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Delivering a quality public health function in integrated care boards

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Local public health teams should be an integral part of multidisciplinary working across place-based partners. **Local directors of public health (DPHs)** provide professional public health leadership and advice across the essential functions in the table below within an integrated care system (ICS) and have a statutory obligation to provide integrated care boards (ICBs) with a 'core offer' of public health advice as per the regulations made under the NHS Act 2006.

Recent national statutory guidance endorses the involvement of DPHs in integrated care partnerships (ICPs) to secure services that meet the healthcare needs of their local communities.

The following checklist is provided by the NHS National Public Health team to support ICBs in providing a quality public health function across the ICS.

It is endorsed by NHS England, the Association of Directors of Public Health, the Local Government Association and the Faculty of Public Health and draws on national and international guidance on what a high quality public health function looks like.

Top tip	How to?	Success measures
1. Know the local population	• Access epidemiological data and understand the risk factors, service utilisation and outcomes of the ICS population by time period and in comparison, to the national profiles. • Learn from community intelligence. • Use the local joint strategic needs assessments (JSNA). • Facilitate collaborative working between public health intelligence teams and NHS analysts to support the move to cross-system intelligence functions.	• Annual reports on the health of the local population are contributing to population health strategies formed by the ICP, deploying the JSNA, and linked to health and wellbeing boards • There are structured joint efforts to pool person-level data on physiological, psychological and social factors to aid a common understanding of risk factors driving ill health and poor outcomes in different population groups. • Joint NHS and public health analytical teams drive actionable insight for ICB, ICP and place-based decision-making forums.
2. Adopt an 'all hazards' approach to resilience and ensure the ICB plays its role in protecting the population	• The ICB is a Category 1 emergency responder. • Co-operate with relevant partners to exercise and prepare for infections, environmental, radiological and chemical emergencies, and liaise with local DPHs. • Be clear about the ICB's role and interdependencies in curtailing outbreaks of infection and threats from food, environment, and occupational adverse events in the local population.	• Senior ICB leaders engage in the local resilience forum and its exercising. • Audits of the handling of outbreaks and incidents within the ICS are undertaken either by the appropriate ICB team or as active input to a regional/national audit.

3. Take account of relevant public health laws, regulations and governance structures	• Maintain clear lines of accountability within the ICS for keeping the law, advising each partner organisation within the ICS on public health regulations and acting with authority as required. • Consider the statutory duty to reduce health inequalities.	• Internal and external governance audits are commissioned including equity audits and identify compliance.
4. Understand the role of partners across the ICS in supporting effective and efficient health systems, multi-sectoral planning and financing of population health	• Ensure access to the right expertise for service reviews and evaluation of the impact of care offered. How is mutual benefit encouraged during controversial change? • How does the ICB promote collaboration with local leaders to develop a shared vision across all partners including providers, councillors, commissioners, clinicians, social care professionals and community representatives? • How can the assets of the voluntary, community and social enterprise (VCSE) sector be harnessed for improved population health outcomes? • Support the skills for system leadership and interdependencies. What clinical accountabilities does the ICB have to reduce health inequalities and how will outcomes be demonstrated? Discuss first with local DPHs.	• Annual partnership survey identifies the ICB as a valued partner. 'System' level achievements are interpreted for their population benefits and celebrated at board level. • Local population outcomes frameworks are jointly developed through the ICP. • Core20PLUS5 measures are tracked, and outcomes reported.

5. Advance public health research	• Provide opportunities to promote the duty to create knowledge and innovation in health and care delivery.	• The ICS becomes a partner in National Institute for Health and Care Research and wider research collaborations. New knowledge and its population impacts are published and the learning shared appropriately.
6. Promote the prevention and detection of non-communicable and communicable diseases	• Prevention of ill health is not solely about prevention of healthcare admissions. • Define how NHS prevention programmes and population health management approaches contribute to robust secondary prevention and are funded in a sustainable manner. • Are screening programmes, NHS Health Checks and immunisation services optimised to reduce inequalities? Embed appropriate prevention in all clinical pathways and strategies. • Make Every Contact Count by providing opportunities for healthcare system staff to be trained in how to have conversations about prevention.	• ICB board papers identify the prevention programmes at least annually. • Include equity audits for impact. • Service delivery innovations balance access to both treatment and preventive services. • Mandatory training schedules for healthcare staff reflect innovative and emerging practices.
7. Consider the NHS's contribution to the wider determinants of health	• Primary prevention occurs outside the NHS, but NHS organisations can contribute. • As a good partner, create opportunities, working through the ICP, place-based partnerships and health and wellbeing boards, to influence the economic, environmental, educational, occupational and social factors that impact health and wellbeing outcomes across the ICS.	• Evidence of how specific ICS inputs contribute to the delivery of local health and wellbeing strategies. • Increasingly use linked data and health analytics to track the net impact of preventative care models on target population groups.

	• Support a Marmot life course approach in your geography.	
8. Support community engagement and social mobilisation for health and wellbeing	• Be connected and listen to those who use local services. Reach into local population groups that do not approach services of benefit. Community-led approaches or working with VCSE organisations are tested methods. • Ways that work for some communities will not work with others. The local authority public health teams from within your ICS will advise.	• Methods of in-reach are shared by the ICS with other ICSs. • Annual surveys identify the contribution of the as valued. • Community groups continue to engage with the ICS. Challenge is actively sought and welcomed.
9. Support and integrate the public health workforce	• Act as an exemplar employer of professional public health colleagues, as required by regulation. • Provide ambitious opportunities for public health leadership at a level of influence, particularly at board level. • Consider how the ICB and ICS can become a sought-after location for public health and clinical training.	• Professional public health leadership is identifiable at senior ICB level and annual workforce surveys identify increases in public health capacity throughout the ICS. • Public health trainees are regularly assigned to ICS and place-based footprints, and placements are successful.
10. Ensure equitable access to high quality health care	• Consider what data and evidence you are using to judge health benefits from commissioned healthcare. Discuss unexplained variation with your DPHs and local public health team to enhance equity in access and outcome. • Advance the rational use of essential medicines and technologies.	• A 'Right Care' approach to sharing the outputs of healthcare commissioned is supported at board level.