



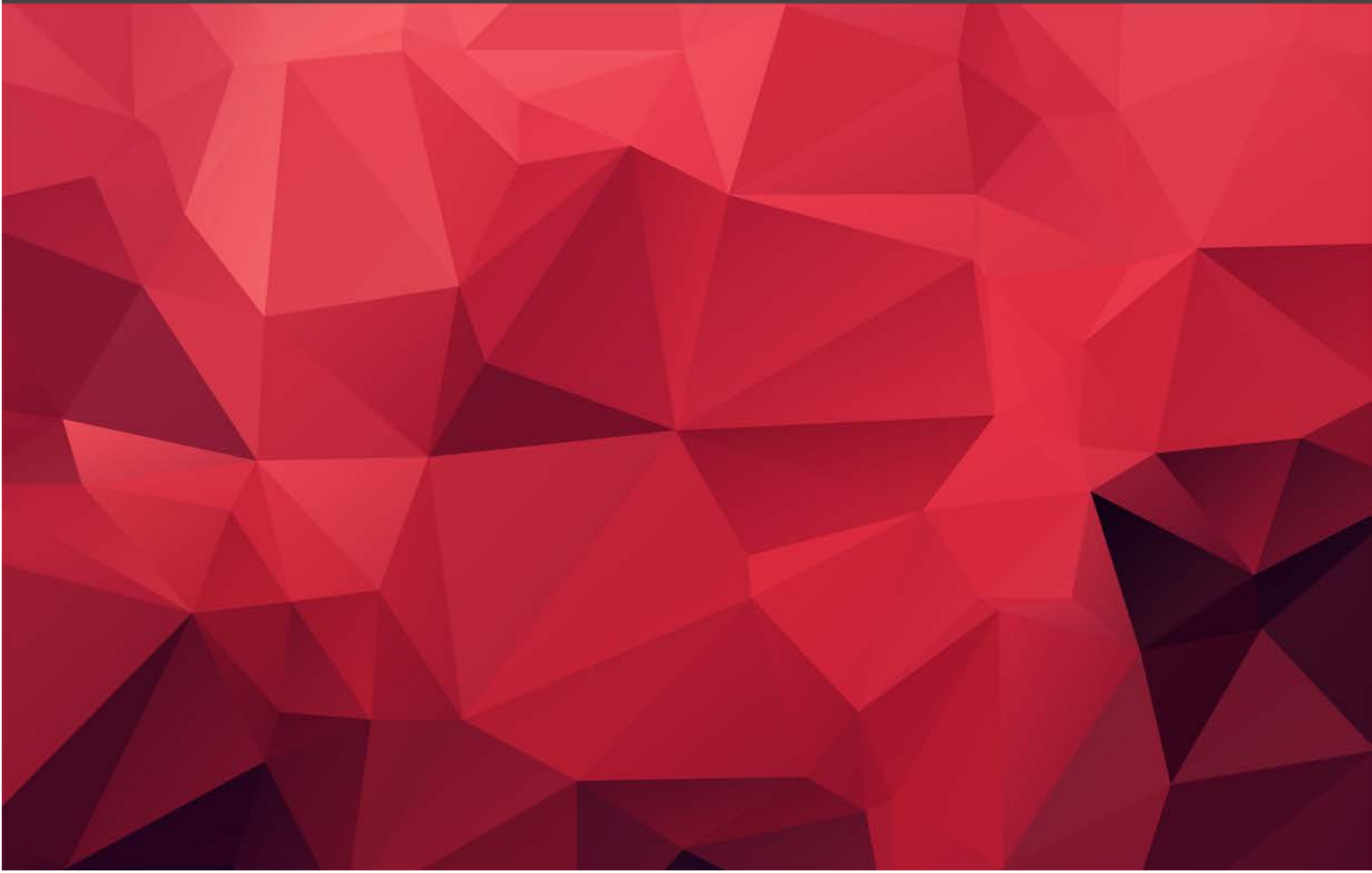
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Collaborative Arrangements for Managing Local Public Health Resources – **Public Health Wales NHS Trust**

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The team who delivered the work comprised Gabrielle Smith and David Rees.

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Collaborative arrangements for managing local public health resources do not work as effectively as they should do.

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Summary report

The public health system in Wales

- 1 The UK Faculty of Public Health defines public health as ‘the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society’¹. This definition means that, in the overall public health system, a broad range of people and organisations contribute to protecting and improving health and wellbeing, and reducing health inequalities in Wales.
- 2 There are three domains of public health practice: health improvement, health protection and healthcare public health. These areas of practice are underpinned by health intelligence functions. (Appendix 1 sets out a short description of the domains of public health practice. This report focuses on the health improvement domain.)
- 3 Public Health Wales NHS Trust (the Trust) was established as part of the wider reforms of the NHS in Wales in 2009. The Trust provides a range of public health services for the protection and improvement of the health and wellbeing of the people of Wales. It also provides evidence-based information and expert advice to a range of stakeholders, including NHS organisations, local authorities and the Welsh Government, on matters related to health and wellbeing. (Appendix 2 sets out the Trust’s four statutory functions.)
- 4 The Trust has a key role in the system by virtue of the fact it is the national public health organisation and is recognised as an international public health institute². The Trust’s wide-ranging functions include providing and managing public health services for the people of Wales, delivering health improvement information to the public and the collection and dissemination of information on health. (Appendix 3 shows pictorially the breadth of work carried out by the Trust.)
- 5 The 2009 NHS reforms also led to the creation of seven local health boards responsible for commissioning and delivering healthcare services and for promoting and protecting public health across a defined geographical area. These organisations included an officer responsible for public health, the Director of Public Health (DPH). The Directors of Public Health (DsPH) are employees and Executive Directors of their respective organisations and with these organisations are responsible collectively for the health of the population they serve.
- 6 The Trust provides specialist public health resources³ at a national, regional and local level, including to local health boards and their DsPH. Each DPH is responsible for directing and managing the work of the local public health team

¹ www.fph.org.uk

² Public Health Wales, like Public Health England, is a member of the International Association of National Public Health Institutes

³ In the context of this audit, specialist public health resources relate to the specialist public health workforce

(LPHT). LPHTs were established largely on the historical legacy of staff numbers and skill mix at the time of the NHS reforms. Currently, LPHTs comprise public health consultants and specialists, public health practitioners and administrative staff. Teams vary in size and the majority of LPHT staff are employed by the Trust and organisationally part of its Health and Well Being Directorate. Several LPHTs include staff who are funded and employed by the health board.

- 7 In 2015-16, the Trust deployed 155 whole-time equivalent staff, equivalent to 12% of its specialist public health workforce, across the seven LPHTs. The budget for these staff, including the salaries of six of the seven DsPH for which the Trust is responsible, totalled £9.26 million or 9% of the Trust's overall budget.
- 8 Although employees and Executive Directors are accountable to their own respective health boards, all DsPH have an honorary contract with the Trust to direct and manage the work of LPHTs. The DsPH are accountable to the Trust for the use of the specialist public health resources provided to them. The Trust, meanwhile, is accountable for securing value for money from its resources, including those provided to and managed by the DsPH. The Trust describes itself as a professionally rich organisation^{4 5} so it must demonstrate that its resources are achieving improvements to population health and wellbeing.
- 9 The Trust provides the health intelligence, knowledge and evidence-base which the LPHTs require to function. These centrally organised and performed functions are also important in enabling the DsPH to discharge their statutory responsibilities. The Trust also provides centrally coordinated screening and health protection services for local health board populations; note that these services were outside the scope of this audit.
- 10 Crucially, no one organisation has been given the leadership role within the public health system. This means that the Trust and health boards, through their DsPH, must agree common goals and a collaborative approach for delivering public health work for improving population health and wellbeing.
- 11 The Welsh Government's vision for public health was articulated in 'Our Healthy Future'⁶ and 'Fairer Outcomes for All'⁷, which set the strategic direction for public health to 2020. This means there is a common national framework and outcomes which all in the public health system should be working to deliver.
- 12 The Trust is dependent upon working collaboratively with health boards, as well as a broad range of other stakeholders to discharge its functions as a national public health organisation. Furthermore, recent legislation⁸ requires public bodies to work

⁴ [Public Health Wales, Our Strategic Plan 2016-2019, March 2016](#)

⁵ [Public Health Wales, Our Strategic Plan 2017-2020, March 2017](#)

⁶ [Welsh Assembly Government, Our Healthy Future, 2009](#)

⁷ [Welsh Assembly Government, Fairer Outcomes for All, 2011](#)

⁸ [Social Services and Well-being \(Wales\) Act 2014; Well-being of Future Generations \(Wales\) Act 2015; Public Health Wales Bill](#)

collaboratively either in support or as members of statutory partnerships. In view of the potential complexities around governance and accountability for the use of resources to improve local population health and wellbeing, the Auditor General considered it an opportune time to assess the effectiveness of the Trust's arrangements for collaborating with DsPH and whether these are conducive to delivering health improvement work across Wales more generally.

Scope of the audit

- 13 The audit focused on the arrangements for delivering services for health improvement through LPHTs, which we were informed was the main function of most staff working in these teams. The audit focused primarily on the relationship between the Trust's national (corporate-based) teams, the LPHTs and DsPH. Although we recognise that public health work is multi-sectoral, the audit did not focus on the views of local authorities or other agencies.
- 14 The aim of our audit was therefore to provide a high-level view of how the Trust's current collaborative arrangements with LPHTs and DsPH work in practice. The objectives of our audit work were:
 - to gain an understanding of the framework for alignment of priorities for local delivery of services to improve health and wellbeing;
 - to form a view of the effectiveness of collaborative working and the adequacy of governance arrangements to deliver common public health objectives; and
 - to identify any obstacles that may prevent effective collaboration.
- 15 While the audit focused primarily on the arrangements relating to health improvement, work related to the health protection domain are referred to for comparative purposes within the report. Although we did not assess the work undertaken by the Trust or LPHTs, there is undoubtedly good work taking place by the dedicated staff that we met.
- 16 The audit looked at the Trust's arrangements for collaboration. We did not assess the extent to which health boards' priorities for public health aligned with those of the Trust nor did we examine the extent to which health boards discharge their statutory responsibilities for improving the health of the populations they serve. Furthermore, we did not examine the role of the Welsh Government in setting direction, leadership and performance management.
- 17 We visited every LHPT and talked to public health consultants and specialists, public health practitioners and administrative staff, including team members employed by health boards. We also talked to all DsPH, two health board Chief Executives and a small number of Trust officers. In total we interviewed more than 100 people. We reviewed pertinent documents produced by the Trust, health boards and the Welsh Government. At various places in the report direct quotes from the staff that we interviewed are used to illustrate the themes to emerge strongly from the audit.

- 18 The participant information sheet detailing the scope of the audit is presented in [Appendix 4](#). This was shared with all teams in advance of the interviews.
- 19 We gratefully acknowledge the assistance and cooperation of staff from LPHTs, DsPH and officers at both the Trust and health boards.

Main audit findings

- 20 The staff that we met within LPHTs are dedicated professionals undertaking crucial work across Wales. Many staff told us that they valued being part of a national public health organisation although a small number did not hold a strong preference as their day-to-day interactions with the Trust were limited. They did however see themselves as serving their local population. The benefits of being part of a national organisation frequently cited by staff included:
- a degree of independence from health boards that stops them getting drawn into secondary care issues;
 - expertise that is appreciated by local partners and the public because it is seen to be objective; and
 - a dedicated infrastructure with the knowledge and expertise that can be shared across Wales.
- 21 It was clear from our meetings with staff that they want to work within a public health system where there is a common vision and everyone knows what their relative role is in relation to health improvement regardless of where they work. To meet these aspirations requires consensual leadership within a public health system with shared priorities and strong collaboration between the Trust, DsPH and LPHTs.
- 22 However, our audit work found that the collaborative arrangements for managing local public health resources do not work as effectively as they should do. We reached this conclusion because:
- effective collaboration in relation to health improvement work is dependent upon consensual leadership but this was not always evident;
 - the Trust has not established effective arrangements to ensure that it is securing value for money from the resources allocated to LPHTs;
 - there is a lack of meaningful dialogue between the Trust and LPHTs about respective roles, responsibilities and priorities and an agreed framework about what work is best done collectively;
 - the Trust does not have robust methods for allocating or changing resources of LPHTs;
 - although the Trust has strengthened arrangements for appraisals and personal development planning, it can do more to assess the needs of local public health teams to support professional development and career progression; and

- the mechanisms for communicating and sharing information between the Trust and LHPTs are under developed.

Next steps

- 23 Although this report identifies a number of weaknesses with the current collaborative arrangements between the Trust and LPHTs in respect of health improvement work, it should not be seen as a criticism of the work or professionalism of staff. The issues identified, however, point to a need for improvements.
- 24 We recognise, in part, that the problems identified in this report relate to matters that are the responsibilities of the Welsh Government and local health boards, as well as the Trust. The Auditor General is therefore minded to undertake an examination of all three roles in local public health arrangements. We are therefore not making firm recommendations in this report.
- 25 In the meantime, however, it is appropriate for the Trust to consider how improvements to collaborative working could be made, including:
- continued working with health boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally;
 - developing effective arrangements to demonstrate that it is securing value for money from the specialist public health resources allocated to LPHTs;
 - clarifying the roles and responsibilities of the Trust's national and local teams in relation to developing and delivering health improvement programmes;
 - progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice, including healthcare public health;
 - agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs;
 - agreeing a mechanism whereby workforce planning discussions take place on a more formal basis between the Trust and DsPH;
 - clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite
 - clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles; and
 - collating information on the collective training and development needs of local public health teams to address skills gaps.
- 26 The Trust's management response is included in [Appendix 5](#).

Detailed report

Effective collaboration in relation to health improvement work is dependent upon consensual leadership but this was not always evident

- 27 There will always be inherent tensions in a public health system where individual stakeholders have different priorities and accountabilities, particularly when seen from a national versus local organisational perspective. To manage system tensions, there needs to be clarity about who is leading the system, who has the authority to make decisions, either locally or nationally, and who is accountable for the decisions made. If there is a question mark over who the systems leaders are, then there may be confusion over which stakeholders' priorities matter while nobody knows who to follow. To mitigate these risks, organisations need to agree collectively the parameters of who does what and why.
- 28 The Trust's first Integrated Medium-Term Plan (IMTP) in 2014 indicated that attempts to describe the public health system had not been wholly successful with relationships within the system described as largely implicit, complex and evolving. The Trust recognised that:
- different perspectives and priorities needed to be reconciled;
 - leadership roles were not explicitly defined and were contested;
 - accountabilities for taking action and achieving outcomes were confused and challenged;
 - cross-organisational performance management arrangements and responsibilities were unclear or disputed; and
 - the mechanisms for aligning priorities and action across organisations were inadequate.
- 29 LPHTs and DsPH were clear that the public health system needs effective mechanisms for: leadership, advocacy, standards setting, health intelligence and evidence base. There were suggestions that these components were not always in place to ensure effective collaboration between the Trust and LPHTs.
- 30 The Trust acknowledged that relationships with DsPH are strained, particularly around health improvement. One reason for the strain was perceived to be the Trust 'not doing what health boards want it to do'. One interviewee commented that 'it feels like health boards need to be a grateful beneficiary but the Trust never asks us what would be helpful to support our local public health agenda'. The Trust told us that it wants to 'do the things only we can do; we don't want to be seen as treading on others toes'.
- 31 We found lots of rhetoric about system leaders without a clear consensus about who should lead. There is a perception amongst some DsPH that the Trust does not see them as equal partners in leading the public health system. This may be due in part to the Trust's description of its leadership role in its two most recent

IMTPs⁹. These descriptions read, 'we lead the public health system to define effective services and prioritised actions' and 'the Trust has a vital role to play through our system leadership'. However, when asked who the system leaders are, the Trust told us that all partners with responsibilities for public health, including the Welsh Government, have a role in leading the system.

- 32 It was not the purpose of this audit to consider relationships other than those between the Trust and DsPH to manage local public health resources collaboratively. However, the role of the Welsh Government in setting direction, leadership and performance management, was raised by staff on several occasions. In relation to the public health system, LPHTs and DsPH perceive the Welsh Government has high expectations that senior leaders will make it work. They were less clear, however, about what the Welsh Government expected in terms of the Trust's role in the delivery of health improvement programmes.
- 33 The Trust's Statutory Instruments¹⁰ describe the functions of the Trust as 'managing public health services' rather than leading. This raises the issue of who has system leadership responsibility, the Trust or the DsPH in their statutory role for local public health.
- 34 While increasingly the Trust is seen by some as the system leader, this, in the view of others, is in conflict with the statutory duties placed on the health board based DsPH. Whilst it may not be desirable to identify a single system leader, there does need to be greater clarity over respective roles of the different stakeholders within the system.
- 35 Staff we spoke to during the audit commonly talked about confusion over leadership and 'who does what' leading to compromised collaborative activities between the Trust and LPHTs. This was seen as compromising the ability to tackle thorny challenges such as:
- securing agreements on what the health improvement priorities are in the face of competing local demands;
 - ensuring that the 'population health' focus is not lost as a result of health boards chasing secondary care performance targets; and
 - identifying incentives or sanctions to make the system work differently and to avoid a sense of 'inertia' across the system.
- 36 LPHTs frequently cited the need for mutual trust to ensure effective collaboration but a small number of staff reported feeling more recently that the Trust wanted to exercise a style of 'command and control'. LPHTs were confident that collaboration could be more effective provided there is:
- 'a willingness and maturity to accept the grey areas around organisational boundaries'; and

⁹ See Footnotes 4 and 5

¹⁰ [The Public Health Wales National Health Service Trust \(Establishment\) Order 2009](#)

- 'a system that is less personality driven and where individual leaders are helped to let go (of control)'.
- 37 Staff frequently raised the issue of national versus local roles and responsibilities. LPHTs and DsPH see the Trust as providing the leadership and advocacy for public health at a national or all Wales level, while they fulfil these roles at a local level. Some DsPH were confident that the Trust should have a lead role in influencing and helping to frame a national public health strategy given its role in public health research and intelligence while they and their teams are better placed to lead local delivery.
- 38 However, the Trust, LPHTs and DsPH referred to the current system being one of contested leadership in respect of public health practice related to health improvement. One individual described the relationship as 'parents pulling in different directions'.
- 39 We are of the view that there is a need to do more to incorporate Prudent Healthcare principles and for the Trust and the LPHTs to do 'only what they can do', and agree what they are best placed to do. Examples were cited where this has happened successfully in the health improvement arena. The Trust has brought together all the organisations in Wales that have a role to play in improving health and wellbeing at a national level through Cymru Well Wales¹¹. This work is something that several DsPH acknowledged they could not have done. The Trust was also seen as being best able to converse and connect different stakeholders across Welsh Government departments.
- 40 Although this audit focused primarily on the relationship between the LPHTs, DsPH and the Trust's Health and Wellbeing directorate, staff were keen to tell us of other parts of the Trust's responsibilities which worked well and where the quality of working relationships and collaboration was better. All LPHTs teams and DsPH cited the good working relationships with the Trust's Health Protection Team and staff indicated that they would like see these relationships replicated more generally.
- 41 The Health Protection Team, which is centrally coordinated has both an all Wales and local presence. We were told that there are well established arrangements and well established teams with clear roles and responsibilities with many, but not all, LPHT consultants taking part in the on-call rota. In the event of a health protection incident, there is a managed and coordinated approach to the work needed. 'It's clear who does what, nationally and locally.'
- 42 As well as clear roles and responsibilities, the Trust, LPHTs and DsPH identified a number of other factors thought to enhance positive collaboration with the Trust's Health Protection Team. These factors included:
- 'good structures and coordination in place ensuring effective communication between the national team and health boards';

¹¹ www.wales.nhs.uk

- 'a level of mutual respect based on well established relationships going back 20 years; there is a level of confidence that services will continue as before'; and
 - 'we're kept in the picture by the local (Health Protection) team, who make it clear where the health board needs to support health protection functions'.
- 43 The issue of vacant or unfilled DPH posts was raised with us on a number of occasions given recent turnover and impending retirements amongst DsPH. This situation risks: (i) loss of leadership for public health locally; (ii) no oversight and management of the LPHT and work programme; and (iii) no channel for communication and collaboration with the Trust. We were assured to learn that these risks are increasingly recognised and that arrangements for mitigation are being put in place.

The Trust has not established effective arrangements to ensure that it is securing value for money from the resources allocated to local public health teams

- 44 No one organisation is wholly responsible for achieving improvements in population health and wellbeing. The Trust and health boards are accountable to the Welsh Government for delivering against the outcomes and indicators set out in the NHS Outcomes and Delivery Framework. These accountability arrangements were not within the scope of this audit but achievement is also predicated on effective collaboration.
- 45 DsPH hold honorary contracts with the Trust to enable them to direct, manage and appraise specified Trust staff based within the LPHTs. Our interviews with DsPH confirmed that these agreements have never been reviewed. These contracts are one of the mechanisms whereby DsPH can account for the use of resources allocated to the LPHTs. DsPH acknowledged their accountability for the use of these resources but for some there were concerns that the Trust wants to direct how they use them.
- 46 Based on interviews with both the Trust and DsPH, meetings to discuss how resources are deployed to meet the needs of both the Trust and the DsPH do not take place. This means that there is no understanding on how the funding for LPHTs is used to deliver shared priorities and whether it is delivering the intended benefits. The Trust has a duty to ensure where it is providing resources to LPHTs that its resources provide value for money because it is accountable to the Welsh Government, and the people of Wales, for the funding it receives ([see also Paragraph 62](#)).
- 47 The Trust is strengthening accountability arrangements with health boards where services are delivered in partnership. Over the last two years, the Trust has been working to formalise these arrangements through a Memorandum of Understanding (MOU). The MOU aims to articulate the specific arrangements and management of services by clearly defining relationships and mutual expectations.

The MOU will eventually cover all services and functions that the Trust provides, including LPHTs. The MOU could satisfy DsPH requests for clarity about what resources they can expect to receive to support them discharge their public health responsibilities.

- 48 As part of audit work, we looked to see what arrangements were in place to monitor and report on the collective delivery of local public health services. LPHTs described the governance arrangements between themselves and the Trust as 'loose' because there is no clear agreement about 'who does what' and how work will be monitored and reported outwith the team. Accountability for delivery of local work plans is to the DPH. It was clear from our visits to local teams and from the documents they shared with us that reporting lines ran from the DPH to their respective Boards and not to the Trust.
- 49 Locally, LPHTs had varying arrangements in place to monitor progress against their work plans using a range of key milestones and performance measures. One team told us it was moving to a more formal programme management model for developing its work plan so that the appropriate systems and processes are in place to support delivery and the right information is available to monitor progress and performance.
- 50 Despite the varying arrangements in place to monitor work plans, several staff commented that:
- 'there seems to be no consequences if milestones are missed'; and
 - 'there is no real accountability for what the team delivers'.

There is a lack of meaningful dialogue between the Trust and local public health teams about respective roles, responsibilities and priorities and a formal framework about what work is best done collectively

There is a lack of meaningful dialogue about what is best delivered collectively

- 51 As part of our audit we discussed the extent to which shared priorities were seen to be in place in respect of local health improvement work and the arrangements for developing LPHT work plans to deliver the shared priorities. We did not explore the content or delivery of work plans. We were solely interested in the arrangements to facilitate and resource the work planning process.
- 52 When the Trust was first established, the position for the Executive Director with responsibility for health improvement remained vacant for many months. This was seen by some DsPH as hindering early communication between the Trust, LPHTs and DsPH. Teams told us that at that time there were no or limited discussions with the Trust to identify or agree priorities for public health work. Instead, teams told us they 'just got on with the work in hand' to deliver on priorities and targets set by Welsh Government as part of the NHS Wales' annual operating framework.

- 53 The introduction of the NHS integrated planning framework in 2014 helped sharpen the Trust's focus on planning¹². It provided a renewed impetus for the Trust to work with DsPH to collectively identify and agree a small number of core public health priorities that everyone could focus on as a 'whole system'. We did not find, however, a framework setting out: (i) how these shared public health priorities would be delivered collectively through the individual contribution of the Trust and the LPHTs; and (ii) a shared view about what success would look like and how this might be monitored and reported by both the Trust and LPHTs.
- 54 The Trust continues to work with DsPH to strengthen and align organisational plans around key public health issues to enable complementary action by health boards and LPHTs in relation to each priority. It is also clear from minutes of the DPH peer group meetings that the need for common goals and priorities are discussed.
- 55 Although aware of the ongoing work to align public health priorities, LPHTs were less confident about the extent to which everyone was working to achieve the same goals. One team saw the priorities belonging to the Trust and not the system, commenting 'Trust's priorities are not always a comfortable fit for our local population'. The Trust regularly shared its draft IMTP with health boards during the annual refresh process, which LPHTs and DsPH told us they welcomed. The Trust's IMTP maps alignment of 'shared priorities' based on information in health boards' IMTPs.
- 56 The lack of clarity around roles and responsibilities within the public health system has not helped. As one individual commented, 'if there was a seamless public health system, then public health priorities would be the same across the seven health boards and Trust and we would work to one plan of action'.
- 57 To make the public health system work in relation to health improvement will require more than simply aligning the DsPH and their teams to the Trust. There needs to be agreement on the priorities that these two parts of the system need to deliver collectively, as well as agreeing individual contributions and measures of success to be monitored and reported.
- 58 LPHTs told us that work plans are designed to address local public health priorities articulated in the health boards' IMTPs and to support delivery of public health targets set out in the NHS Outcomes and Delivery Framework¹³. LPHTs design and implement their work plans with the balance of work agreed by the DsPH. LPHTs largely organise their work around public health topics like tobacco control or themes such as 'early years'. Staff are allocated work based on their expertise and experience as well as interest and development needs.
- 59 LPHTs told us that local work plans are not generally designed to support delivery of the Trust's IMTP priorities, nor do the Trust and LPHTs collaborate with each

¹² Wales Audit Office, [Public Health Wales Annual Audit Report 2014](#), January 2015

¹³ Welsh Government, [NHS Outcomes and measures guidance, WHC\(2016\)023](#), March 2016

other when developing their work plans to agree approaches to common issues. A number of different views were expressed including:

- 'if it's not in the IMTP (the Trust's), we shouldn't do it';
- 'the senior management team (of the LPHT) should align our work retrospectively to the Trust's plan';
- 'whose IMTP are we delivering?'; and
- 'we don't know what the Trust expects us to do'.

- 60 Teams were confident that if asked, they could demonstrate how their work plan supported delivery of the Trust's IMTP. One team commented that the Trust's IMTP was 'so high level that you couldn't disagree with it but we can't see the thread that connects it with what is done locally'.
- 61 The Trust is largely unsighted of the content of local work programmes. One team reported that 'until recently, we were never asked about our work plan or what resources are needed to deliver it'. Others reported that in the past they had been asked about their work and that teams willingly shared information but this had ceased with the departure of one of the Trust's Executive Directors. The Trust told us that recent attempts to find out more had been met with resistance by some DsPH. The Trust's comments chime with comments from some DsPH who were unclear why the Trust wanted to see local work plans.
- 62 Based on our interviews, there are widely held views amongst LPHTs and DsPH that the Trust wants to direct and manage their work. However, when we put this question to the Trust, it acknowledged that DsPH and LPHTs were best placed to understand the needs of their local populations and it 'doesn't want to tell them what to do'. For some staff, it felt as if they had 'two masters'.
- 63 In our view, it is reasonable for the Trust to want an understanding of the work delivered by LPHTs, not least because the Trust is accountable for securing value for money from the resources it provides, as well as a duty of care to its employees. In addition, the Trust needs to ensure that levels of resourcing are appropriate for the delivery of evidence-based and safe public health interventions across Wales.
- 64 The Trust describes itself as a professionally rich organisation¹⁴, which chimes with comments from some staff in LPHTs. Nearly half (48%) the Trust's staff (excluding medical and dental staff) are paid at pay band 6¹⁵. Information available for two health boards shows that one-third of staff are paid at pay band 6 or above. Given the rich grade mix and potentially limited specialist public health resource as

¹⁴ See Footnotes 4 and 5

¹⁵ Agenda for Change is the NHS pay and grading system that covers all staff except doctors, dentists and very senior managers. The grading system uses nine bands with one the lowest and nine the highest. There are a number of pay points within each band. The first pay point within band 6 starts at just over £26,500 while the top pay point in band 9 is just over £100,000.

described in its IMTP, the Trust needs to understand what its staff are doing and whether they are doing the right things.

- 65 Furthermore, the Trust needs to understand the nature of the work carried out by LPHTs to underpin resource allocations for delivering local public health services. Healthcare public health was seen by LPHTs and DsPH as an important element of public health practice. Organisationally, healthcare public health sits within the Trust's Directorate for NHS Quality Improvement and Patient Safety/1000 Lives Improvement Service. However, national support by the Trust for this aspect of practice was described as having 'withered on the vine'.
- 66 It is evident from our interviews that there is a lack of clarity about how this element of public health practice should be supported by the Trust, both at an all Wales level and locally. As the Trust does not have a full picture of the work done by its staff, it cannot appreciate the extent to which they support health boards in this area of practice, for example in relation to service reviews or Individual Patient Funding Requests.

The various documents setting out roles and responsibility for public health services in Wales fail to clearly articulate how the Trust and the Directors of Public Health should work together

- 67 Effective collaboration requires clarity about roles, responsibilities and leadership in the public health system. Notwithstanding the functions and responsibilities set out in the legislation, there is no single definitive document setting out how the Trust and the health boards should collaborate to discharge their public health functions.
- 68 Based on our interviews, there is no common agreement around what the system should look like and what it means to have one single public health system, particularly in relation to health improvement. A number of documents that we examined have attempted to set out the context for partnership working in the public health system in Wales. The evidence suggests however, that these have been only partially effective or even ineffective in practice.
- 69 For example, the generic job description for DsPH clearly states that DsPH are an integral part of public health services in Wales. DsPH are responsible for public health advocacy, leadership and action, working with the Trust as part of a unified public health system. The Trust would support DsPH to fulfil their roles by providing specialist public health resources
- 70 A tripartite agreement between the Trust, health boards and local authorities was developed in 2010. This agreement was intended to put the relationship between these organisations on a firm foundation, setting out clear expectations and responsibilities for organisations to work together. One of the principles set out in the document is that local and national activity would be integrated such that each supported the other across all domains of public health practice. The 2010-11

annual operating framework¹⁶ indicated that this agreement provided the firm foundation for all organisations to work together in a mutually supportive way to tackle the public health challenges facing Wales. There is no evidence, however, that this agreement was shared with the Boards of individual health boards or ever reviewed to ensure it was 'fit for purpose'.

- 71 Meanwhile, the Welsh Government's 2011 long-term agreement (LTA) with the Trust set out the services to be provided to stakeholders, reflecting the Trust's statutory functions. The LTA made clear that the Trust would work in partnership with DsPH as part of a public health system. The Trust would have a key role in implementing the health board's local public health delivery plans through the seven LPHTs and the delivery of a range of centrally managed services and programmes. As the LTA was an agreement between the Welsh Government and the Trust, DsPH would have been unsighted of the detail. The LTA ended in 2014 when all NHS bodies moved to the three-year integrated planning framework.

The Trust does not have robust methods for allocating or changing resources of local public health teams

- 72 To be successful, the public health system requires a prudent workforce that is, people with the right combination of skills and experience, the right competencies and in the right place.
- 73 At the time of the 2009 reforms to the NHS, there were 19 LPHTs aligned to the 22 former local health boards. These teams comprised a public health director and a small team of at least three public health practitioners, who largely delivered health promotion programmes. The 19 teams were subsequently organised into seven local public health teams, which varied in size.
- 74 In 2011, the Trust reviewed the allocation of local resources¹⁷ to strengthen under-resourced teams over time. The aim was to fund additional investment in those teams seen as under-resourced with no reduction in the size of larger teams. Information produced by the Trust at that time shows that it funded 82 WTE posts across LPHTs compared with the 155 WTE staff in post in 2015-16. Although the WTE number of staff has nearly doubled, team size still varies.
- 75 In addition to Trust funded staff, some LPHTs include a small number of staff who are funded in whole or in part by several health boards. The Trust employs some of these health board funded staff, who make up a small proportion (3%) of the staff deployed across LPHTs.
- 76 A consistent perception amongst LPHTs and DsPH is that the Trust is expanding to the detriment of local investment. Some interviewees went so far as to describe this expansion as 'empire building'. This perception is not borne out by our analysis

¹⁶ Welsh Government, [NHS Wales Annual Operating Framework 2010/11](#), January 2010

¹⁷ The majority of the resource allocated by the Trust to LPHTs is in the form of staff with very little non-pay funding.

of the Trust's workforce information which shows that the Trust's workforce increased by 15% between 2015-16 and 2016-17¹⁸. This increase was due to a substantial number of staff transferring into the Trust from the NHS clinical networks and diabetic retinopathy screening service and recruitment to two of its directorates (Policy, Research and International Development and Operations and Finance). A handful of staff were recruited to the Trust's Health and Wellbeing Directorate.

- 77 LPHTs held varying views on whether teams were adequately resourced. Some LPHTs, including the DPH, were confident that numbers of staff were 'about right' while others complained of being under resourced. Irrespective of numbers of staff, LPHTs were less confident about whether teams had the range of skills needed for the future and 'whether the right staff were doing the right things'.
- 78 Strategic workforce planning documents for the Trust's Health and Wellbeing Directorate in March 2016 indicated no requirement to increase numbers of public health professionals until at least 2019. It is clear from our work that there is still a need to develop a method for effectively allocating resources to LPHTs, including determining the minimum number of staff needed to deliver the same set of functions.
- 79 When we visited LPHTs in autumn 2016, we learned that the Trust had begun to review resource allocations across teams. LPHTs were anxious that any rationale for allocating local resources should take into account factors, such as local deprivation, geography, rurality and population density. In addition, there were concerns that the Trust might consider reallocating funding for vacant posts in teams described as 'over-resourced' to those teams considered under-resourced.
- 80 The Trust has indicated that it wants to move away from resourcing LPHTs based simply on inputs or activity and move towards funding for outcomes. It intends to develop a formulae or clear rationale for allocating local resources that takes into account multiple factors like deprivation.
- 81 DsPH rely on the Trust for the specialist resources to deliver their public health responsibilities across all three domains of public health practice. It was clear from our interviews that DsPH want greater clarity about the allocation of resources from the Trust in relation to the three domains of public health practice.
- 82 We found that regular discussions about the numbers of staff needed to deliver local public health services or to support wider public health practice locally do not take place between the Trust and DsPH. Instead, discussions are ad hoc, taking place when vacancies arise within the team. Consequently, for those teams where turnover is low, there are limited opportunities to stimulate workforce planning discussions.
- 83 Some LPHTs acknowledged that they were 'top heavy' in relation to senior pay bands and welcomed the opportunity from staff turnover to establish new roles

¹⁸ See Footnote 5

more suited to the changing nature of their work, as well as lowering salary costs. Where teams want to recruit to new roles, they told us discussions are held with the finance team in the first instance. Recent examples of new roles include communications officers with social marketing skills, analysts to increase local analytical capacity and programme managers to improve planning and performance monitoring of the local work plan.

- 84 Although supportive of LPHTs looking to create new roles, the Trust does not believe that these roles should be replicated across all teams. For example, in relation to social marketing, the Trust plans to establish a central Behaviour Change and Public Information team to support social marketing and public awareness. This could go some way to supporting the skills LPHTs are looking for provided there is sufficient capacity and clarity about how the Behaviour Change and Public Information team will support LPHTs. One DPH welcomed this addition but sounded a note of caution reporting that, historically, the Trust's central communications team was not always responsive to the needs of LPHTs. Equally, the Trust and DsPH could explore opportunities for LPHTs to host posts for pan Wales work.

Although the Trust has strengthened arrangements for appraisals and personal development planning, it can do more to assess the needs of local public health teams to support professional development and career progression

- 85 As part of the audit we examined how the Trust and LPHTs worked together in relation to staff appraisal and training and development. We thought this of importance to effective collaboration between the Trust and the LPHTs.

Arrangements are in place to support professional registration but more clarity is needed on how this is used to demonstrate professional competence and career progression

- 86 The UKPHR is a voluntary register accredited by the Professional Standards Authority. It was established in 2003 to regulate all multi-disciplinary public health specialists and practitioners from backgrounds other than medicine and dentistry. In 2011, the UKPHR started to regulate public health practitioners¹⁹. UKPHR registration is intended to show that public health specialists and practitioners have

¹⁹ There are four routes to specialist registration enabling staff to work as consultants, standard route (completion of a five-year public health training programme), assessment of defined specialists (portfolio route), dual registration (for those already on the Specialist register of either the General Medical Council or General Dental Council) and recognition of specialist status (exceptionality). Public health practitioners are drawn from multidisciplinary backgrounds bringing a range expertise to their roles and work across the full breadth of public health practice. Practitioner registration is via a portfolio route.

attained appropriate standards of competence and to provide recognition and status as a member of the public health workforce.

- 87 The Trust has a Professional Development Team that supports national workforce and professional development across the whole public health sector, including the NHS in Wales, local government, the third sector, academia and Welsh Government. It hosts the local assessment scheme for all public health practitioners in Wales. The scheme supports individuals working across the public health sector to develop portfolios of evidence against the UKPHR's Practitioner Standards and to apply for registration.
- 88 The Trust and DsPH are supportive of staff wanting to develop portfolios of evidence and at the time of our audit work, the Trust was running introductory events about the process. The Trust indicated that few staff starting a portfolio of evidence complete the process while some staff felt 'pushed down the portfolio route'. LPHTs described the process as 'hard and time consuming' and one which needed them 'to stay motivated'. Practitioners are expected to complete the process within 12 months. One positive benefit cited by some staff of developing a portfolio of evidence was the opportunity to collaborate with colleagues in other teams.
- 89 Staff indicated that they would welcome guidance from the Trust setting out the minimum level of competence required to work as a public health practitioner because 'not everyone wants to pursue the portfolio route to register with the UKPHR'. Our interviews found no obvious incentives for staff to complete the process and register with the UKPHR. The Trust needs to clarify its expectations in relation to voluntary registration with the UKPHR and whether it is or should be a requirement to undertake particular roles.
- 90 The Trust's 2016 IMTP indicated that it would be assessing the requirement to fund postgraduate degrees in public health to ensure public health professionals have the necessary theoretical knowledge. Staff, however, were confused about whether this postgraduate degree was needed for career progression. Staff told us that in the past a postgraduate degree in public health was seen as the gateway to more senior roles but less so nowadays because there was less money available to fund such courses. Recent advertisements for senior posts indicate that postgraduate qualifications in public health or equivalent are required. However, there is no explicit reference that registration with the UKPHR is desirable or essential to the job.

New arrangements are helping to strengthen appraisal processes and personal development planning but more needs to be done to assess the collective development needs of local public health teams

- 91 In 2016, the Trust implemented a new appraisal and performance and development review (PADR) process called My Contribution. The policy applies to all staff, except medical and dental staff registered with the General Medical Council or General Dental Council who take part in a separate appraisal process.

The first full cycle of the process concluded at the end of March 2017. LPHTs were positive about the new process describing the previous appraisal and PADR process as 'patchy'. At the time of our audit work, staff were taking part in mid-year performance reviews with the Trust seeking information on levels of compliance with the process. According to staff, it is only in the last few years that the Trust has sought information on compliance with the appraisal process.

- 92 Some staff with line management responsibility in the LPHTs reported using the recently revised Public Health Skills and Knowledge Framework as the basis for agreeing individual personal development plans for non-consultant staff. Staff from all teams told us, however, that they have never been asked to share their personal objectives or individual development plans with the Trust. This means that the Trust cannot form an objective view of the training and development needs of its staff to progress their careers and to address gaps in capacity and capability across LPHTs. Unlike their colleagues, consultants within the LPHTs reported routinely sharing PADRs and job plans with the Trust's Executive Director for Public Health Services/Medical Director.
- 93 Although critical appraisal and interpreting data are core competencies for specialists in public health, some staff questioned whether teams had sufficient levels of expertise or experience to apply these skills to underpin their practice. Other staff described the changing nature of their work and the perceived need for new skills, such as social marketing. Local team training and development plans were intended to address these perceived skills gaps but there were no mechanisms to help teams collaborate with each other around common training and development needs.
- 94 Instead, training and development needs are managed and coordinated by individual teams. A public health consultant or principal practitioner generally takes responsibility for designing the team training and development programme. One team intended carrying out a training needs analysis to ensure training and development was appropriate and targeted. LPHTs will seek support from the Trust's People and Organisational Development team if needed or will invite colleagues from the Trust's corporate-based teams to present their work or provide training.
- 95 The Trust has made significant investment in leadership and management capability having identified weaknesses in management development several years ago²⁰. A number of staff across the LPHTs told us that they could, if they wanted, take part in the leadership and management development training programme that the Trust was running. Those staff participating were positive about the experience.
- 96 However, we found that administrative staff had very different training and development opportunities, depending upon their local team. Administrative staff felt 'boxed in' and capable of doing so much more to support the public health

²⁰ Wales Audit Office, [Annual Audit Report 2015 Public Health Wales](#), January 2016

agenda locally'. These staff also see local health boards implementing administration apprenticeships and feel that the Trust could consider similar schemes to support their career development.

- 97 Recent recruits to LHPTs, who had joined the Trust from local public health teams in England, were positive about the public health system in Wales compared with their experience in England. The system in Wales was seen as providing more opportunities for career and professional development, largely because Trust staff could work at an all Wales level or locally within LPHTs.
- 98 Staff acknowledged personal responsibility for maintaining professional competence and performance but reported that it is often difficult to find opportunities for work-based learning, such as shadowing colleagues or secondments with other teams. There are no shadowing opportunities and no real capacity to rotate through other LPHTs or the Trust's national teams.
- 99 Secondments of less than one year are seen as unattractive by staff not least because of the time needed to backfill their post. Staff felt that the Trust did not appreciate the impact and risks to teams' work plans should individuals take up a secondment. For other staff, secondments were seen as a way of connecting the LPHT with the Trust's national teams.
- 100 The Trust's 2016 IMTP highlighted its intention to increase collaborative working and engagement between all directorates, divisions and LPHTs by providing opportunities for staff to work across different areas. Our interviews found that the Trust has no easy way to do this or to draw in expertise from LPHTs. We were concerned to hear from several individuals in LPHTs that opportunities to work with the Trust's national teams had been denied. The reasons suggested include the Trust not involving the DPH in the initial approach to staff, a lack of clarity about the likely time commitment or no backfill for their post. As part of its arrangements for increasing collaborative arrangements between teams, the Trust will need to liaise with DsPH to see whether such arrangements are mutually compatible for both the individual concerned in respect of development needs and the needs of the LPHT and its programme of work.

The mechanisms for communicating and sharing information between the Trust and local public health teams are under-developed

- 101 Effective collaboration requires clear channels for communication with flows of information, such as national and local work programmes or evidence underpinning local public health services, both timely and in an agreed and easy to use format. The information should add value and be directed to those who need it.
- 102 Theoretically, it should be easy for the Trust to share information with LPHTs as the Health and Wellbeing Directorate, of which LPHTs are a part, includes the Observatory and Library and Knowledge service and the teams responsible for all Wales health improvement programmes. Our interviews with LPHTs identified that

there is no standardised approach for sharing information about what works well and what different players were doing at both a national and local level.

- 103 Other than the Trust's staff bulletin, there were no regular channels of communication between the Trust and LPHTs in relation to delivering local public health services for health improvement. We were told of examples of good practice in relation to communication and information sharing around immunisation where there is effective and regular communication between the Welsh Government, the Trust, LPHTs and the health boards' immunisation co-ordinators.
- 104 Based on our interviews, there is no mechanism to coordinate work being developed or carried out by the Trust's national teams and LPHTs or between one LPHT and another. An example was cited of how a local team working on substance misuse discovered that they were mirroring work on the same topic being carried out concurrently by one of the Trust's corporate teams, leading to wasted time and effort. LPHTs also cited a lack of clarity from the Trust about what health campaigns it planned to support during the year. The lack of coordination may be due in part to the Trust's lack of understanding of local work plans. One possible channel for greater coordination in this area is the DPH peer group meetings.
- 105 Greater clarity about the roles and responsibilities of the Trust's national teams for health improvement and LPHTs is needed to improve understanding and mutual respect. LPHTs were often unfamiliar with who worked on the various all Wales health improvement programmes. Teams were frustrated that it was not easy to find out, relying instead on personal relationships where these existed.
- 106 Consistently across the LPHTs, there was an expectation that the Trust's national teams would engage with them as all Wales health improvement programmes were developed. Many staff in the LPHTs felt that national teams could do more to work with them. However, we were informed that attempts by national teams to engage and share work with LPHTs had been rebuffed in the past because LPHTs felt they were already doing the work.
- 107 A small number of staff that we met had experience of working across both the Trust's national and local teams. These staff told us that colleagues based nationally were wary of approaching LPHTs with LPHTs described as unwelcoming. LPHTs were equally irritated that the Trust, as they saw it, failed to acknowledge successful initiatives in place locally. LPHTs frequently referred to the Trust taking initiatives 'in-house and claiming them as their own'.
- 108 We concluded that variability in information flow is influenced by the working styles of the Trust's corporate leads. It is important to say that there were exceptions and that relationships with national teams were seen as improving particularly where there is a common purpose or a willingness to engage with LPHTs. For example, one team indicated that the engagement team within the Screening Division is working with them to improve the uptake of screening services across their local population. In relation to work on health improvement, all LPHTs cited the good working relationships with the Trust's national team for tobacco control. What

seems to set apart this team is its regular communication and forum for regular meetings.

- 109 The Trust's latest IMTP indicates that for each of the health harming behaviours, such as smoking and alcohol consumption, it has established, in partnership with LPHTs mechanisms for the leads in each area to come together to discuss common priorities and shape work programmes. This should address many of the concerns raised by LPHTs during our interviews, not least providing a better understanding of all Wales programmes and providing a mechanism for leads with LPHTs to connect with each other.
- 110 The size of the Trust and the geographic dispersal of staff means that 'bumping into people, corridor chats and informal conversations' do not take place. However, where there is a degree of co-location, staff remarked that communication and working relationships were improving. LPHTs felt the Trust could do more to locate staff working on all Wales health improvement programmes with local teams as a way of improving communication and building trust and mutual respect.
- 111 While LPHTs praised the Library service for quick and timely responses to requests for help, there was criticism of the health intelligence function, where requests for data and support for analysis from the Observatory were not met in a timely fashion. LPHTs reported that the Observatory provides a 'gold' standard service but this meant the speed of response was too slow. LPHTs wanted a service that was 'good enough'.
- 112 Despite issues around timeliness, the LPHTs describe the Observatory as being 'worth its weight in gold' and that the quality of its products lent credibility to their work. We were also told that when the Observatory received ad hoc requests seen to be beneficial to all LPHTs, it would produce outputs on a 'once for Wales' approach. However, LPHTs complained of sometimes feeling overwhelmed with the volume of information and felt the Observatory could provide more support to interpret it.
- 113 The Observatory has a number of systems in place to communicate with LPHTs. These include:
- attending the DPH peer group meetings to share their annual programme of work and proposed data products with the aim of agreeing priorities;
 - a single point of contact within the Observatory for each LPHT; and
 - a liaison group at which a LPHT representative attends and where the plan of proposed products is also shared. LPHT representatives on the group told us that they had no real ability to influence the work but meetings provided opportunities to network with colleagues in other teams.
- 114 There was a perception amongst some LPHTs that programmes of work of the Trust's different corporate and national teams were not always joined up. For example, staff were unclear how the emergent work of Adverse Childhood Events

(ACE)²¹ linked with current programmes around the early year's theme or how 'First 1000 Days'²² links with the work on ACEs. Staff were confused over this disconnect and although LPHTs described the work around ACEs as 'brilliant', they had no idea what it meant for their local work.

- 115 Some staff commented on poor levels of communication on decisions to disinvest in specific programmes, such as the MEND²³ programme for childhood obesity. LPHTs reported that the programme had not been replaced leaving a void or lack of direction about what they should be doing in terms of obesity programmes for children and young people.
- 116 Both the Trust and LPHTs need to manage a number of relationships with the same local authority and third sector partners. However, there are no arrangements for coordinating communication or information sharing with these partners by the Trust or LPHTs. LPHTs frequently reported 'always tripping over other colleagues' outside their team or seeing others as 'on my patch'. LPHTs reported being caught by surprise when partners referred to meetings or events organised by the Trust's corporate teams to which they were unsighted. LPHTs also reported having to 'pick up the pieces' if the Trust did not follow up on 'its promises'. We found that in most LPHTs, senior staff – consultants and principal practitioners – managed the relationship with individual local authorities on behalf of the team. A simple solution to improve coordination might be a single point of contact within each LPHT with whom Trust corporate teams could liaise and share information.

²¹ www.wales.nhs.uk

²² www.wales.nhs.uk

²³ MEND stands for Mind, Exercise, Nutrition, Do it

Appendix 1

Domains and functions of public health practice

Exhibit 1: description of domains and functions of public health practice

The table describes the domains and functions of public health practice.

Descriptions of public health practice	
Health improvement	<ul style="list-style-type: none">• This domain covers wide ranging action to improve health and wellbeing of local populations and to reduce health inequalities including:<ul style="list-style-type: none">– assessing health and wellbeing needs of local populations;– developing effective initiatives and interventions to improve health and wellbeing;– building strategic partnerships; and– enabling and supporting local communities.
Health protection	<ul style="list-style-type: none">• This domain covers wide ranging action including:<ul style="list-style-type: none">– ensuring the effectiveness of immunisation programmes;– ensuring the safety and quality of food, water, air and the general environment;– preventing the transmission of communicable diseases;– managing outbreaks and the other incidents which threaten public health; and– ensuring emergency and major incident preparedness.
Healthcare public health	<ul style="list-style-type: none">• This domain covers the planning and development of services to ensure they meet population needs including:<ul style="list-style-type: none">– ensuring equity of service provision, clinical governance, safety of services and quality improvement; and– screening services to detect changes indicative of specific health problems.
Health intelligence	<ul style="list-style-type: none">• This function underpins all of the above three domains of public health practice and includes:<ul style="list-style-type: none">– surveillance and monitoring of population health and assessment of the determinants of health and wellbeing;– support for evidence-based practice; and– assessing the effectiveness of policies, programmes and services.

Source: Faculty of Public Health, [Functions of the local public health system, 2014](#)

Appendix 2

Public Health Wales Statutory Functions

Public Health Wales National Health Service Trust (Establishment) Order 2009, SI 2009/2058 sets out the Trust's four statutory functions. These are:

- to provide and manage a range of public health, health protection, healthcare improvement, health advisory, child protection, microbiological laboratory services, and services relating to the surveillance, prevention and control of communicable diseases;
- to develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public; to undertake and commission research into such matters and to contribute to the provision and development of training in such matters;
- to undertake the systematic collection, analysis and dissemination of information about the health of the people of Wales, including cancer incidence, mortality and survival; and prevalence of congenital anomalies; and
- to provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.

Appendix 3

Public Health Wales – what it does

The infographic shows the broad range of work carried out by Public Health Wales.



Source: Public Health Wales

Appendix 4

Participant information sheet

Review of collaborative arrangements for managing local public health resources

Why we are doing the audit?

The Auditor General is the public sector watchdog for Wales, which includes examining how NHS bodies manage and spend public money. Wales Audit Office staff carry out this work on behalf of the Auditor General.

The review of collaborative arrangements for managing local public health resources is part of the Auditor General's programme of external audit work at Public Health Wales. In 2015-16, the amount funded for local public health teams was in excess of £9 million, representing approximately 9% of the Trust's budget.

It is important that the Auditor General satisfies himself that these resources are well spent. In order to do this, it is necessary to look at the collaborative arrangements through which these funds are administered.

Why we want to meet with staff from local public health teams?

Our audit focuses on Public Health Wales' arrangements to provide and account for local public health resources. We are not auditing the work or performance of local public health teams.

In order to provide a high-level, factual picture of how the current collaborative arrangements work between Public Health Wales and local health boards, we need to understand what local public health teams do and the support they receive to do their work. When we meet with individuals or groups of staff, we want to cover a number of themes. These themes are:

- Individual roles and responsibilities within the team; and
 - how these roles and responsibilities are agreed;
 - the extent of support that individuals or teams receive from Public Health Wales (ie the corporate centre) to fulfil these roles and responsibilities or to do your jobs; and
 - activities that individuals undertake on behalf of Public Health Wales.
- The work programme or work plan that the team is responsible for delivering, including how the programme or plan is developed, resourced, monitored and reported; and
 - the extent of Public Health Wales' support, input or oversight of the team's work programme or work plan;

- the extent of investment in local teams to deliver work programmes or work plans;
 - any requirements to report to Public Health Wales.
- Individual/personal objectives and how these link to the team’s work programme/plan and the arrangements for training and development; and
 - the extent of Public Health Wales’ input to or oversight of personal objectives and personal development plans.
- The level of interaction individuals or the team have on a day-to-day basis with Public Health Wales; and
- Mechanisms individuals or teams have to share work or expertise with the wider team, other local public health teams or nationally.

Appendix 5

The Trust's management response

The table sets out the report's recommendations and the actions that the Trust intends to take in partnership with the public health system to address the issues raised. The detailed actions fall within three main themes: roles, responsibilities and accountability; relationships; and system capacity and capability.

Improvement action	Management response	Lead	Completion date
<p>1. Collaborative arrangements for managing local public health resources do not work as effectively as they should do.</p> <p>The Wales Audit Office recognises, in part, that the problems identified in this report relate to matters that are the responsibilities of Welsh Government, Health Boards and Public Health Wales.</p>	<p>1a) In the context of the Well-being of Future Generations FG Act, WG to establish a mechanism to describe the public health system leadership, including the respective roles and responsibilities for the specialist public health system and to develop options for consideration by all relevant bodies on an operational model for specialist public health at a local level.</p> <p><i>Theme: roles, responsibilities and accountability</i></p>	Welsh Government	20 April 2018
	<p>1b) In the meantime, Public Health Wales and Health Boards will strengthen the existing arrangements for the governance, assurance and reporting arrangements in relation to the management of LPHTs. An overarching governance framework will be developed and will clarify and optimise accountability and reporting arrangements, thereby ensuring that the Board of Public Health Wales can account for the appropriate use of the local public health resource. The work will build on the current MoU</p>	Task and Finish Group led by PHW	31 January 2018

Improvement action	Management response	Lead	Completion date
	and ensure that governance and accountability arrangements can be tailored for local circumstances. <i>Theme: roles, responsibilities and accountability</i>		
	1c) To discharge its duties in relation to accounting for the local public health resource, Public Health Wales will meet Local Health Board DsPH at least annually. Escalation of issues will be through existing Executive to Executive meetings and, in future, Board to Board meetings. <i>Theme: relationships</i>	PHW	First round of PHW/DPH meetings completed by 31 March 2018
2. Continued working with Health Boards through the DsPH to agree the public health priorities that need to be delivered collectively, including identifying individual contributions to delivery and agreeing how outcomes will be measured collectively and monitored and reported locally and nationally.	2) Public Health Wales, Health Boards and Welsh Government will, through the Public Health Directors' Group, build on existing arrangements and establish a more strategic and planned approach - aligned to Integrated Medium Term Plans - securing a collective focus on a number of evidence-based priorities. The agreed approach will clarify roles and responsibilities, reporting mechanisms; include agreed output and outcome measures of both national and local programmes; and feed into refreshed accountability mechanisms (1b). <i>Theme: roles, responsibilities and accountability</i>	PH Directors Group	31 January 2018
3. Developing effective arrangements to demonstrate that PHW is securing value for money from the specialist public health resources allocated to LPHTs.	3a) Public Health Wales will establish a transparent mechanism to agree a fair distribution of resources between LPHTs. <i>Theme: relationships</i>	PHW	28 February 2018
	3b) PHW will establish a transparent mechanism for how value for money will be measured through the use of these and central resources. <i>Theme: relationships</i>	PHW	30 April 2018
4. Clarifying the roles and responsibilities of the Trust's national and local teams in	4a) As part of action 1a, Public Health Wales will work with Welsh Government and Health Boards to clarify the respective roles and responsibilities for health improvement. This will include clarity in relation	Welsh Government	30 April 2018

Improvement action	Management response	Lead	Completion date
relation to developing and delivering health improvement programmes.	to what is developed nationally by Public Health Wales and what is delivered locally by Health Boards. <i>Theme: roles, responsibilities and accountability</i>	PHW Health Boards	
	4b) In developing and implementing its long term strategy, Public Health Wales will work with Health Boards to maximise improvements in public health. <i>Theme: roles, responsibilities and accountability</i>	Welsh Government PHW Health Boards	30 April 2018
5. Progressing work to develop reliable methods for allocating specialist public health resources to LPHTs and other stakeholders that covers the breadth of public health practice including healthcare public health.	5) The distribution of resource is included as part of action 3 above. In support of the output of action 1a, Public Health Wales will work with the Public Health Directors' Peer Group to define and agree: <ul style="list-style-type: none"> • the respective roles for healthcare public health at a local level • the required support/resource from by PHW • the required support/resource from Health Boards. <i>Theme: roles, responsibilities and accountability</i>	PHW	28 February 2018
6. Agreeing appropriate mechanisms for communicating and sharing information between the Trust and LPHTs.	6a) Public Health Wales, in collaboration with DsPH, will improve the existing mechanism for effective communication and knowledge sharing across the public health system. <i>Theme: relationships</i>	PHW	31 January 2018
	6b) DsPH and Public Health Wales to commit to ensuring that all LPHT staff have fair access to staff development and engagement processes organised by Public Health Wales. <i>Theme: System capacity and capability</i>	PHW and DsPH	Immediate effect
7. Agreeing a mechanism whereby workforce planning discussions take place on a	7a) The Director of People and Organisational Development and other relevant Directors of Public Health Wales will regularly meet DsPH to discuss immediate and medium term workforce needs and skill gaps for each LPHT.	PHW	Commence by 31 December 2017

Improvement action	Management response	Lead	Completion date
<p>more formal basis between the Trust and DsPH</p>	<p><i>Theme: System capacity and capability</i></p> <p>7b) As part of the PHW 10 year strategy development and in the context of the WFG Act, PHW will collaborate with DsPH and LPHTs on developing and implementing a strategic workforce plan for LPHTs as a more integral plan for the specialist public health system. (This will include understanding the current skill gaps to deliver such a workforce plan.)</p> <p><i>Theme: System capacity and capability</i></p>	<p>PHW supported by DsPH</p>	<p>31 January 2018</p>
<p>8. Clarifying the requirements for career progression for staff working within LPHTs, including whether a post-graduate degree in public health is a pre-requisite.</p>	<p>8) Public Health Wales to establish a further Task and Finish Group with DsPH, Health Education and Improvement Wales and WG to develop and implement a programme for personal and professional development, leadership and management development and career progression. This will include the professional qualifications and registration required for specialist public health roles.</p> <p><i>Theme: System capacity and capability</i></p>	<p>PHW supported by DsPH</p>	<p>31 January 2018</p>
<p>9. Clarifying expectations for staff working within LPHTs about voluntary registration with the UK Public Health Register and whether it is, or should be, a requirement to undertake particular roles.</p>	<p>9) Included as part of action 7 above.</p>		

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