Department of Health & Social Care

Public Health England

Framework Agreement between the Department of Health and Social Care and Public Health England

February 2018

Annex B: Public-facing communications

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B1. The Communications Annex is an annex to the main Framework Agreement which defines the critical elements of the relationship between the Department of Health and Social Care (DHSC) and Public Health England (PHE). Section 4 of the Framework Agreement sets out how DHSC and PHE discharge their accountability responsibilities effectively. Section 4 makes clear that the Secretary of State is accountable to Parliament for the health system as its 'steward', including PHE, and that the DHSC Permanent Secretary (as the Principal Accounting Officer) is accountable to Parliament for the issue of any grant-in-aid to PHE.

B2. This provides the context in which the Communications Annex (the annex) sets out the basic principles guiding co-operation and collaborative working between the DHSC and PHE across all aspects of communication and marketing activities to deliver impactful and cost-effective communications in the context of our shared accountability to Parliament and the public.

B3. The principles are supported by and reflected in the jointly-agreed health and care communications operating model that provides the operational framework for our co-operation (see Figure 1 below).

B4. The directors of communication in DHSC and PHE will ensure this document is shared, understood and adhered to across all communications functions and by all relevant members of staff, including where appropriate central, regional and local teams.

B5. DHSC and PHE commit to regularly reviewing the effectiveness of the arrangements described in this annexe via the Health Hub and other regular meetings and discussion forums.[1] Both organisations will identify opportunities for shared learning and improvement and also identify any further amendments that may be required to this document over time.

B6. This annex is supported by a number of formal and informal networks and meetings and forums that provide additional opportunities for agreement on joint working in relation to specific communications functions and activities. In addition to these networks, DHSC and PHE may propose the development of additional

[1] The Health Hub is the quarterly meeting of the directors and heads of communications from DHSC and its ALBs

agreements to address specific issues. These agreements will have the same binding function as the annex.

B7. DHSC and PHE agree on the following principles of co-operation, building on the health and care communications operating model agreed by the Health Hub in May 2017, and which apply to all areas of our communications activity:

i. We have mutual respect for the different roles and responsibilities of each organisation

We recognise that each organisation has unique objectives and responsibilities related to its specific role within the health and care system which impacts on its communications activity.

This means that we agree, for instance, that DHSC and PHE will continue to establish and maintain independent relationships with all those interested in or affected by each organisation's work, including the media.

ii. We co-operate and co-ordinate our work

We recognise that each organisation has a unique role and purpose within the health and care system. However, we also agree that co-operation and co-ordination around external and internal communication is necessary in order to maintain public confidence in the health and care system.

On the basis of our jointly-agreed operating model, we will regularly identify and agree shared priority areas of co-operation and integrated working that support the health and care system's shared priorities. We will agree and implement an integrated communications approach for those areas and ensure this approach is fully embedded across organisations.

iii. We operate a 'no surprises' policy

We keep each other informed and updated on any issues that may impact on or affect other organisations or departments, ministerial or wider government priorities, or any issues that may have a reputational impact on the system.

We will do this in a timely manner to allow others to react and/or provide input in advance of content being shared with the public, media or other stakeholders.

In particular, we agree that PHE and DHSC should give each other sufficient advance notice and sight of decisions or publications in order to allow the Department or PHE to consult or seek any clearances (including cross-government clearance) that may be required prior to the publication of a report or announcement that sets policy or has operational, financial or policy implications.

We will ensure that policy and sponsor colleagues are informed about any decisions, announcements or consultations of which we are aware.

We will use established communications routes such as weekly teleconferences, media-planning grid discussions and other forums in an open and transparent manner to keep each other informed; and we commit to supplementing these conversations through other additional information exchange if and when appropriate.

iv. We seek to enhance the efficiency and effectiveness of our work

We will strive to share skills, best practice and resources in order to increase the efficiency and effectiveness of our work. We will use the joint forums to identify and agree areas where this is possible and of benefit to all involved.

We will use the cross-system Health and Care Communications Board and other supporting processes to scrutinise major paid-for communications and marketing activities to ensure best value for money is achieved.

We will seek to identify areas where, through co-operation and co-ordination across the health and care system, we can achieve additional efficiencies.

B8. There may be exceptional circumstances, such as legal cases or data protection issues, where adhering to these principles may be challenging. We agree to seek to resolve such issues mindful of our overarching shared responsibility to maintain public confidence in the health and care system at all times.

The health and care communications operating model

B9. The principles of co-operation between DHSC and ALBs is supported by a jointly-agreed structure to support effective co-operation, co-ordination and collaboration – the health and care communications operating model (the operating model, Figure 1 below). This was agreed by the Health Hub meeting in May 2017.

B10. The operating model does not replace or supersede any existing accountabilities or operating frameworks in place within any ALBs or DHSC. Its purpose is to provide clarity, definition and a set of "rules of engagement" that govern how we operate as a network of communicators, and how we agree on and address areas of shared interest.

B11. The operating model will be kept under review and may be amended as circumstances require. However, changes will require the agreement of the majority of Health Hub members and be supported by the Director of Communications of the DHSC, as the group head of profession.

B12. The areas of shared interest and co-operation are grouped around three broad headings:

- **strategy (shared plans):** how we jointly agree on areas of co-operation and how that co-operation is put into practice and its implementation monitored
- **standards:** how we maintain the highest professional standards and capability to build a skilled workforce which works effectively and efficiently, and adopts innovation and industry global best practice
- **spend:** how we ensure that paid-for communications and marketing activity supports our shared priorities, is of the highest professional standards and achieves best value for money

B13. The three areas of common interest are dealt with by the Health and Care Communications Board (HCCB). The Communications Capability Board and the Brand Board provide reports into the HCCB.

B14. DHSC and its ALBs agree to support and actively engage in the operating model and its bodies and to implement and support the decisions made within that model. The terms of reference for each of the bodies are agreed within the respective bodies.

Figure 1. Health and care communications operating model