



Public Health  
England



FACULTY OF  
PUBLIC HEALTH



# Public Health in the 21<sup>st</sup> Century

## Organising and managing multidisciplinary teams in a local government context

## About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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## Introduction

This guidance was developed jointly by the Local Government Association (LGA), PHE, the Association of Directors of Public Health (ADPH) and the Faculty of Public Health (FPH). Unison was involved in developing the document on behalf of the local government National Joint Council (NJC) unions and the other unions represented on the NJC Public Health Group (see glossary).

A working group comprising the LGA, PHE, ADPH and FPH drew up the guidance. Its status is purely advisory, although reference is made to statutory guidance and legislative requirements where necessary.

The guidance concerns the appropriate employment of public health professionals who carry out roles as consultants in public health and directors of public health and who are included on the GMC Specialist Register/GDC Specialist List or the UK Public Health Register (UKPHR) for Public Health Specialists. However, the working group does recognise that the public health workforce is much wider than that and as workforce development gathers pace across the system, further guidance may be produced.

The intention is to set out:

- an outline of the challenges that councils have identified so far in developing public health teams
  - a brief description of the development of public health teams prior to the transfer to local authorities to provide a context for future development
  - a discussion of the mix of skills and disciplines that councils may need to ensure they have access to in taking forward innovative approaches to public health
  - advice on approaches to terms and conditions of employment, including a discussion of any equal pay risks
  - recommendations for future action at national level around continuity of service
- In the course of developing the guidance, the working group has:
- conducted a literature review of available ideas around multidisciplinary teams
  - surveyed a sample of councils to identify what they regard as challenges and opportunities
  - commissioned advice on issues around terms and conditions and equal pay

## Purpose of the guidance

The LGA held two events in November and December 2013 called “Public Health: Beyond Transition”, which focused on the major ongoing human resource questions facing councils as public health functions bed into local government. A summary of the key points raised can be found in Appendix 1. The main concerns are around terms and conditions for appropriate recruitment and how to ensure a balanced portfolio of skills in teams, which need to provide both specialist input and ensure good political relationships.

Such concerns are typical in the wake of a major reorganisation; however, it is always important to avoid the risk that anxiety about human resource issues becomes a barrier to innovation. Any decisions and actions around terms and conditions should flow from the business needs of the organisation. This is a situation that is entirely familiar in other areas such as children’s services where many policy priorities are developed nationally. Councils are facing multiple challenges as they reorganise services in integrated partnerships to take account of changing needs in an era of continuing austerity.

Working through health and wellbeing boards, councils will continue to set their priorities in public health. Good quality workforce planning will then come into play as the skills needed to deliver commitments are identified. The aim will be to get the right people for the jobs in hand or to find other ways to access the necessary skills in the wider public health system.

Following the “Beyond Transition” events, the LGA, PHE, ADPH and FPH issued a joint statement that committed the partners to the production of “good practice guidance on the skill mix, which councils may want to consider in a local public health team”. In particular, the aim was to “include specific advice about the employment of doctors who make up around 50% of staff currently in training” and to “address issues around staff mobility and the benefits this brings to the wider system, as well as the criteria which councils may wish to take into account when they are considering employing doctors, including equal pay considerations”.

An important principle agreed at the “Beyond Transition” events was to test any idea for developing the public health system by asking the question: “Does it help the free flow of the workforce across organisational boundaries?” The continuing success of public health requires a flexible and highly skilled workforce and this can only be achieved if people can move easily between organisations. Clearly, the development of innovative, multidisciplinary teams is important to improving public health as well as professional flexibility.

In preparing this guidance, the working group noted that the new public health system is, in many ways, pioneering a novel approach to collaborative delivery across a dispersed system. It seems clear that in the future there will be an ever-greater push towards service integration in a multi-organisational environment, with a complex and perhaps fluid division of responsibilities. At this point it is unsurprising that everyone is seeking new ideas and solutions and we should not be afraid of innovative and radical approaches.

## Results from the sample survey

The working group agreed that it is important to capture emerging thinking and practice that will inform discussion across the public health system. Further work on this is required and the group recommends a wider formal research programme. The group sent a list of six questions to a sample of councils, asking about:

- the vision for the service in five years time
- changes to structures since April 2013
- any barriers to change that they had identified
- issues that the sector should work on together to optimise change
- the skills mix required
- any priorities for national support and advice

The request attracted responses from 11 councils with a good spread of size, type and location. While interesting, the responses can only provide a snapshot one year on from transition, with many councils just beginning their thinking. In summary, the responses suggested:

- most councils believe that there will always be a need for a central specialist public health function to influence other policy areas and oversee commissioning and other activities
- there will be much more integrated working with partners in the future in common with other health and social care services
- most respondent councils have not made significant changes to the structure of their public health teams since April 2013
- where changes have been made the most common approach is to link public health to children's and adults' services
- the main obstacles to change identified by respondents are the human resource issues that have driven the production of this document and other work:
  - equal pay risks
  - problems with staff moving flexibly across the public health system
  - a limited talent pool

- insufficient support for skills development
- a number of councils will be looking to share services with other councils and will be making sure that governance structures are simple, thus helping rather than hindering shared innovation as well as guaranteeing necessary local autonomy
- some councils highlighted the importance of partners combining intelligence and research functions to create robust joint strategic needs assessments and health and wellbeing strategies
- turning to skill needs, nearly all respondents saw the need for public health specialists to develop political awareness and to:
  - improve commissioning skills and commercial acumen especially at senior level
  - develop “soft” skills around leadership and programme management
  - understand the planning process, the existing built environment and links with transport, economic regeneration etc
- in terms of national support, many respondents wish to see:
  - guidance on public health specialist roles
  - a skills passport to assist career pathways
  - training to facilitate recruitment
  - ease of movement between roles, right across the public health system
  - guidance on recruitment, pay and conditions and managing medical consultants and NHS very senior managers
  - training and support around NHS pensions, appraisal and medical revalidation requirements, and clarification of the local role of PHE

The survey therefore reinforced the existing views on priorities and the importance of developing a multidisciplinary approach for public health as discussed in the next section.

# Multidisciplinary approaches to public health and lessons for modern teams

The reorganisation of public health in April 2013 is the latest development in a long period of change and modernisation for the function. It is hugely significant that responsibility for developing teams and approaches now lies with local government. However, it is instructive to understand and take account of professional developments in the past in order to inform decisions.

Over the past 150 years, public health has had a history of swinging back and forth between uni-professional practice, a medical model approach and multidisciplinary working. The employment of medical staff in public health roles has a long established history. The predecessors of today's directors of public health originated from medical officers of health, who were employed by local authorities as far back as 1847. Other senior medical roles in public health also emerged during the 1900s at both county and district level in local government. It was only after the 1974 NHS reorganisation that the medical officer of health and other senior medical staff working in local authorities (along with health visiting and maternal and child health) came under the auspices of health authorities. With that came new job titles such as specialists in community medicine. It was not until the Acheson report in 1988 that the title of consultant in public health medicine became the recognised job definition. The use of the consultant title brought parity with other NHS consultants in terms of independence and autonomy in practice. Specialist registration came in 1996 under European law with changes to medical training. Appointment to consultant posts continues to be made through an Appointments Advisory Committee as a quality measure.

Other professions have also played a key role in the development of public health in England. They include health visitors (who started life as sanitary inspectors), and environmental health practitioners.

For more than ten years, national policy decisions have supported a commitment to multidisciplinary public health teams. The opening up of the profession to non-medically qualified public health specialists, operating on the basis of equality with medically qualified specialists, has enriched public health, bringing people from a range of clinical and non-clinical backgrounds into the profession. For the first time, in 2002, professionals with backgrounds other than medicine were able to train as specialists in public health. Access to specialist training through open competition has facilitated the multidisciplinary nature of public health practice and removed the glass ceiling that had previously limited career paths.



On successful completion of training non-medical specialists are able to use the title of consultant in public health and compete for consultant posts and director of public health posts with medically qualified colleagues through an Appointments Advisory Committee.

The commitment to multidisciplinary public health teams is very important; however, a major barrier to this has been the long-established tradition of highly focused professional practitioners that can cultivate protective boundaries around areas of expertise. This is not to say that an individual's professional background is unimportant; as the joint statement from the partners to this guidance said "the strength of a multidisciplinary team often lies in the breadth of experience which individuals bring". There are countless examples across the country of highly successful public health specialists from a range of different backgrounds. This is reflected in the growing number of directors of public health who come from non-medical backgrounds.

As public health teams continue to develop in local government, councils will need to employ a mix of medically and non-medically qualified public health specialists alongside other staff who bring particular skills to the task of improving and protecting the public's health. The skills of medically qualified staff are clearly essential in enabling the team to fulfill the broadest range of functions including providing medical public health advice to clinical commissioning groups (CCGs) and other local NHS partners. As with other examples where particular professional skill sets are required, such as legal services, councils will of course seek to weigh all the usual factors around cost, quality, consistency of service and other risks when deciding how best to ensure they have access to medically qualified staff. Councils will also recognise the leadership contribution that medically qualified staff can make alongside other public health staff in the delivery of new responsibilities that councils now have in relation to health and wellbeing boards. In many cases, the opportunity cost of not having a dedicated directly employed resource will be the most telling argument with factors such as speed of response and familiarity with local circumstances coming into play. There are many examples of such resources being shared between councils where practical of course.

As we work together to improve the public's health it will be important to have an open mind about the breadth of skills that will be needed to deliver the transformation in health outcomes and reductions in inequalities to which we are all committed

## Identifying the right skill mix in the local environment

Councils inherited a mixed and variable workforce in terms of numbers employed, skills mix, grades and job titles of public health staff. There had been considerable variation in the nature of public health teams within NHS primary care trusts – both within and across regions – which emerged for various reasons including historical practice, variation in functional responsibilities outside of core work, and financial pressures. The differential allocations and resources that councils received for public health reflect this.

A diverse range of specialist knowledge, skills and experience within a public health team is a major asset in local government. It optimises organisational capability to effectively deliver public health functions across all three domains of public health: health improvement, health protection, and provision of health and care services for the population. The exact number of staff and type of roles required are for local determination, taking into account different factors and circumstances. Councils need to ensure that, within their public health workforce, they have the right mix of specialists and practitioners from different professional backgrounds to enable them to discharge their duties effectively.

Past experience has shown that, where the same set of functions is delivered, a similar size of core team is required. This is true even for a small population. A larger population may not necessarily require a proportionately larger team to deliver some functions like information and statistical analysis but it may for others such as relationship building and managing partnerships. Team size is also affected by the complexity of the local community. For example, a small, highly diverse population with complex health issues may require a larger public health team than a larger, but simpler population in terms of health needs. When replacing public health posts, councils need to consider recruiting where there are gaps in the combination of professional backgrounds that will improve overall effectiveness.

Having a varied combination of skills and professional backgrounds within the core public health workforce will also increase the recruitment pool and allow for movement across the wider system. Longer-term issues likely to influence the skills and knowledge necessary for an effective public health function will also need to be considered. Every local authority plays its part in building the future workforce irrespective of employer, and no one authority can leave this to another. This requires organisational structures that support continued professional development and which cultivate talent and leadership or management development to ensure there is a continued flow of relevant expertise across the range of public health domains.

## The role of public health specialists in local authorities

Councils have a legal duty to take action to improve the health of people in their area. They have a range of public health functions to deliver spanning across all three domains of public health as highlighted in the previous section. The director of public health is the lead officer on all health matters and is the person that elected members and senior officers look to for leadership, expertise and advice on a range of issues.

Within the core public health team of the council, public health specialists will have an extensive role across the whole spectrum of preventive work, including promotion of health and wellbeing and addressing inequalities within the population as part of the wider determinants of health agenda. Specialists will also require knowledge and experience around a range of health protection issues such as infectious disease outbreaks and emergency preparedness.

Given the responsibility of councils to commission direct clinical care for individuals with certain medical conditions, including services for sexual health and drug and alcohol misuse, public health specialists will have a central role in the effective discharge of these functions. Additionally, they have an important role in ensuring that the NHS and CCGs, in particular, receive the public health advice required. This advice will cover areas such as planning and evaluation of services, quality improvement, clinical governance, patient safety, equity of service provision and prioritisation of health and social care.

Building on existing skills and developing new ones across all sectors is fundamental to an inclusive public health system. As leaders in the public health system, councils are an important training location for a range of staff as part of their experience towards gaining a professional training qualification. This will include public health specialty training registrars and other clinical staff such as GP trainees, whose practical training experience is fully funded by Health Education England local education and training boards (LETBs). Around 50% of people entering specialty public health training are doctors so it is important to ensure that the public health specialist team includes doctors to reflect the backgrounds of trainees in order to enhance the credibility of the learning experience offered but also to ensure there is a balanced workforce employed in local authorities.

It is a matter for councils to make decisions on how they work. There may be some instances where councils may choose different models of working. This might, for example, include sharing specialist posts or functions with another council or organisation as a way of ensuring delivery of core public health work while

achieving optimum efficiency and access to the widest possible skill mix and expertise within its public health professional workforce. The working group acknowledges that there is further work to be done on the future requirements of the public health workforce and that innovative and new approaches will need to be developed over time.

## Equality issues when recruiting to public health specialist posts

This section considers the equality issues, primarily but not exclusively, in relation to equal pay legislation, arising from making new appointments to public health specialist posts and to new posts arising from restructuring public health services.

### Scenario 1: Post requiring medical qualifications

Where a public health post genuinely requires medical qualifications in order to be able to undertake all, or more probably some, of the job duties, for example, to a specialist post in control and treatment of communicable diseases, or one with a specific involvement in healthcare commissioning, then the appointment of a doctor to the post is likely to be justified and may indeed be essential. Even in these circumstances, however, local authorities must satisfy themselves before the recruitment exercise what level of specialist medical knowledge is required in order to demonstrate the market factor – does the job need someone of consultant knowledge and experience? Once this is ascertained, the employing authority must be confident that it cannot recruit a doctor at less than the relevant health service salary (not necessarily the salary of the potential recruit), for example, by reference to job advertisements for similar roles, or by having tried and failed to recruit at a lower salary; this should then provide a labour market defence to any equal pay claims, whichever the gender of the new appointee (See [Enderby] in Appendix 3: Summary of relevant case law), Authorities are advised to keep an audit trail of the evidence used to determine their position.

Points to bear in mind include:

- a) The duties requiring medical qualifications should be clearly set out in the job description for recruitment purposes, drawn up in conjunction with PHE and the FPH. There could be equality risks in deeming a post to require medical qualifications simply to have a doctor on the team, without specifying the duties requiring these qualifications. The appropriate level of medical qualifications/specialist experience should be included in the person specification.

The advertised salary is likely to be at a commensurate level for the required level of medical qualifications/experience as would be paid in the health service, as this is likely to be the main source of relevant expertise for the foreseeable future; and new trainees will also have been on NHS salaries during their training. Advice should be taken from PHE and the FPH on all these aspects

<http://www.nhsemployers.org/case-studies-and-resources/2014/03/md-22014>

- b) Even though the salary is in nearly all cases likely to be justifiable in terms of providing a labour market defence, it would be sensible for transparency purposes, and in case of challenge, to evaluate the job on the relevant job evaluation scheme, ascertain the substantive grade and salary on the relevant grading and pay structure and maintain a record of this and the market factor element (the difference between the health service salary and the local authority evaluated salary)
- c) Each element of salary will need to be reviewed separately, with the substantive job evaluated salary increasing in line with any negotiated local government pay settlements and the market factor element then reviewed by comparison with any changes to health service salaries
- d) Consideration should be given as to whether other terms and conditions will follow the health service model or whether some will be in line with the local authority's terms and conditions

### Scenario 2: Other specialist public health posts (where public health specialist qualifications are required and medical qualifications may be relevant but are not essential)

This is likely to be the most commonly occurring scenario, as public health specialists may come from a range of backgrounds, all of whom will be eligible for such posts as long as they have the appropriate level of public health qualification and registration. In these cases it will be crucial to have a clearly recorded audit trail for all stages of the decision-making process, including for example:

- a) A job description, drawn up in conjunction with PHE and the FPH, which clearly specifies the job duties and responsibilities; and a person specification setting out the nature and level of qualifications, including professional registration, required for the post
- b) The job should be evaluated on the relevant job evaluation scheme, its local authority grade and salary determined, and the market factor element separately identified for purposes of transparency

- c) In most circumstances, in order to establish whether a market payment is required, in theory, at least, the job should initially be advertised at the local authority evaluated grade and salary, with records being kept of numbers of suitably qualified candidates, if any. If no appointment can be made, then it is appropriate to re-advertise at a higher salary, reflecting a market supplement. In the particular context of recruitment to specialist public health posts, the relevant labour market is known and clearly defined as the NHS, with salaries and relevant national evaluation profiles published on the NHS Employers' website ([www.nhsemployers.org](http://www.nhsemployers.org)). Therefore, the preliminary recruitment exercise at local government rates may be considered redundant, where it is apparent from the outset that an attempt to recruit at the local authority evaluated rate would fail. However, it remains important to identify the correct NHS rate for the post in question
- d) Health service practice has been to advertise such posts at both salaries, for example, public health consultant at Agenda for Change band 8d/9 or medical consultant salary from £75k to £102k (see [Angestelltenbetriebsrat der Wiener Gebietskrankenkasse] in Appendix 3: Summary of relevant case law), and some local authorities have followed this approach, but it should be noted that this specific practice has not been tested before a UK employment tribunal
- e) A recruitment procedure which follows PHE and the FPH guidance and involves careful recording of all aspects of the process to ensure that the candidates are placed in rank order according to their suitability for carrying out the job duties, and identifying all those who meet the post requirements, but without explicit reference to whether or not medical qualifications are held
- f) A pay determination exercise in relation to the highest ranked candidate. If by far the best candidate against the selection criteria and medically qualified, then a salary in the range for health service consultants is likely to be justifiable, if the candidate will not accept the post at the local authority evaluated rate. However, if the second or a lower ranked candidate meets all essential criteria, is in all respects suitable for the post and holds public health (but not medical) qualifications, then serious consideration should be given to preferring this candidate on "value for money" and equality grounds, if the candidate will accept the post at the local authority evaluated rate or a lower rate than the higher ranked candidate(s) will accept
- g) Some health service employers, having appointed medically qualified candidates to public health posts that do not require such qualifications, have apparently enhanced the job description to include responsibilities that are commensurate with the medical salary. This practice may carry greater risks in the local government context of challenge under the discrimination provisions of the

Equality Act 2010, on grounds of enriching roles for one group and not for those outside that group

- h) As above, each element of salary will need to be reviewed separately, with the substantive job evaluated salary increasing in line with any negotiated local government pay settlements and the market factor element then reviewed by comparison with any changes to health service salaries
- i) Consideration should be given as to whether other terms and conditions will follow the health service model or whether some will be in line with the local authority's terms and conditions

### Evaluating public health specialist roles on local government job evaluation schemes

In all of the above scenarios it is recommended that the job be evaluated on the relevant local government scheme (see also *Public Health Job Evaluation Guidance*, 13 September 2013). Points to bear in mind include:

- a) Because public health specialist roles require a minimum of a master's degree level equivalent, and some may require doctorate level qualifications, they are likely to, and should, be assessed at relatively high levels on factors measuring knowledge, even when the post does not require additional managerial knowledge. This was clarified in revised guidance following the 2013 review of the Local Government Services National Joint Council (NJC) Job Evaluation Scheme (JES). Similar principles should be applied to other schemes in use in the local government sector, to avoid under-evaluation of highly specialist roles
- b) As such jobs are regarded as independent practitioner roles in healthcare terms, they are also likely to be assessed at relatively high levels on Freedom to Act/Initiative factors, even though their managerial scope may be smaller than traditional local government equivalents
- c) Many public health specialist roles require post holders to develop relationships across sectors (local government, health, voluntary organisations, private sector). While not unique to public health roles, it is important that such features be appropriately assessed under whatever factor(s) measure communication skills and/or contacts
- d) Under the Local Government Services NJC JES, the impact of public health jobs will be measured under the Responsibility for People – Wellbeing factor, either through the direct hands on route or more probably via the policy and service development route. For local authorities using the Hay scheme, impact is taken

into account under the Accountability factor. The national advisory social worker profiles illustrate how this should be done, with the relevant evaluations being determined in consultation with Hay consultants

Some local authorities have opted to use the NHS JES for public health and other integrated healthcare roles, on the grounds that the appropriate labour market for all qualified specialist roles is the health sector. The following points should be taken into consideration:

- the consequence of the approach is likely to be that different public health team jobs will be evaluated on different job evaluation schemes as the labour market defence argument is unlikely to apply to support roles and cost issues are also likely to make applying health service salaries to all these roles untenable. There may be difficulties at the boundary in determining which JES should apply and there can be equal pay issues if the two schemes would give different outcomes for individual jobs
- unlike the schemes in use in the local government sector, the NHS JES has strict nationally agreed implementation conventions (there is no scope for local conventions), and procedures, which cover, for example, panel size and composition, training of panel members. Failure to follow these requirements may render the resulting evaluations invalid in legal terms. Full details of the NHS JES procedures and information about training courses for panel members is on the NHS Employers website ([www.nhsemployers.org](http://www.nhsemployers.org)). It may be possible to “buy in” NHS JES evaluation services from a local trust or commissioning support unit (CSU), but the local authority would then lose direct control of evaluations for which it will be legally accountable, if challenged



# Preserving continuity of service for voluntary moves between local authorities, health service bodies and PHE

This section explains the issue in relation to public health and sets out some possible options for action. The working group has asked the NJC public health group to organise the necessary discussions and consultation to take matters forward because the NJC group involves a wide range of interested parties. The local government trade unions will be engaged in any formal negotiations through the NJC itself. Because the issue has implications beyond public health a wide range of organisations needs to be involved in discussions.

## The issue

Within local government and the health service, it is the norm that some contractual benefits are based on the employee's length of continuous service, for example, sick pay, annual leave and enhanced maternity rights. In addition, statutory redundancy entitlements are based on continuous service and again it is the norm that any enhancement over and above the statutory entitlement is based on a measure of continuous service. However, although the actual terms and conditions and ways of measuring continuous service in the health service and local government share some similarities they are actually separate and distinct.

In local government, where employees move between local authorities, provided there is no break period between the two employments, the Redundancy Payments (Continuity of Employment in Local Government, etc) (Modification) Order 1999 ("the **Modification Order**") preserves service for the purposes of statutory redundancy entitlements and, therefore, in most cases for any enhanced contractual redundancy entitlements which may apply in the relevant authority under its discretionary policy statement under the Local Government (early Termination of Employment) (Discretionary Compensation) (England and Wales) Regulations 2006 ("the Discretionary Compensation Regulations"). The Modification Order also preserves such service for moves between other bodies covered by the order. Those bodies are those which are generally viewed as being within the local government "family", such as arms-length management organisations (ALMOs), police and fire authorities, joint boards, associations of local authorities and some bodies that were formerly under local government control.

In addition, under paragraph 14 of Part 2 of the Green Book, continuous service with anybody on the Modification Order counts for the purposes of annual leave, the occupational sickness scheme and the occupational maternity scheme ('contractual benefits'). Other national schemes of conditions of service contain similar provisions. Therefore, where the new local authority employer employs the new employee on Green Book or other national terms, past continuous local authority service (or other Modification Order body service) will be counted for the purposes of those contractual benefits.

Similar arrangements apply to preserve service for contractual benefits and redundancy purposes for moves between health service bodies under a combination of nationally negotiated terms and conditions and the Redundancy Payments (National Health Service) (Modification) Order 1993.

However, where employees move voluntarily from a health service body to a local authority or PHE and vice versa, there is no obligation on the new employer to recognise service with the previous employer for the purposes of contractual benefits, such as occupational sick pay and holiday, and for redundancy purposes. Therefore, employees who have built up service and, therefore, associated contractual and redundancy entitlements may be reluctant to move from a health service body to a local authority, and vice versa, creating a barrier to recruitment.

## Proposal

To help facilitate employee moves between health service bodies, local authorities and Public Health England, we are considering whether continuity of service for the purposes of contractual benefits and redundancy entitlements should be preserved, by way of any of the options 1 to 4 set out below.

**The working group itself recommends that efforts should be made to adopt option 2 below as soon as possible with a commitment to move to option 4 when it is practical to do so, but it is recognised that many shades of opinion will need to be taken into account.**

In the case of all options, the following points apply:

- consideration needs to be given to whether the relevant option would apply to all employees in the relevant employers, or just to those working in certain public health roles
- the equalities considerations of restricting it to certain groups would need to be investigated
- if local authorities chose to or had to recognise service with health service bodies and PHE it would result in additional costs for authorities in terms of the additional

contractual benefits that would have to be provided. It could also lead to higher redundancy costs, in terms of the additional service the authority would recognise when calculating redundancy benefits. However, some authorities consider that those additional costs would be a price worth paying to facilitate employee moves, so that employees would work in the body where their skills are best matched

- as well as attracting moves to local authorities, preserving continuity could, conversely, encourage moves from local authorities
- providing for continuity of service between health service bodies, local authorities and PHE might lead to further calls for similar continuity preservation options to be extended more widely to include civil service bodies, such as the Department for Work and Pensions

### Option 1: Local authorities agree to recognise health service and PHE service at a local level

How: Authorities would enter into contractual agreements with relevant employees or change local terms, conditions and policies accordingly to recognise health service and PHE service for specified contractual benefits.

For redundancy, health service/PHE service would not count towards a statutory redundancy payment. However, local authorities could consider amending their discretionary redundancy policies to incorporate recognition of continuous service with the health service/PHE. If health service/PHE service was recognised, the local authority redundancy terms in respect of the number of, and amount of, a week's pay for each year of service would still apply, so it is worth noting that authorities would not be agreeing to provide health service/PHE redundancy benefits.

Consideration would need to be given to whether reciprocal arrangements in health service bodies and PHE should be sought.

Pros: It would be up to each authority, enabling them to determine their approach on a case-by-case basis.

Cons: It could result in inconsistency of treatment, thereby potentially raising equality issues. The absence of a national practice could mean prospective employees might not even consider moving to another sector, as they will assume benefits accrued through length of service will be lost. On the other hand, if a prospective employee has benefited from service being recognised on a previous cross-sector move, they may assume it will be granted again on a later move when in fact it is not, leading to confusion and potential resentment.

## Option 2: National recommendation that local authorities recognise health service and PHE service

How: NJC recommendation that authorities recognise health service and PHE service for specified contractual benefits. The NJC could also recommend that local authorities could consider amending their discretionary redundancy policies to incorporate recognition of continuous service with the health service/PHE. Consideration would need to be given to seeking a reciprocal recommendation for health service bodies and PHE.

Pros: It would help encourage option 1.

Cons: It would not be binding, so ultimately it raises the same potential problems as are identified for option 1.

## Option 3: National terms and conditions amended to recognise health service and PHE service for specified contractual benefits

How: Amendments would be made to the national collective agreements through the NJC mechanisms so that continuous service incorporated service with bodies on the Modification Order (as is the case now) plus continuous service with the health service/PHE.

The national agreements in local government could not cover redundancy benefits. Statutory redundancy pay remains governed by the statutory provisions set out in the Employment Rights Act 1996 and the Modification Order. Any enhanced redundancy payments over and above the statutory entitlement are a matter for each individual local authority. They must comply with the provisions of the Discretionary Compensation Regulations and each authority must publish its discretionary policy and keep it under review. Any national agreement that stipulated how redundancy payments were to be calculated, would amount to an unlawful fetter on authorities' statutory obligations to apply and keep under review their own discretions when making redundancy payments.

Consideration would need to be given to seeking a reciprocal agreement for health service bodies and PHE.

Pros: This option would provide greater consistency of treatment.

Cons: The agreement would only apply to those authorities applying the national collective agreements. Costs would be imposed on authorities from a national level.

As it would not cover redundancy, its impact might be limited in terms of attracting potential recruits from the health service and PHE.

#### Option 4: Modification Order amended to include health service and PHE service for redundancy purposes

How: A Department for Communities and Local Government amendment to the Modification Order. It is assumed the amendment could be drafted in such a way as to not apply to other Modification Order bodies such as ALMOs, although that would result in complex legislation so clear guidance would have to accompany the amended legislation.

Consideration would need to be given to seeking a reciprocal agreement for the health service Modification Order.

Pros: This would provide a national approach. In circumstances where a local authority employee is at risk of redundancy but gets a job with a health service body or PHE, no redundancy payment would be payable provided the offer was made before the employee leaves and they took up the new role within four weeks of leaving the authority.

Cons: The potential additional redundancy costs (ie through local authorities having to recognise any health service and PHE continuous service when calculating redundancy benefits) would be imposed through national legislation and where applicable could not be avoided.

# Appendix 1. Summary of issues identified at the “Beyond Transition” events – challenges in developing public health teams

During the “Beyond Transition” events a great deal of information was collected on the issues that are most exercising councils as employers, which is summarised below:

- councils have some difficult questions to address about the appropriate terms and conditions to offer in recruiting public health specialists, especially consultants
- the employment of medical consultants could bring theoretical equal pay risks and these need to be understood and managed
- there is a clear disparity of pay between the NHS and local government markets. It was noted, for example, that there are very few jobs in the NHS with a market adjustment at present, which is not the case in some sectors of local government
- clarity is needed about how best to offer continuity of service, the lack of which can be a major disincentive to free movement. Movement between the NHS and local government has always raised issues and this will be an increasing issue with the integration of health and social care
- some councils have concerns about grappling with the integrity of the public health specialism and how to get everyone working together in the same culture, although there is recognition of the strong skills cross-over in both directions
- what happens when a council recruits new staff onto NHS T&Cs? Are there equal pay risks?
- in the NHS, it is common practice to recruit to public health consultant roles by advertising two salary grades (medical and non-medical) and paying the successful candidate as appropriate depending on their professional status; many councils regard this technique as increasing equal pay risks
- councils would welcome further advice on harmonisation of terms and conditions and the relationship between the transfer scheme for public health staff and the organisational need for restructuring, which some councils are pursuing sooner than others

- the national template job descriptions, in some cases, appear to include national and regional responsibilities that might unnecessarily inflate grades if not a genuine requirement of the job
- the next refresh of the UK Public Health Skills and Knowledge Framework must include awareness that the future public health workforce is based mainly in local authorities
- a key question is about the exact definition of public health specialist roles. Local government has an established role in health delivery so the 'public health' contribution is not necessarily confined to specifically labelled public health specialist/professionals
- there is a vision and indeed a likelihood of increasing portfolio careers in public health; the public health workforce strategy needs to help make this type of career easier
- there is a need to avoid a two-tier public health system
- recognition that numbers of public health medical consultants and dentists need to be maintained at a national level
- some delegates were of the opinion that public health teams should contain at least one medically qualified person but there will be a different type of public health career in future

## Appendix 2. Definition of the public health workforce

The activities undertaken by the public health workforce are focused around what is currently referred to as the three domains of public health. These are health improvement, health protection, and improvement of health services for the population.

There have been some difficulties in using nationally consistent terminology and definitions of the public health workforce, particularly for those who are classified as the “core” or specialist public health workforce. A widely used way of describing the public health workforce was set out in a previous review of public health that been used to help shape training, and which is useful for this purpose. The three broad public health workforce categories have been described as public health specialists, public health practitioners (also specialist practitioners) and wider workforce. While this reflects the current context of public health practice, it is not to suggest that local councils and other employers of public health staff should not be innovative around the public health workforce to meet new issues and the changing landscape.

### Public health specialists

Public health specialists work as leaders at a strategic and senior management level, or at a senior level of scientific expertise. They will be able to properly plan and advise in one or all of the three domains of public health: health protection; health improvement; and the provision of healthcare and related services. The majority of public health specialists hold positions such as director of public health or consultant in public health. A public health specialist can be from a medical or non-medical background, but all will have completed either an accredited public health specialty training programme or will have been approved to work at ‘consultant level’ via submission of a comprehensive portfolio of evidence of their educational/training and experiential practice, which will have been independently assessed and verified through the UK Public Health Register (UKPHR). They are also required to undertake continuing professional development (CPD) and revalidation to ensure they remain on the relevant specialist register and licensed to practice (where appropriate). This means that the consultant is qualified to Faculty of Public Health (FPH) standards and formally regulated, including procedures to identify fitness to practise and apply sanctions if necessary.



## Regulation and revalidation of public health specialists

There are currently three systems under which public health specialists are regulated, all of which apply standards set by the FPH. These are:

- a) General Medical Council (GMC): The GMC holds a Specialist Register for Public Health Medicine. In 2004, the GMC agreed with the UKPHR (the current voluntary regulator—see below) that those who have specialist registration in public health with the GMC could be dually registered with UKPHR
- b) General Dental Council (GDC): As with the GMC, the GDC holds a Specialist Register for Dental Public Health. Dentists can also be dually registered with the UKPHR
- c) UK Public Health Register: In March 2003, the UKPHR was established (as a private company limited by guarantee and not having a share capital) with the aim of promoting public confidence in specialist public health practice in the UK through independent voluntary regulation. The register is intended for public health specialists from a non-medical/dental background who have either: completed the national training programme; or who have compiled a portfolio demonstrating they meet the competencies required to practice as a public health specialist.  
According to its website, UKPHR:
  - administers and publishes a register of competent public health specialists
  - does not have a formal revalidation process, but after five years registrants are required to re-register (requiring evidence of continuing professional development participation, appraisal evidence and a new application form with a legal declaration)
  - deals with registered public health specialists who fail to meet the necessary standards (its fitness to practise procedures are set out in its governing documents)

Approximately 60% of public health specialists are from medical/dental backgrounds. The remainder is from a variety of professional backgrounds including environmental health, nursing and microbiology. Currently, medical and dental specialists are required to undergo revalidation every five years in order to maintain specialist registration. PHE has the role as Responsible Officer for the co-ordination and management of revalidation requirements of medical specialists in public health. This includes medical staff employed by local authorities. However, specialists from non-medical backgrounds who are on the specialist register of the UKPHR will be expected to undergo the same revalidation process to maintain professional registration as their medical colleague counterparts. This process will be implemented at some point during 2015 once the legal mechanisms have been put in place. It is expected that the register of non-medical

specialists in public health will transfer and be maintained by the Health and Care Professions Council.

### Public health specialty training

The UK national specialist training programme for public health is open to anyone with the appropriate entry qualification. All public health specialists regardless of background are required to undertake the same GMC approved training scheme, which takes five years (or equivalent) to complete. In England, the specialist training programme is administered by Health Education England Local Education and Training Boards (LETBS) through the Postgraduate Dean/School of Public Health. There is an annual application process for the public health specialty training scheme. A rigorous assessment and selection process is undertaken through a national assessment centre. Applications to the training scheme remain popular with 600 to 700 applications being received for around 70 to 75 places each year. The percentage of recruits from medicine fluctuates from 40 to 50% each year. The training programme provides high-quality training which develops the public health knowledge, competence and capabilities of public health specialty registrars to standards set by the FPH to enable them to work in senior specialist roles.

### Public health practitioners

Public health practitioners spend all or a major part of their time undertaking elements of public health practice. Typically, they may undertake roles that focus on prevention or promotion of health from selected or vulnerable groups, or from the whole population within a certain geography. The practitioner workforce is not a homogenous group and work at various levels of seniority and grade mix within a public health team/service. A proportion of public health practitioners will also have registration with a professional body. This might include for example the Nursing and Midwifery Council if a practitioner is a nurse or midwife by background; the Health and Care Professions Council for someone with an allied health professional background, such as dietetics; and the Environmental Health Registration Board if practising as an environmental health practitioner. Some practitioners may also complete a local practitioner development programme, if available. Successful completion will allow voluntary registration as a public health practitioner with the UKPHR after submission of an independently assessed and verified portfolio.

Many public health practitioners also have a high level of specialist expertise and knowledge in an area of work and will be regarded as a specialist practitioner in their field. This practice is different to someone who is on a specialist public health register, which offers a different career path usually as a consultant in public health or director of public health. Some public health practitioners, however, may choose to complete the public health specialty training programme as part of a personal career development

plan. If they are working at a more senior practitioner level they might currently opt to submit a portfolio for specialist registration in their defined area of practice to gain entry onto the specialist register of the UKPHR.

### Wider public health workforce

Large numbers of people within the wider workforce have a role in health improvement and reducing health inequalities, although they may not recognise this. This includes NHS clinicians and many key local government occupations such as teachers, social workers, those working in the criminal justice system, drug action teams, transport engineers, town planners, housing officers, and regeneration managers. This is not an exclusive list and many thousands more contribute to public health through their roles in society.

### The UK Public Health Skills and Knowledge Framework

As part of function-mapping, it is important that local authorities identify the nature of essential skills required for current and future teams. In reviewing the skill mix in the public health team, local authorities may wish to draw on the UK Public Health Skills and Knowledge Framework. This framework provides a tool that outlines the skills and knowledge needed across all three groups of the workforce for public health – specialists, practitioners and wider workforce. It can help to:

- promote personal, team, organisational development to ensure a skilled public health workforce fit for purpose to deliver public health agendas and outcomes
- inform career and skills and knowledge progression and development for everyone who contributes to improving and protecting the health and wellbeing of the population, and reducing inequalities
- provide a consistent and coherent suite of skills and knowledge that incorporates everyone's contribution.

The framework is there to support public health development and should be used in conjunction with other frameworks specific to different organisations and employers to help inform where public health skills and knowledge can enhance delivery of public health outcomes and where additional training of staff may be of benefit. It is not a substitute for other frameworks or, for example, job evaluation and although related it is not intended that it maps directly to Agenda for Change or other similar pay structures. The framework consists of nine levels from level 1 (where people have little previous knowledge, skills or experience in public health) to level 9 where people will be setting strategic priorities and direction and providing leadership to improve population health and wellbeing. This framework can be found on the Public Health Online Resource for Careers, Skills and Training (PHORCaST) website, which is funded by Health Education England and has been set up to help recruit, retain and develop the careers

of people working in public health at all levels, and working in all sectors. It provides people and organisations with a wide-ranging source of information about roles and careers in public health, and it provides advice about how to assess your current position and how you might develop your skills and knowledge through education and training. (<http://www.phorcast.org.uk/>).

The framework will be reviewed during 2014/15 as part of a national stakeholder engagement process. This will also support and be an integral part of developing and testing an online Public Health Skills Passport that will assist individuals in navigating a career in public health, within organisations and across the system.

## Appendix 3. Summary of relevant case law

*Enderby v Frenchay Health Authority and the Secretary of State for Health* [1993 IRLR 591 ECJ]

The state of the employment market, which may lead an employer to increase the pay of a particular job in order to attract candidates, may constitute an objectively justified economic ground for the difference in pay. If the national court is able to determine precisely what proportion of the increase (=difference) in pay is attributable to market forces, it must necessarily accept that the pay differential is objectively justified to the extent of that proportion. If that is not the case, it is for the national court to assess whether the role of market forces in determining the rate of pay was sufficiently significant to provide justification for all or part of the difference. Therefore, it must determine, if necessary by applying the principle of proportionality, whether and to what extent the shortage of candidates for a job and the need to attract them by higher pay constitutes an objectively justified economic ground for the differences in pay between the jobs in question.

*Rainey v Greater Glasgow Health Board* [[1987] IRLR 26 HL]

A difference in pay between a female prosthetist and her male comparator, employed on like work but recruited from the private sector on his existing terms and conditions when the prosthetic service was established prior to her employment, fell within the statutory defence where the fact that the new service could never have been established within a reasonable time if the employees of the private contractors had not been offered a scale of remuneration no less favourable than that which they were enjoying was a good and objectively justified ground for offering that scale of remuneration. There was no suggestion that it was unreasonable to place the prosthetists on the particular point of the scale which was in fact selected, and it was not a question of the women being paid less than the norm but of the comparator being paid more because of the necessity to attract him.

*Cumbria County Council v Dow (No 1)* [[2008] IRLR 91 EAT]

It is not enough for an employer to establish that some differential is justified by market forces without giving the tribunal a proper evidential basis for determining whether it is the whole amount or something short of that.

*Angestelltenbetriebsrat der Wiener Gebietskrankenkasse v Wiener Gebietskrankenkasse* [[1999] IRLR 804 ECJ]

Two groups of employees who have different professional qualifications cannot be regarded as employed on “the same work” for the purpose of Article 141, even where the same activities are performed over a considerable length of time (in this case, psychotherapy), if the different groups cannot be considered to be in a comparable situation. Professional training is not merely one of the factors that may be an objective

justification for giving different pay for the doing the same work; it is also one of the possible criteria for determining whether or not the same work is being performed.

(Austrian case concerning claimants and comparators both carrying out duties as psychotherapists, but where the female dominated claimants had trained first as graduate psychologists, while the male dominated comparators had first trained as doctors. The ECJ considered that the two groups drew on different skills and qualifications acquired in different disciplines and this affected the nature of the work and how it was done. Furthermore the comparators were required to perform other medical tasks in an emergency, which the claimants were not required to perform).

*Kenny v Minister for Justice, Equality and Law Reform* [[2013] IRLR 463 CJEU]

Where seemingly identical tasks are performed by different groups of people who do not have the same training or professional qualifications for the practice of their profession, it is necessary to ascertain whether, taking into account the nature of the tasks that may be assigned to each group respectively, the training requirements for the performance of those tasks and the working conditions under which they are performed, the different groups in fact do the same work within the meaning of Article 1412.

(Irish case relating to predominantly female clerical workers in the police service seeking to compare themselves with male comparators in clerical posts 'designated' for police officers).

[Case extracts, excluding explanatory notes in italics, from Michael Rubenstein: *Discrimination, A Guide to the Relevant Case Law*, 27th edition, 2014].

## Glossary

|      |   |   |
|------|---|---|
| ADPH | Association of Directors of Public Health | <p>The Association of Directors of Public Health (ADPH) is the representative body for directors of public health (DsPH) in the UK with the aim of maximising the effectiveness and impact of DsPH as public health leaders. ADPH seeks to improve and protect the health of the population through collating and presenting the views of DsPH; influencing legislation and policy; facilitating a support network for DsPH; identifying their development needs; and supporting the development of comprehensive, equitable public health policies.</p> <p><a href="http://www.adph.org.uk/">http://www.adph.org.uk/</a></p>   |
| CCG  | Clinical commissioning group              | <p>Clinical commissioning groups (CCGs) are groups of general practices that work together to plan and design local health services in England by 'commissioning' or buying health and care services including: planned hospital care; urgent and emergency care; rehabilitation care; community health services; and mental health and learning disability services.</p> <p>All general practices belong to a CCG and CCGs work with patients and health and social care partners (eg local hospitals, local authorities, local community groups etc) to ensure services meet local needs.</p> <p>CCCGs are overseen, at a national level, by NHS England a new body that ensures that CCGs have the capacity and capability to successfully commission services for their local population. NHS England will also ensure that the CCGs meet their financial responsibilities. At a local level, health and wellbeing boards have been set up in local authority areas to ensure that CCGs meet the needs of local people by bringing together CCGs and local councils to understand the health, social and wellbeing needs of their community.</p> <p>Adapted from <a href="http://www.bhamsouthcentralccg.nhs.uk/what-are-ccgs">www.bhamsouthcentralccg.nhs.uk/what-are-ccgs</a></p> |

**FPH**      **Faculty of Public Health**

The Faculty of Public Health (FPH) is: the standard setting body for specialists in public health in the UK; an advocate for public health; a membership organisation; a registered charity; and a faculty of the UK's Royal Colleges of Physicians (Edinburgh, Glasgow, London). The FPH was established in 1972 by the Royal Commission on Medical Education in recognition of the growing need to treat public health practice as a distinct specialty, and the unique contribution it makes to health improvement. The faculty has worked to develop public health as a multidisciplinary specialty to encompass the growing diversity of its members' professional backgrounds and public health as a whole. This commitment was reflected in the name change in 2003 from the Faculty of Public Health Medicine to the Faculty of Public Health. See <http://www.fph.org.uk>

**GDC**      **General Dental Council**

The GDC registers qualified dental professionals; sets and enforces standards of dental, practice and conduct; protects the public from illegal practice; assures the quality of dental education and investigates complaints. See <http://www.gdc-uk.org/Pages/default.aspx>

**GMC**      **General Medical Council**

The GMC protects, promotes and maintains the health and safety of the public by making sure that doctors follow proper standards of medical practice. It has four main functions: keeping up-to-date registers of qualified doctors; fostering good medical practice; promoting high standards of medical education and training; and dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC is the independent regulator for doctors in the UK, controlling entry to the medical register and setting the standards for medical schools and postgraduate education and training. The GMC also determines the principles and values that underpin good medical practice and can take action when those standards are not met. When any doctor fails to meet GMC standards, the council will act to protect patients from harm – if necessary, by removing the doctor from their register and removing their right to practise medicine. <http://www.gmc-uk.org>



**LETB**      Local education and training board

The 13 local education and training boards (LETBs) are the part of Health Education England (HEE) that are responsible for the training and education of NHS staff, both clinical and non-clinical, within their area. LETB boards are committees of HEE made up of representatives from local providers of NHS services and cover the whole of England. HEE exists to improve the quality of care delivered to patients by focusing on the education, training and development of current and future healthcare staff. With employers and professionals as part of their governing bodies, LETBs aim to improve the quality of education and training outcomes to meet the needs of patients, the public and service providers in their areas.

LETBs have the flexibility to invest in education and training to support innovation and development of the wider health system. They also ensure that money in the new system follows students and trainees on the basis of quality and education and training outcomes. LETBs are key to ensuring that the system responds to the recommendations of the Francis report and in helping to improve the quality of care at every turn.  
<http://hee.nhs.uk/about/our-letbs/>

**LGA**      Local Government Association

The LGA works with councils to support, promote and improve local government. The LGA is a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. It aims to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

Key priorities are funding for local government; economic growth, jobs and housing; and public service reform. See [www.local.gov.uk/](http://www.local.gov.uk/)

**NJC**      **National Joint Council for Local Government Services**

The NJC is the national negotiating committee for around 1.1 million local government employees. It is responsible for annual pay negotiations and oversees common national terms and conditions as well as producing advice and guidance on a variety of issues including job evaluation and employment law. The recognised trade unions on the NJC are Unison, GMB and Unite. The NJC covers England, Wales and Northern Ireland and is a voluntary association. The employers' side of the NJC includes the Local Government Association (LGA), the Welsh LGA and the Northern Ireland LGA. The LGA provides the secretariat for the NJC and the employers' side but the membership of the employers' side is constitutionally separate from the LGA's own board structures. Around 46 councils, mainly in the south-east of England are not members of the NJC.

The NJC Public Health Group is an advisory group set up by the NJC after the transfer of public health staff to local government. The group gives consultative representation to the British Medical Association and the Royal College of Nursing, which are not recognised for collective bargaining purposes in local government. The group has a remit to make recommendations to the NJC and to prepare documents for approval and publication by the NJC. The group includes PHE and ADPH.

The NJC Job Evaluation Scheme is the most commonly used JE scheme in local government and is owned and overseen jointly by the employers and unions through the NJC. In practice many senior jobs in local government are evaluated using other schemes such as the Hay scheme.

**PHE**      **Public Health England**

PHE is an executive agency of the Department of Health whose mission is to protect and improve the nation's health and to address inequalities.

PHE is responsible for: making the public healthier by encouraging discussions, advising government and supporting action by local government, the NHS and

other people and organisations; supporting the public so they can protect and improve their own health; protecting the nation's health through the national health protection service, and preparing for public health emergencies; sharing information and expertise with local authorities, industry and the NHS, to help them make improvements in the public's health; researching, collecting and analysing data to improve understanding of health and come up with answers to public health problems; reporting on improvements in the public's health so everyone can understand the challenges and the next steps; and helping local authorities and the NHS to develop the public health system and its specialist workforce. Details of PHE specialist workforce responsibilities are given in the Public Health Workforce Strategy, 2013. See [www.gov.uk/government/organisations/public-health-england](http://www.gov.uk/government/organisations/public-health-england)

UKPHR United Kingdom  
Public Health  
Register

The UK Public Health Register is an independent, dedicated regulator for public health professionals in the UK, providing professional regulation to public health specialists and public health practitioners from a variety of backgrounds, all of whom have a common core of knowledge, and skills.

The register is particularly for those public health professionals who have no other regulatory body. The underpinning principles for the UKPHR include: public protection; fairness; transparency; robustness; collaboration with appropriate bodies. The register is administered by a not-for-profit company. This arrangement protects the independence of the register. See [www.publichealthregister.org.uk/](http://www.publichealthregister.org.uk/)

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