Public health self-assessment tool for Sector Led Improvement programme

Developing Excellence in Local Public Health

Completion of this self-assessment by host PH departments will help to guide SLI reviewers to focus attention most appropriately during their visit. There are six elements to this framework:

1. Health improvement
2. Health protection
3. Healthcare
4. Knowledge and intelligence
5. Capacity building
6. Governance and systems

For each element there are three sets of descriptors for different levels of practice:

	Basic	**Developing**	**Excellent**
1 Health improvement			
1.1 LA health inequality assessment in JSNA, JSIA including asset based assessments *(note related questions in sections 3.2 and 4.3)*	Health inequalities referenced in the HWB strategy, intelligence systems in place to map multiple disadvantage and how it changes over time. Social determinants of health are addressed across the LA by close working with environmental services, economic development,	Includes up to date reference to core data sets, links to a range of outcome indicators and clear evidence of outcome focus actions. Use of local research and nationally available evidence to advance local knowledge about how health outcomes can be	These data sets used to influence decision making, including resource allocation in the LA, CCGs, NHS providers and other stakeholders. Data used by local communities to secure NHS investment using the PH Grant as leverage. Evidence of qualitative

	transport, housing, children and young peoples' and social services, benefits advice, etc. Basic asset based assessments completed.	improved, e.g. use of NICE guidance on behaviour change. Well-developed asset based assessments completed and used in strategic planning.	information, case studies and asset based assessments used to influence strategy. Evidence of information on inequalities being specifically referenced in strategies and initiatives that successfully improve health and wellbeing and reduce inequality.
1.2 PH programme development	Commission appropriate and effective health and wellbeing initiatives based on the JSNA, JSIA, asset based assessments and HWB strategy. They must reflect the broader LA role in addressing health inequalities. Programmes are in line with NICE quality standards.	Detailed specification in programmes built on local research and other available evidence. Evidence of infrastructure and cultures across the organisation that incorporates PH strategies, e.g. designated lead roles.	Evidence across all LA departments of PH input. Evaluation that specifically measures the impact of health and wellbeing programmes on local people. Local implementation of national PH policy leading to sustained improvement of outcomes in the PHOF and NHSOF.
1.3 Partnership working for health improvement *(note related section 5.3 partnerships to build PH capacity)*	Strategic alliances and partnerships built and sustained within the local health economy evidenced by development and implementation of joint projects. Functioning HWB evidenced by regular meetings and attendance	Well-functioning HWB evidenced by good engagement and participation across programmes resulting in joint actions. Resources managed via pooled budget arrangements to supplement the PH Grant and	Positive working relationships evidenced by good examples of joint working with LA members and officers, CCGs, NHS providers, PHE, statutory sector partners, the voluntary and community sector and private sector organisations.

	by partners. Evidence of joint funding of programmes with internal and external partners to address health inequalities. Examples of health impact and combined impact assessments across sectors. Examples of use of LA legal and regulatory powers to improve health.	appropriate use of the Better Care Fund. Evidence of the use of health impact and combined impact assessments across sectors to shape policies affecting the wider determinants of health. Effective use of LA legal and regulatory powers to improve health.	PH plays a leading role in the HWB which has a clear sense of purpose, is focussed on its strategic priorities and is effective in driving the agenda. Explicit responsibilities for each HWB member and they are held to account in a constructive way. Clear relationships between the HWB and other strategic partnerships in the locality.
1.4 Community engagement	Community representative engagement in JSNA, HWB and Healthwatch.	Community engagement in consultations on all health improvement programmes.	Community engagement in programme development and delivery using a range of techniques such as consultations, surveys, focus groups, participatory appraisals, action research, etc.
1.5. Communication and PH	Reference PH function in addressing health inequalities in HWB strategy and other LA plans.	Use of a range of communication tools including the media to inform people of the risks and benefits to health and wellbeing of particular lifestyle, social and environmental factors. Reference local research and other available evidence to demonstrate impact.	Local engagement from community leaders and the general population in targeted campaigns to improve health. Evaluation of effectiveness of communication in targeted campaigns.

1.6 PH capability and capacity	Awareness of the PH Knowledge and Skills Framework across the LA. Evidence of using it in planning, strategic developments and of mapping requirements to the PHOF. *(See web link to PHKSF at end of this document)*	LA leads the sustainable development of capacity and capability to improve population health and wellbeing. Use of specific initiatives evidenced in the JSNA, JSIA and HWB strategy. Evidenced in financial returns of use of value for money and return on investment tools to inform spending allocations.	Evidence of planning and delivery of training programmes to build PH capacity across the LA workforce and other in sectors. Evidence of financial controls applied across all local government spend.

2 Health protection			
2.1 Health protection assurance framework	Agree it with local stakeholders an overarching health protection assurance framework. It should include: Identification of key elements of health protection and allocation to an appropriate lead; Assessment of risks for each element and control measures put in place; All risks are reviewed regularly at least annually; Governance arrangements are in place to oversee health protection work; An annual review of the assurance framework, with new risks being identified, and existing risks reviewed.	Health Protection Group, Board or Committee is in place, meets at least quarterly and implements the assurance framework.	New risks in health protection work are efficiently identified within year and incorporated into the assurance framework. HWB is fully engaged and is assured of the delivery of health protection functions. Local authority independent scrutiny panel undertakes annual review of health protection.
2.2 Vaccination and immunisation	Assurance provided to the LA from NHS England (Commissioner for the service), that the programmes are being effectively delivered. Governance arrangements are in place with appropriate	There is access to relevant information on the LA website, e.g. LA contact person for health protection, web-link to relevant sites. Take active role in promoting	Mechanisms in place for reporting, accountability and scrutiny of vaccination programmes by HWB and Scrutiny Panel. *(See web link to Centre for Public*

	representation from LA PH staff. Regular performance reports are produced. Regular risk assessments carried out and assurance statements received outlining progress or lack of it, and control measures are put in place. PH provides local advice to promote programmes.	vaccination and immunisation, e.g. through school place offer letters, etc. Take steps where performance is inadequate to improving performance. Lessons from untoward incidence are built into service improvement.	*Scrutiny's "10 questions to ask if you are scrutinising local immunisation services" at end of this document)* Overall performance against PHOF measures for all vaccination and immunisation in the top quartile of national performance or are showing significant and sustained improvement.
2.3 Screening	Assurance provided to the LA from NHS England (Commissioner for the service), that the programmes are being effectively delivered. Governance arrangements are in place with appropriate representation from LA PH. Regular performance reports are produced, standards are met and targets achieved. Regular risk assessments carried out and assurance statements received outlining progress or lack of it, and control measures are put in place.	Health Protection Group, Board or Committee is in place, meets at least quarterly and implements the assurance framework. Take steps where performance is inadequate to improving performance. Lessons from untoward incidence are built into service improvement.	Overall performance against PHOF measures for screening in the top quartile of national performance or are showing significant and sustained improvement. Mechanisms in place for reporting, accountability and scrutiny of vaccination programmes by Health and Wellbeing Board and Scrutiny Panel.

2.4 Infection prevention and control (IPC)	To be assured that there is a safe and effective system of IPC in place in the district. Commission appropriate and effective IPC service in the community Ensure LA has access to IPC specialist advice (either in-house, or commissioned service, or as part of a memorandum of understanding with CCG). Governance on IPC in place (e.g. District Infection Prevention and Control Committee; or Health Protection Committee/Group). All commissioned providers are compliant with CQC standards and relevant legislation in relation to IPC; and they meet set national government targets for IPC.	IPC specifications are embedded in contracts of all relevant LA commissioned services. Identification of gaps in IPC and commissioning of appropriate services to meet those gaps. A plan is in place to manage IPC generally and manage specific risks such as C. Difficile and MRSA. Annual statements of declaration by providers of commissioned services that they are compliant with IPC standards, as part of contract review.	Mechanisms in place for reporting, accountability and scrutiny of IPC programmes by HWB and Scrutiny Panel. Healthcare acquired infection targets are met.

2.5 Environment including: enforcement, trading standards, food, animal health, water, air quality and health and safety	Demonstrate joint working with Environmental Health department in LA, with reference to PHOF indicators where ever possible. Joint work on creating a sustainable environment: energy efficiency, housing standards, contaminated land and landfills, air quality, radon, airborne radiation, and climate change. Collaboration on environmental enforcement (antisocial behaviour): noise nuisance, PH nuisance (litter), filthy and verminous premises, dangerous dogs, etc. Joint work on trading standards: underage sales of tobacco, and alcohol; protection of children from harm; injuries from unsafe products, etc. Joint work on corporate health and safety, licensing occupational safety, skin piercing, alcohol licensing etc.	Demonstrate successful partnership working between PH and Environmental Health department in all areas, e.g. by development of a joint action plan, pooled budgets to fund the joint action plan, etc. Effective data collection of relevant PHOF indicators. Ensure issues related to health protection are incorporated into work programme, e.g. actions to reduce impact of fast food outlets on health through licensing process, work with schools, and raising awareness, joint work on fire safety, etc.	Mechanisms in place for reporting, accountability and scrutiny of environmental programmes by HWB and Scrutiny Panel. Demonstrate health outcomes for relevant PHOF indicators are significantly better than the national average or are showing significant sustained improvement, e.g. excess winter deaths, tobacco control profiles, LA profiles, obesity, etc.
2.6 Drugs and substance misuse	Effective strategy development group in place.	Identify gaps in service provision and develop action plan to address gaps.	Mechanisms in place for reporting, accountability and scrutiny of substance misuse

	Commission drugs and substance misuse services as required. Harm reduction strategy in place. Governance arrangement in place to monitor performance against outcomes. Achieve national targets for drugs and substance misuse; Compliance with NICE Guidance on substance misuse, e.g. interventions to reduce substance misuse amongst vulnerable young people and needle and syringe programmes.	Develop standards on other substances such as “legal highs” or prescription drugs. Commissioning of widespread community access to hepatitis testing in venues such as community pharmacies. Harm reduction strategy in place which captures the harm reduction interventions in addition to of needle exchange, blood born viruses, such as overdose prevention training, wound care for injecting drug users, etc.	programmes by HWB, other relevant strategy boards and Scrutiny Panel. Exceed national BBV targets, provision of ‘gold standard’ for needle exchange (a minimum equipment offer specified by the 2009 NICE guidance on Needle and Syringe Programmes updated 2014). Offer of foil within specialist and needle exchange provision, as per 2014 Home Office guidance. Provision of training from specialist providers to community pharmacy needle exchanges.
2.7 Prevention of injury and suicide prevention	Have in place actions to prevent unintentional injury. Have a plan in place to address deliberate self-harm. Identify lead on suicide prevention. Establish suicide prevention group with relevant partners with agreed strategy and action plan.	Recording and sharing of data related to unintentional injury, self-harm and deaths due to suicide. Undertaking on going suicide audit. Achieving national outcomes and targets.	Health outcomes are significantly better than the national average or are showing significant sustained improvement. Mechanisms in place for reporting, accountability and scrutiny of programmes by HWB, other relevant strategy boards and Scrutiny Panel.

2.8 Sexual health	Commission a fully integrated sexual health service based on the needs of the local population. This should include: STI screening and treatment, partner notification, the full range of contraception, health promotion function, and outbreak management. There is an established Sexual Health Partnership Board works to an agreed strategy and action plan and which monitors performance. Compliance with national guidance, including NICE, BASHH, etc. key outcomes are achieved.	Link with other commissioners such as NHSE and PHE, who are responsible for related services to ensure full integration at a local level. Coordinate all providers and stakeholders to ensure that people are seen in the right part of the system at the right time by the right person. Data collection and performance reporting . Focus on health outcomes.	Overall performance against outcome measures for sexual health in the top quartile of national performance or are showing significant sustained improvement. Mechanisms in place for reporting, accountability and scrutiny of programmes by HWB, other relevant strategy boards and Scrutiny Panel.
2.9 Emergency preparedness, resilience, and response (EPRR), incidents and outbreaks	Protect the health of the population from hazards and threats ranging from relatively minor outbreaks and incidents to full scale emergencies such as influenza pandemic, infectious disease outbreaks, flooding, major transport incidents, terrorist attack, etc. Relevant plans are in place including: • Major incident plan • Mass casualty plan • Pandemic Flu plan	Compliance with national guidance and standards for local areas. Systematic review of service level agreements or memorandum of understanding with partners to provide assurance that plans meet national standards, core competencies and requirements. Emergency plans in place for psychosocial support and recovery, excess deaths, mass	Plans reviewed by HWB annually and reports of significant incidents received and reviewed. Full engagement with other relevant groups e.g. LRF, LHRP.

	• Excess death plan • Severe weather plan Undertake regular exercises to test plans and ensure that they are effective. Ensure governance arrangements are in place (e.g. Local Health Resilience Partnership) and clarify the role of PH in the arrangements. Staff trained in communications and plans are in place to warn and inform the public during incidents. Staff can undertake risk assessments to identify and prioritise work streams in an incident. Assurance received from providers regarding their emergency plans and business continuity arrangements. Ensure PH incidents and outbreaks are dealt with effectively at the most appropriate level. .	treatment plan. Ensure flexible approach to learning from major incident events and exercises. Escalation protocol for health protection concerns are in place. Action plans are produced following incidents and exercises identifying key improvement areas.	
2.10 Surveillance of communicable	DPH receives assurance from PHE of competent surveillance of	Data recorded in a dashboard or similar format, and stored in such	Performance reports and information on outcomes received

disease	infectious (notifiable) diseases; systems are in place in the LA to receive relevant information and take appropriate action. Infectious diseases information is monitored and systems are place so that appropriate PH actions are taken, e.g. up to date surveillance report (NOIDS, situation reports) are received, staff are trained appropriately, clear communication systems are in place, there is an on-call system. Review of communication of surveillance information that needs to be received at local level.	a way that it can be interrogated and analysed effectively, e.g. on TB incidence. Agree stakeholders to be included in circulation of information. Systematic review of service level agreements or memorandum of understanding with partners, to provide assurance.	by Health and Wellbeing Board and appropriate action taken. Surveillance intelligence is uses to prevent further incident, near misses or unnecessary escalation.
2.11 Public Health capacity and capability	Appropriate senior PH, other professional and support staff in place to ensure capacity and capability to manage health protection functions in the LA. Delivery of delegated PH functions by LA cabinet in compliance with Faculty of PH standards and guidance.	Annual audit of workforce capacity and capability to identify any potential gaps and develop action plans to address any such gaps. Develop and agree standard for PH workforce capacity and capability in the LA.	Relevant performance outcomes in the PHOF are in the top quartile nationally, or are showing significant sustained improvement.

3 Healthcare			
3.1 Health services commissioning - governance *(note that although this section is written as if a PH team relates to one CCG it is acknowledged that some PH teams relate to two or more CCGs.)*	Agreed Memorandum of Understanding (MoU) or similar document with local CCG(s) that details: • evidence that MoU meets statutory requirements • resource that will be available for this function • agreed annual work plan. Delivery of MoU identified within PH staff objectives job plans. At least twice yearly liaison meetings between PH team and CCG to discuss work plan. MoU identifies PH staff working on commissioning health services.	Clear plans and timescales in place for reviewing and re-specifying MoU. Escalation plan to ensure resolution in the event of disagreement. Quarterly 3 way meetings between the lead consultant PH, the DPH and CCG lead. PH staff co-located with CCG. PH staff membership of CCG executive group or equivalent. PH staff have access to CCG IT and desk space and to CCG staff and mandatory training needs jointly agreed, and staff fully compliant.	Evidence that there is in year flexibility in delivery of MoU and annual work plan. Jointly funded PH posts in place. Formal appraisal and performance management of PH consultant lead includes feedback from CCG. PH staff in attendance at CCG Governing body and delegation of authority from DPH. PH staff are members of CCG integrated commissioning teams.
3.2 Health and social care service prioritisation	CCG, LA Adult Social Care and LA Children's Social Care prioritisation discussions involve PH staff. PH input into development of	PH demonstrably providing explicit evidence-based advice evaluating clinical and social care and the cost effectiveness of interventions to inform	CCG, LA Adult Social Care and LA Children's Social Care budget setting and commissioning plans clearly show the influence of PH expertise.

	business cases. JSNA includes clear priorities for the CCG. Where part of MoU with CCG, PH staff have advisory role in Individual Funding Requests (IFR).	decision making. PH demonstrably critically appraising business cases of proposals for new CCG service developments or re-configurations. CCG explicitly uses JSNA in its planning and priority setting. Where part of MoU with CCG, evidence that PH staff actively contribute to the development of IFR policy and governance.	CCG and LA 2 and 5 year plans show link to population need. Use of health economics in evaluation of proposals and to inform prioritisation decisions. CCG explicitly uses JSNA, JSIA and Health and Wellbeing Strategy in its planning and priority setting. Where part of the MoU with CCG, evidence that PH staff lead the development of IFR policy and that this is evidence based and equitable.
3.3 Equity	LA PH team and CCG have agreed approach to equity, including agreed shared definition. CCG recognise that they have a contribution to make to reducing health inequalities, through clinical commissioning and through actions by member practices.	PH team influences CCG to undertake Health Equity Audits and Equity Impact Assessments. LA PH team and CCG have agreed the contribution that health services commissioning can make to addressing health inequalities. The CCG has a strategy for reducing health inequalities that has had input from PH and has changed how they do business.	Demonstrable commissioning or re-commissioning of clinical services as a result of HEA or EIA that leads to a demonstrable increase in health equity. Health inequalities demonstrably reduced as a result of PH input and CCG action.
3.4 Quality	LA PH team and CCG have agreed approach to quality,	Demonstrable PH input into CCG service specifications that	Quality of services demonstrably improved as a result of PH

	including agreed shared definition.	include clearly identified clinical, quality and productivity outcomes. Information on service quality reviewed by PH, including benchmarking against other Districts, and NICE guidance, as appropriate.	involvement in drawing up service specifications or monitoring of service quality.
3.5 Evaluation *(Note evaluation included with more detail in section 4.5)*	PH role in evaluation identified in MoU.	One or more topics (e.g. services delivery, service changes, re-commissioning) evaluated against explicit criteria and using a variety of evaluation techniques.	Evaluation demonstrably impacts on commissioning plans, service delivery and outcomes.
3.6 Patient safety	LA PH team and CCG have agreed approach to safety, including agreed shared definitions.	PH staff participate in risk analysis, interpretation of data on incidents and serious untoward events.	PH staff have major role in risk analysis, interpretation of data on incidents and serious untoward events.
3.7 Healthcare development	PH role in healthcare developments identified in MoU	Any significant new healthcare development is explicitly informed by a needs assessment (if not already covered in JSNA) an equity audit or equity impact assessment.	New healthcare developments have demonstrable impact on health of population overall (to improve it) or health inequalities (to reduce them). Care pathways or clinical services re-specified and re-commissioned based on PH advice to CCG.
3.8 Leadership	Senior PH staff have attend meetings with senior clinicians in local provider units, in both primary	Senior PH staff have good, effective relationships with senior clinicians in local provider	Clear evidence of respect for PH leaders across the health and social care economy as a whole in adult

	and secondary health care and with LA senior managers in adult and children's social care.	units in both primary and secondary health care and with LA senior managers.	and children's services.

4 Knowledge and intelligence			
4.1 Information governance *(Information teams will have a working knowledge of the NHS IG Toolkit. See web link below.)*	Working towards Level 2 NHS IG Toolkit Assessment if council-wide or 100% Level 2 if hosted user.	100% Level 2 NHS IG Toolkit across the council or working towards Level 3 if hosted user.	Working towards Level 3 NHS IG Toolkit Assessment across the council or 100% Level 3 if hosted user.
4.2 Data flows and information gathering *(This section draws on the Public Health Knowledge and Skills Framework – see web link at the end of this document).*	Source data/information from routinely available public sources. Access, extract and use data from established flows from partner organisations. Submit requests to established partner organisations for variations or bespoke extracts of data.	Recognise the limits of routine information, research the sources of publicly available information and identify source organisations to liaise with. Scope requirements for new data/information flows. Identify the benefits of new data/information sources to the PH function.	Negotiate with data/information source, SIRO's, Caldicott Guardians on access/extracts to data/information. Access a network of key intelligence colleagues across organisations to discuss sources and their quality. Contribute to national debate on data/information flows into LA PH teams.
4.3 Joint strategic needs assessment	Meets minimum statutory guidance and referenced in the HWBS.	Includes information on communities of interest,	Intelligence and insight relating to communities of interest, vulnerable

(see linked questions in section 1.1)	Includes information on population, demography, wider determinants, health inequalities, health behaviours, communicable and non-communicable disease and care services. Process of producing the JSNA engages key stakeholders including voluntary, community and faith sector and is accessible and available to professionals and the public alike. Owned, led, managed and subject to timely review by the HWBB. Uses both quantitative and qualitative data.	vulnerable groups, protected characteristics, unmet need, community assets and equity. Range of methods used to develop the evidence including asset based approaches, audit, analysis, evaluation, rapid reviews and research. Explicit links made between needs identified and priorities, outcomes, actions and interventions in the HWBS. On-going needs assessment programme which includes an action plan for addressing gaps and involves stakeholders in taking it forward.	groups, protected characteristics, unmet need, community assets and equity is readily available and regularly updated. Discernible 'golden thread' from the needs assessment through the HWBS to commissioning plans, outputs and outcomes for a range of topics. Culture of needs assessment in the organisation which actively involves service managers, front line staff, clients/patients and carers.
4.4 Knowledge management	Staff are able to access a wide range of data sets, indicators, tools and resources about the population's health and wellbeing including those developed or managed by HSCIC and PHE. Staff are able to access and use an appropriate variety of electronic knowledge and evidence resources including ATHENS and	Staff are able to access support in commissioning/developing knowledge and intelligence to support their decision-making. NICE and related guidance is systemically forwarded to named staff to act on and an audit trail of improvement actions exists.	There is a single local knowledge and intelligence portal (incorporating JSNA) which may be accessed via partners, professionals and the public alike. Integrated knowledge and intelligence is used to support commissioning priorities, strategies and plans.

	NICE. Staff are updated regularly on latest news, relevant publications and up to date national and local intelligence on health and wellbeing trends as appropriate. Registered with NICE as a stakeholder and with other 'what works' centres as they formalise their process and this guidance is distributed to staff.	Evidence reviews, evaluation and new and emerging evidence of local need and what works to improve health and wellbeing are routinely scanned, forwarded to and assessed by HWBB and commissioners as appropriate.	An annual development programme for knowledge management and commissioning intelligence is agreed jointly with the HWBB and partner agencies. Staff take part in NICE consultations, production of evidence reviews and sharing of best practice (including publication in peer-reviewed journals).
4.5 Research and evaluation	Advice and guidance is available on conducting, commissioning and using research and evaluation and this includes ethical practice, data quality and methods. All commissioned interventions include success criteria and outcomes to be achieved. There are examples of regular academic collaboration. The PH team has access to academic resources (e.g. Athens accounts).	Strategic and commissioning decisions are informed by research evidence, with an audit trail of actions. Evaluation uses robust outcome measures and is built into all PH commissioned interventions from the outset. PH collaborates with other organisations in carrying out research. The PH team is actively engaged in knowledge generation (research and evaluation) in collaboration with partner organisations, academic	Audit and evaluation is built into the development agenda. This includes cost-benefit analysis, equality and health impact assessment. PH undertakes original research that is linked with work within the LA and has appropriate research governance in place. Evaluation actively contributes to a robust local evidence base of what does (and does not) work to improve health and wellbeing. Evidence-informed practice is reported in publicly available form.

		and other institutions.	
5 Capacity building			
5.1 Leadership for public health	DPH is a leader in the LA with some access to influencing decisions at executive director level. PH staff are engage and work collaboratively with a range of people and agencies to improve population health and wellbeing and reduce inequalities. Identify opportunities and develop structures to take forward approaches to improve population health and wellbeing. Coordinate programmes or projects to improve population health and wellbeing.	DPH is a leader in the LA with good access to influencing decisions at executive director level. PH role with LA members identified and developed. Work effectively with different media to communicate key issues relevant to health and wellbeing. Demonstrate leadership within and across organisations to improve population health and wellbeing outcomes and reduce inequalities.	DPH is an important and effective leader in the LA and is able to influence decisions across the organisation with a seat at executive director meetings. Demonstrate PH staff leading change in a complex environment handling appropriately uncertainty, the unexpected and conflict. Leadership in delivery of PH excellence regionally, sub-regionally and nationally. Demonstrate the PH advocacy role and an independent voice on behalf of the public and an ability to influence LA decisions.
5.2 Organisational development	PH makes some contribution to annual priority setting processes for the city/borough/county and for the LA as an organisation. System in place for staff take part in an annual review of their work,	PH contributes to developing health related priorities for the city/borough/county and for the LA as an organisation. All staff take part in an annual review of their work, negotiate	PH leads on developing all health related priorities for the city/borough/county and for the LA as an organisation. Effective systems in place to cascaded priorities down through

	negotiate objectives for the coming year that are related to departmental and organisational objectives and they have a personal development plan. PH structure in place to meet organisational and PH priorities. Capacity sufficient to respond to basic requirements of the PH function and to emergencies.	objectives for the coming year that are related to departmental and organisational objectives and they all have a personal development plan. Development of the wider PH workforce in LA and key partners. Development work with elected members on health and wellbeing.	the organisation in a way that produces transformation change and enables individuals and the organisation to grow. Develop assurance system and processes across the health and wellbeing system
5.3 Partnerships to build PH capacity *(see section 1.3 partnerships working for health improvement)*	Partnership working happening within the LA and with other organisations. Partners recognise their role in contributing to PH outcomes.	Partnership working well developed within the LA and with other organisations. PH staff sit on all key committees and groups that contribute to achieving PH outcomes. Choice of formal and informal partners is seen as crucial to managing change and development.	The LA, CCG, local providers, PHE, NHSE and VCS structures work effectively together. They are collectively capable of developing and delivering responses to the key health challenges and contributing to improving PH outcomes. Mature partnerships use system based approach. Difficult and challenging discussions take place that lead to positive outcomes Partners leading and investing in PH related interventions.
5.4 Workforce:	The training of PH specialty	PH specialty registrars progress	The location is seen as an

training PH specialist registrars, the PH team and the wider workforce	registrars is supported. The LA achieves and maintains accreditation as a training location by ensuring that it meets the standards required for specialty training. This is demonstrated through the annual reporting mechanism and Quality Panels. Development and training opportunities are available for all PH staff. Capacity is built in the wider workforce. PH training is available for LA staff and partner organisations e.g. MECC, mental health first aid, HIA, etc.	well through their training achieving relevant milestones in a timely manner. The location provides a rich and diverse training experience for all PH staff. Workplace based initiatives in the LA and with partners includes training and support to improve staff health, stress management, managing LTCs. Evidence available of investment in capacity to deliver this training. PH secondment opportunities developed across a variety of organisation.	attractive location for specialty registrars in which to develop their careers. Enhanced PH capacity of the overall workforce is seen as an outcome of health and wellbeing interventions and programmes. CPD development programmes run in the LA with local partners, sub regionally and regionally. Bespoke training and development for specific services such as housing, planning, environment, etc., to enhance their PH capacity.
5.5 Community	Evidence of community engagement across the area. Evidence of community development in high need areas. Data available to assess the health and wellbeing of local communities and monitor the impact of interventions.	Community capacity built through commissioning training for health champions and advocates. Asset based assessments of communities which lead to co-production of health and wellbeing interventions and community resilience initiatives. Interventions in place which build individual and community	Successful programmes in place with strong evidence that they contributes to improving outcomes in local communities (and in dispersed communities of interest that exist amongst larger populations). The impact of interventions is monitored. Evidence that community voice is heard and responded to. –‘ *you said….. so we did…..’*

		capacity and social capital to improve PH outcomes.	
6. Governance and systems			
6.1 Overall governance *(note that information governance is covered in section 4.1)*	PH structures and processes are included where appropriate, within the LA constitution. There is a clear understanding from LA officers and members regarding the role and function of PH within the LA. PH business and financial plan are in place and are formally signed off as part of LA processes.	There is a clear understanding from partner organisations regarding the role and function of PH within the LA. PH business planning can be clearly linked across LA departments and NHS organisations.	There is a clear understanding across the community regarding the role and function of PH within the LA. The Overview and Scrutiny function addresses the health and wellbeing agenda, the work of the PH and the HWB and is well informed and well supported.
6.2 Risk management	PH contributes to the LA assurance system and the production of the risk register for the organisation including a comprehensive assessment of PH risks.	PH contributes fully to the LA assurance system recognising that the production of the risk register for the organisation and actions to mitigate risks are key tasks. PH risk register links with both LA and partners registers and includes a shared understanding of nature and grading of risks.	Risk register is routinely used in framing strategy and policy. There is a clear process for decision making regarding mitigating actions arising from the risk. These actions are recorded and assessed as to whether they are effective.
6.3 Clinical governance and	Clinical governance requirements are embedded within contracts and	Reports on the clinical governance of commissioned	Clinical governance processes are seamless across health,

patient safety	including arrangements for dealing with serious incidents. Clinical governance is understood within the wider LA and recognised within their governance and risk management systems.	services are received and reviewed. Findings are fed in to the commissioning process. Robust links are made with clinical governance systems across local health and social care.	social care and children's services.
6.4 Audit	Audit work is undertaken by individual staff in line with professional requirements.	Departmental audit programme in place linking up individual activities with records of how audits have affected practice.	Full programme of PH audit documented and in place with priorities identified and audit cycles fully completed. Audits and their outcomes are clearly linked to changes in service planning and service outcomes.
6.5 Use of evidence	Use of national and international evidence of effectiveness in policies and strategies across the LA including NICE and other guidelines.	Comprehensive policy in place for the introduction of new guidelines and the use of evidence in strategy and commissioning decisions including a system for monitoring use of guidelines. .	Use of evidence embedded in the work of the LA and linked to relevant outcomes in the PHOF.

Reference documents:

Details of the 2008 (updated 2009) reference document for the Public Health Knowledge and Skills Framework can be found at the following website:

http://www.sph.nhs.uk/sph-documents/phscf/

2013 updates can be found at:

http://www.phorcast.org.uk/page.php?page_id=313

The Centre for Public Scrutiny's "10 questions to ask if you are scrutinising local immunisation services" are found at:

http://www.cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_94_CfPS_IMMUNISATION_10_Questions_FINAL.pdf

The NHS Information Governance Toolkit can be found at the following web-link (you will need an organisation code, user ID and password which should be available in each information department):

https://www.igt.hscic.gov.uk/

The LGA have produced a short document (9 pages text and 5 paged appendices) outlining the methodology and guidance for Health and Wellbeing Peer Challenge. This could be used as a basis for training and a guide for the SLI process or it could be customised for this purpose.

http://www.local.gov.uk/documents/10180/49968/health+and+wellbeing+peer+challenge+methodology+and+guidance+14+pages+accessible+jan+2014.pdf/0434d00c-f100-483f-8ac5-415739e35fd8