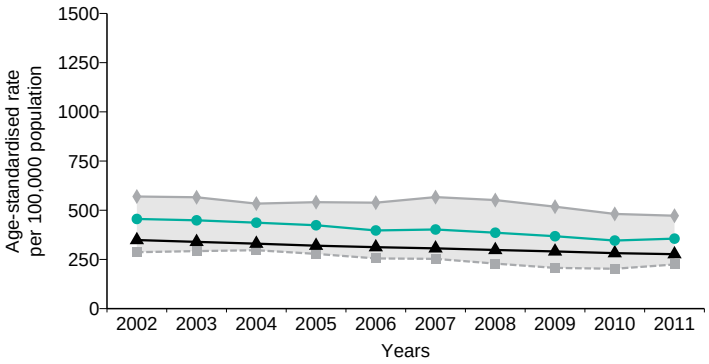
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

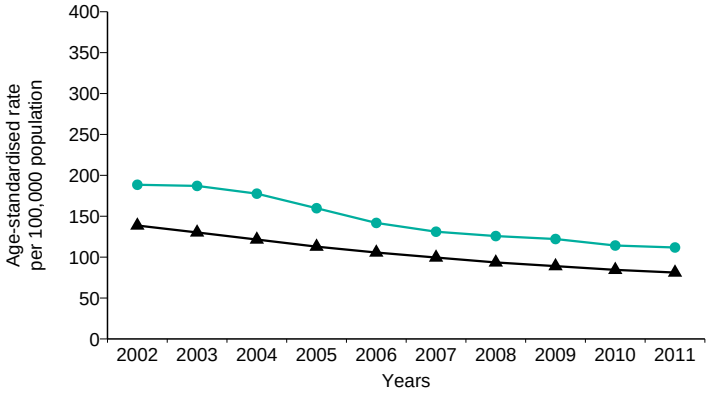
Early deaths from all causes: MEN



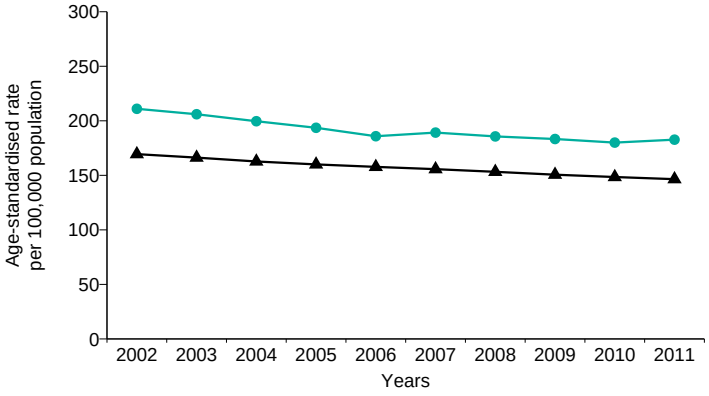
Early deaths from all causes: WOMEN

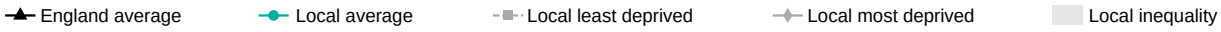


Early deaths from heart disease and stroke



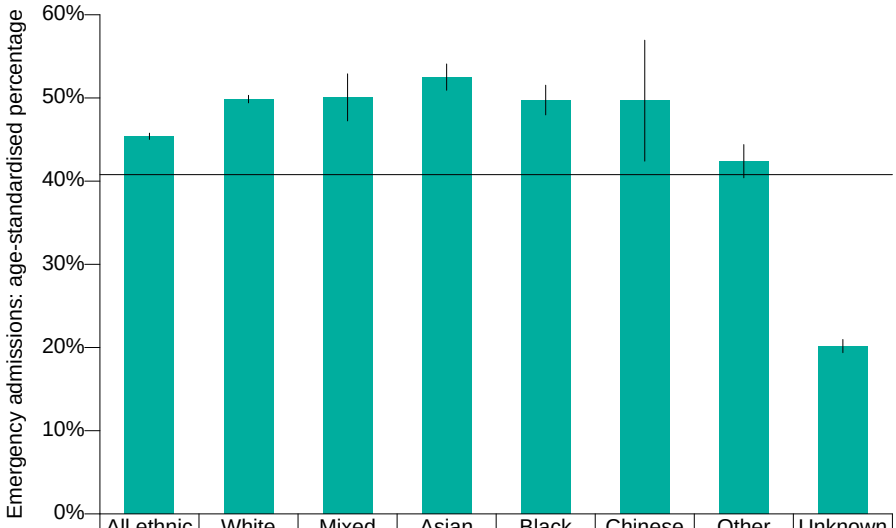
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group



All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
30,384	22,986	720	2,041	1,523	91	1,055	1,968	Local number of emergency admissions
45.4	49.9	50.1	52.5	49.7	49.7	42.4	20.2	Local value
40.8	41.3	40.8	45.4	45.0	37.0	46.5	30.3	England value

This chart shows the percentage of hospital admissions in 2012/13 that were emergencies for each ethnic group in this area. A high percentage of emergency admissions may reflect some patients not accessing or receiving the care most suited to managing their conditions. By comparing the percentage in each ethnic group in this area with that of the whole population of England (represented by the horizontal line) possible inequalities can be identified.

Nottingham

England average (all ethnic groups)

95% confidence interval

Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

Health Summary for Nottingham

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average

Regional average^ England Average

England Worst 25th Percentile 75th Percentile England Best

Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	England Range	Eng best
Our communities	1	Deprivation	160,553	52.0	20.4	83.8		0.0
	2	Children in poverty (under 16s)	19,120	35.2	20.6	43.6		6.4
	3	Statutory homelessness	78	0.6	2.4	33.2		0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)	1,191	49.8	60.8	38.1		81.9
	5	Violent crime (violence offences)	5,820	19.2	10.6	27.1		3.3
	6	Long term unemployment	4,515	20.9	9.9	32.6		1.3
Children's and young people's health	7	Smoking status at time of delivery	823	17.9	12.7	30.8		2.3
	8	Breastfeeding initiation	3,176	68.9	73.9	40.8		94.7
	9	Obese children (Year 6)	536	21.7	18.9	27.3		10.1
	10	Alcohol-specific hospital stays (under 18)	20	32.1	44.9	126.7		11.9
	11	Under 18 conceptions	181	37.7	27.7	52.0		8.8
Adults' health and lifestyle	12	Smoking prevalence	n/a	24.4	19.5	30.1		8.4
	13	Percentage of physically active adults	n/a	51.9	56.0	43.8		68.5
	14	Obese adults	n/a	21.7	23.0	35.2		11.2
	15	Excess weight in adults	453	60.7	63.8	75.9		45.9
Disease and poor health	16	Incidence of malignant melanoma	25	9.4	14.8	31.8		3.6
	17	Hospital stays for self-harm	703	204.2	188.0	596.0		50.4
	18	Hospital stays for alcohol related harm	2,205	878	637	1,121		365
	19	Drug misuse	2,706	12.7	8.6	26.3		0.8
	20	Recorded diabetes	14,501	5.2	6.0	8.7		3.5
	21	Incidence of TB	22	21.3	15.1	112.3		0.0
	22	Acute sexually transmitted infections	4,247	1,398	804	3,210		162
	23	Hip fractures in people aged 65 and over	220	541	568	828		403
Life expectancy and causes of death	24	Excess winter deaths (three year)	110	15.1	16.5	32.1		-3.0
	25	Life expectancy at birth (Male)	n/a	76.9	79.2	74.0		82.9
	26	Life expectancy at birth (Female)	n/a	81.5	83.0	79.5		86.6
	27	Infant mortality	21	4.7	4.1	7.5		0.7
	28	Smoking related deaths	422	358	292	480		172
	29	Suicide rate	21	7.6	8.5			
	30	Under 75 mortality rate: cardiovascular	196	111.8	81.1	144.7		37.4
	31	Under 75 mortality rate: cancer	316	183	146	213		106
	32	Killed and seriously injured on roads	142	46.6	40.5	116.3		11.3

Indicator Notes

1 % people in this area living in 20% most deprived areas in England, 2010 2 % children (under 16) in families receiving means-tested benefits & low income, 2011 3 Crude rate per 1,000 households, 2012/13 4 % key stage 4, 2012/13 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2012/13 6 Crude rate per 1,000 population aged 16-64, 2013 7 % of women who smoke at time of delivery, 2012/13 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2012/13 9 % school children in Year 6 (age 10-11), 2012/13 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2010/11 to 2012/13 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2012 12 % adults aged 18 and over, 2012 13 % adults achieving at least 150 mins physical activity per week, 2012 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2009-2011 17 Directly age sex standardised rate per 100,000 population, 2012/13 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2012/13 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11 20 % people on GP registers with a recorded diagnosis of diabetes 2012/13 21 Crude rate per 100,000 population, 2010-2012 22 Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate) 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2012/13 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.09-31.07.12 25 At birth, 2010-2012 26 At birth, 2010-2012 27 Rate per 1,000 live births, 2010-2012 28 Directly age standardised rate per 100,000 population aged 35 and over, 2010-2012 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2010-2012 30 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 31 Directly age standardised rate per 100,000 population aged under 75, 2010-2012 32 Rate per 100,000 population, 2010-2012 ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info Please send any enquiries to healthprofiles@phe.gov.uk