ADPH

Business Plan 2007-2010

Nicola Close, Chief Executive

May 2008

Contents

Introduction

This plan is written primarily to provide an agreed basis for the Association to move forward. It does however also give a map of where the Association is and where it aims to go and therefore will be useful in informing others. Its purpose then is threefold.

- To provide an agreed baseline, direction and objectives for the Executive and staff to work to.

- To give standards by which members and core-funders can evaluate progress.

- To inform potential partners and collaborators and other interested individuals and organisations of the purpose and direction of the Association.

The plan has a three-year time-scale (2007-2010). The more detailed appendices, which contain shorter-term time-specific objectives, will be revised on a rolling basis with a major review in 2009 in readiness for a new three-year plan.

The Plan and its appendices detail the development and delivery of membership services and activity on behalf of members, which in summary are:

- the opportunity for involvement in policy development and advocacy;

- representation on government and other bodies, and response to consultations;

- collaborative campaigns and support of other public health campaigns;

- core data set of members to provide overview of the DPH population;

- supporting networking and communication between members;

- a website providing information to members on the Association and its activities, and a daily newsfeed of topical public health issues

- membership enquiries and regular communications through local representative structure and e-DPH;

- events aimed directly at DsPH and their current issues: conferences; workshops; sessions at others' events;

- DPH development support: Annual Report competition; learning sets; master classes; step-up programme.

The chief executive has written the plan after discussions with the executive and between members at events and meetings over the last two years. It has not been difficult to get a consensus on where we should be by 2010. The review in 2009 will need to look at whether the vision and working methods should continue to develop beyond 2010 or remain in a steady state.

Context

Public Health has been high on the political agenda for several years now. The Wanless reviews brought a new understanding of the economic importance of public health measures to improve and protect health. The intransigence of health inequalities, the increasing importance of emergency planning and the need to commission health services more intelligently all mean the role of Public Health across the three domains is greater than ever.

Looming crises in obesity and sexual health, problems caused by smoking, alcohol and drugs, the growing fear of pandemics and the rise in bio-terrorism all require public health expertise and leadership. The role of the Director of Public Health (DPH) with oversight across the whole agenda in leading public health teams and collaborating across agencies is key to achieving successful health outcomes.

The threat of climate change and the consequent health effects brings a new urgency to the sustainable development agenda and leadership from DsPH could make a real difference to attitude and outcomes.

Devolution has brought some divergence in health policy across the UK but irrespective of changes in NHS structures and differences in the health agenda in the four UK countries the DPH as guardian of the population's health remains a vital and challenging job.

There are many national Public Health Associations with a variety of remits. The emphasis now is on collaboration and partnership where goals are similar and support for each other where agendas overlap. Funding and indeed expertise is limited and duplication of effort is clearly wasted resource. The national Public Health organisations with a remit across the whole of public health are coming together not only to share knowledge and experience and maximise resources but also to strengthen their voice as advocates for health.

The Association

History

The Association of Metropolitan Officers of Health was founded in 1856: "an Association for the purpose of mutual assistance and the advancement of sanitary science", with John Simon as the first president. By 1859 the membership included non-metropolitan officers and in 1869 the name changed to the Association of Officers of Health to reflect this.

The Association had a complex history as the role and remit for public health officers changed. By 1975 it had grown to be the Association of District Community Physicians and the current name came about in 1989.

The original purpose was as a lobbying and campaigning body and later as support and to facilitate knowledge sharing for its members. The current constitution was formulated in 2005 as it became clear that the need for the Association was increasing and a more robust and modern framework was required to give it a legitimate base.

Funding was secured from the Department of Health in England in 2006 to begin this modernisation process which is now well under way. This Business Plan maps the major remaining tasks in creating a robust and well-founded subscription-based association fit for modern public health directors across the UK.

Values

As a public health Association the ADPH aims to follow the values as laid down by the Faculty of Public Health. As a public sector organisation it expects its staff and executive to follow Nolan's seven principles of public life along with the more recently realised imperative of environmental awareness. These can be encapsulated in the following points:

- equity and fairness;
- empowerment and inclusiveness;
- effectiveness and evidence-base;
- selflessness and objectivity;
- openness and honesty;
- integrity and accountability;
- and leadership with respect for all others and the environment.

Vision

How independent is the ADPH?

The ADPH will have a collaborative approach to their work, forming partnerships where possible, supporting others' initiatives and maximising impact by the use of shared resource where effective and appropriate.

The ADPH should however preserve a respected wholly independent and influential voice, speaking for and from local DsPH and also as advocates for DsPH and Public Health nationally.

Where does the ADPH align itself?

DsPH have key functional links to both the NHS and Local Government as well as a professional alignment with Public Health. The balance between these three 'masters' has to be carefully nurtured and developed.

The ADPH will therefore align itself centrally between the triangle of NHS, Local Government and Public Health, valuing partners from all three areas as of equal importance.

Aims & Objectives

The aim of the ADPH is to support Directors of Public Health (DsPH) in improving and protecting the health of the population by working to:

- collate and present the views of DsPH on public health policy to national governments, the media and other organisations;
- influence legislation and policy at a local, regional, national and international level;
- facilitate a support network for DsPH to share ideas and good practice and support problem-solving;
- identify and fulfil the development needs of DsPH where practicable and appropriate;
- in collaboration with others, further the development of comprehensive, equitable public health policies through relevant statutory and other bodies.

This will be achieved through work under the broad headings of Policy (including advocacy and collaborative work) and Membership services (including events and development support).

What ADPH is and what it is not

The above details what the ADPH aspires to be; a society of DsPH supporting the DPH work and role within the three contexts of NHS, local government and public health. As Board level leaders, managers and professionals, DsPH have a highly complex role and deserve the extra support that a dedicated Association can give. This will not detract from the support that DsPH gain individually or professionally on more specific issues from other groups and organisations to which they belong.

It is important in such a crowded field as that of public health bodies that there is also clarity as to what we are not. The ADPH, at least until 2010 will neither have the capacity or will to conduct health campaigns, produce locally applicable guidelines and toolkits or undertake major research. We would however expect to contribute to any such initiatives where appropriate, collaborate with partners to initiate some and even provide leadership where practicable and relevant.

There will be many times when we will want to initiate work but as a matter of principle we will aim to be inclusive and collaborative in approach. Aside from the desirability of a collaborative and partnership approach, it will be essential given the small resource it commands for the ADPH to work with others as a matter of course to achieve its goals.

Priority areas for initiating work will be where:

- DsPH are the major stakeholders;
- DsPH have specific and separate issues to consider;
- the DsPH contribution will have greater impact if expressed independently;
- there is a gap that is a priority for DsPH that is not being covered by others.

Relationships

Objective 1: *Review and prioritise relationships, widen the circle of relevant contacts and develop an understanding of how we should work together.*

From the definitions above it is clear that there needs to be clarity in our relationships with other relevant organisations. As a broad principle we will think about organisations under three headings. This classification is not exclusive, binding or restrictive in any way but merely a device for mapping the community.

Partners - those networks and organisations sharing many of our goals that we work closely with on a regular basis; automatically look to for support on a variety of issues; endorse much of their work; perhaps share some functions and / or make joint bids for funding; and meet with regularly to share common ground.

Collaborators - those networks and organisations sharing some of our goals that we work closely with on a number of issues; look to for support on specific issues; endorse some of their work; perhaps make joint bids for funding; and share information and news with on a regular basis.

Links - those networks and organisations sharing at least one of our goals that we may work with on specific issues or campaigns and wish to retain friendly and supportive links.

Our partners will include for instance the Faculty of Public Health, the LGA and the NHS Confederation. Collaborators will include the ADASS, ADCS, CIEH, PH Commissioning Network, the HPA and the Association of Public Health Observatories. Further links will be with single topic public health organisations such as ASH or the Terrence Higgins Trust or broader based organisations with a public health stream such as the BMA, NHS Alliance etc.

Policy

Objective 2: *The President will lead a programme of advocacy through both planned and opportunistic methods fielding other executive, members and staff where appropriate.*

Objective 3: *The ADPH will prioritise and respond to consultations where appropriate using agreed protocols to ensure broad membership support for the messages.*

Objective 4: *The ADPH will be proactive in approach developing systems to support 'horizon-spotting' of relevant issues.*

Objective 5: *The ADPH will produce policy statements, sometimes in collaboration with others, to cover priority topics and ensuring broad membership agreement.*

Objective 6: *The ADPH will work with others to initiate and or support relevant health campaigns and other policy work and provide expertise for committees and groups where appropriate and practicable.*

The leadership role of the DPH should be reflected in the policy arm of the ADPH by work aimed at influencing legislation, policy and practice for health. On many occasions this will be undertaken in collaboration or partnership with others whether initiated by ADPH or not.

Occasionally, particularly where an issue may be of more than usual importance to members or potentially contentious, the whole membership will be surveyed to seek views. This may be done through an e-mail trawl or through the constituency representatives.

The planned work will be informed by annual priorities set by the Executive and can be roughly divided under the following headings.

Advocacy

As well as a planned programme of advocacy addressing priority topics there will be an opportunistic approach through responding to policy statements, news items, media requests, invitations to present etc. Where funding allows this will be supported by an external public relations company, probably as a shared resource across other public health associations.

Although led by the President, the Executive and where appropriate other members and staff, will have a role to play in both formulating the planned programme and also responding to media requests.

Consultation responses

There is a regular stream of consultations (including requests for evidence) that relate to public health policy and practice and the ADPH will issue a response where the Executive feels it is appropriate and practicable, sometimes in collaboration with others.

In general, these will be formulated in draft form by a small group of the Executive including the Chief Executive and sent round for comments from the rest of the Executive who will, where time permits, seek the views of their constituencies. The comments will be collated by staff and the President or Vice-president will sign off the final submission. Occasionally other members will be asked to contribute their expertise.

Policy statements

It would be helpful for those responding to ad hoc requests to have a body of evidence-based policy statements that will provide the background, issues and messages we would wish to communicate. To this end we will undertake a planned programme to deliver short statements to cover a variety of topic areas. Priority will be given to high profile topics in the first instance.

This work will be undertaken to agreed protocols and often in collaboration with the Faculty or other public health partners. Other relevant organisations will be asked to endorse these policies.

Collaborative campaigns

Occasionally the Association will consider that an important issue will be appropriate for a campaign across several organisations. This may be because a few key actions will deliver a disproportionate number of health benefits or where the issue is of unusual importance for public health.

The ADPH will then support and sometimes initiate campaigns to move this forward. The Association does not have the capacity to undertake the managing of such initiatives but will provide leadership where appropriate.

The first of these initiatives is the campaign to promote healthier environments to encourage more physical activity and active travel which is currently underway. ADPH will be a central contributor encouraging a broad collaboration across health, physical activity, transport, elderly, children, mental health, and other organisations.

Support for other PH work

As well as leading on policy work as above, the ADPH will support other groups where we agree with the goals and general approach. This support may be offered in a variety of ways, eg by issuing joint or concurrent statements, endorsing others' policies or statements or making positive remarks when asked to comment etc.

The ADPH is regularly asked to give DPH input into a variety of national committees and groups and will aim to provide this where possible. We will seek volunteers for these positions with appropriate knowledge and experience using our membership but they will not normally represent the Association as such. However, they will be requested to report back to the Executive on their work in order to keep the Association up to date on national work.

Membership services

Objective 7: *Develop and maintain a membership contact database to ensure good communication.*

Objective 8: *Develop, collect and collate a core dataset of full members to provide an overview of the DPH population and to inform the planning of membership services.*

Two of the core purposes of the ADPH are to provide a networking and knowledge exchange facility for members and to provide development opportunities. These deliverables are the most visible for members and therefore hugely important for the association's future.

In order to provide appropriate membership services it is essential that an understanding of the membership be developed and maintained. To this end a core dataset of membership will be collected, collated and regularly updated. As well as a contact database this will provide details of the background, interests and development needs of full members. This latter will be used to provide an overview of DsPH which in anonymised form could be used to inform workforce discussions nationally.

Networking

Objective 9: *Monitor and evaluate the new representative executive structure to ensure regular comprehensive input from all constituencies.*

Objective 10: *Communicate regularly with all members and ensure availability of staff to receive membership enquiries and suggestions.*

Objective 11: *Develop and deliver an annual programme of high quality events that are accessible and relevant for members and ensure that feedback and learning from these events is made available to those members unable to attend.*

Communications

The representative Executive structure should improve the two way vertical communication from members to the Association and back. This will be monitored to ensure input from members to the executive to inform decision-making and policy work as well as information from the Executive to members relating to organisational and policy work.

Regular e-DPH newsletters will be sent to members to keep them in touch with Association business, events and opportunities as well as developments from partners and the wider public health community. Where appropriate, occasionally requests for opinions, e-votes and surveys will be sent to all members or groups of members.

As mentioned under infrastructure above, the web-site has a large and potentially larger part to play in communications and this will be explored further.

Events

There will be an annual conference and AGM open to all members which will focus on areas of high interest for DsPH. There may also be other workshops on specific topics, particularly policy priorities. Executive workshops will be held at least once a year to formulate policy priorities and discuss forward plans.

The ADPH will also input into partners' events by for instance leading a session at a conference (eg the Public Health Debate at the FPH conference) or contributing to the development of public health input.

DPH Development support

Objective 12: *Continue to build on the success of the Annual DPH Report Competition.*

Objective 13: *Explore, develop and bid for funding for relevant development opportunities for DsPH and ensure successful delivery where funding is available.*

Objective 14: *Explore possibilities and develop a model for a sustainable step-up programme for those moving from a Consultant role to that of DPH.*

DPH Annual Report competition

The Annual DPH Report Competition has now been successfully running for three years. We will continue with this, building on its previous success.

Learning sets

We have already initiated discussions with ADASS and ADCS around holding regionally based learning sets between Directors of Adult Social Services, Directors of Children's Services and DsPH to maximise the potential of the three-way relationship in terms of joint strategic needs assessments and health inequalities. The other Associations are enthusiastic and we will continue to plan and bid for funding in order to progress this as quickly as possible.

Master classes

Previously the ADPH held successful Master Classes for DsPH. These were discontinued with the last structural changes and the NHS financial deficit. We will investigate the previously used model and if funding is available consider a similar provision to support DsPH who have not had the advantage of this specialist leadership training.

Step-up programme

Currently, with the exception of more generalised leadership courses, there is no programme that supports the development of relevant skills to successfully achieve the transition from Consultant to DPH. The ADPH will aim to improve this situation as a longer-term project. We will explore the possibilities for the provision of a sustainable programme for newly appointed and potential DsPH to 'step up' from the Consultant role to that of DPH. We will develop, with partners, the necessary infrastructure and investigate securing appropriate funding to instigate an evaluated pilot programme with a view to a long-term provision.

Infrastructure

Objective 15: *Develop an infrastructure that is 'fit for purpose' in the short-term (until 2010) considering convenience and cost-effectiveness.*

Objective 16: *Consider the longer-term goals of the Association and develop a sustainable and cost-effective long-term infrastructure plan.*

Objective 17: *Determine appropriate permanent staffing levels for the Association to ensure it meets its agreed objectives.*

Objective 18: *Specific consideration should be given to greater utilisation of the website for communication and discussion and how this can be achieved efficiently and a plan developed.*

Objective 19: *Consider the environmental impact of the Association on an on-going basis and by undertaking a carbon footprint exercise.*

Accommodation

The Association has set up an office in Cambridge hosted by the local Primary Care Trust. The arrangement has been agreed until April 2009 in the first instance.

The office has one divided room with three modern ergonomically shaped desks. Use of the PCT's kitchen and toilet facilities is provided along with a main reception, site and building security and parking.

This provides good value for money whilst retaining the ability of staff to travel widely and attend regular meetings in London.

Staffing

Until the summer of 2007 the Association did not have staff and relied on external project management (including the Faculty of Public Health and ALPHA) to organise events and development opportunities largely paid for by DH grants. The DH funding in 2007 provided the ability to employ staff to set up the framework to take it forward.

Currently there are three members of staff (2.1 wte) who are seconded from Cambridgeshire PCT until April 2009. These are: Chief Executive (full time); Project Manager (20 hrs per week); Administrator & Project Manager (20 hrs per week). In addition, the Project Manager undertakes some public health work for the PCT (5 hrs per week) which is separately funded.

There is a capacity short-fall at the basic administration level and short-term temporary support is brought in where this is deemed appropriate. When funding is more secure, consideration will be given to employing a part time administrator (Band 3 / 4) as a more effective solution.

Staff work flexibly with the ability to work from home on occasion. They are part of the local public health network and the Chief Executive has regular meetings with the local DPH to ensure local accountability.

IT and communications

Telecommunications and IT are provided under the main PCT contract. As well as a telephone system with voicemail this provides a secure computer network on the NHS web with the specific e-mail address of @adph.nhs.uk.

All electronic folders are automatically backed up and firewall and anti-virus protection is standard. The Chief Executive has remote access to her folders and e-mails.

All staff are highly skilled in software applications and regular appropriate use is made of database, spreadsheet, presentation and word documents and the internet.

Most communications with members and others are now carried out using e-mail and this is proving very effective as well as keeping stationery and postage costs to a minimum. Teleconferencing is used as a matter of course for the monthly executive meetings and other planning meetings reducing travel cost and time.

Website

The current ADPH website (www.adph.org.uk) is hosted by XT-Motion who charge an hourly rate for updating, re-working pages or adding features. Basic updating can be done in-house. The site hosts a Meltwater newsfeed which is updated daily in-house.

The website has a far greater potential to act as a source of information and communication as well as a vehicle for discussions on policy and planning for the Association. Consideration will be given to utilising web technology further to enhance communications.

However, websites are easily outdated and consistently high maintenance. Short-term the website will be updated to ensure it is current but consideration needs to be given to whether we would be better having support from a partner for this facility.

Environmental impact

As a core value of the Association, regard to environmental and health impact should be a consideration in all policy and planning activity. Concern for the use of resources is of-course an economic necessity but the use of non-sustainable resources should also be a part of all planning decisions.

In particular, face-to face meetings and events should be evaluated for impact before and after and only undertaken where the alternative would have a significantly lesser outcome.

The ADPH has signed up to the Convergence of Health and Sustainable Development Manifesto which requires it to conduct a carbon footprint exercise. This will be carried out as soon as is practicable.

Governance

Objective 20: *Review the current constitution and suggest appropriate amendments to be agreed at the AGM in 2008.*

Objective 21: *Agree additional descriptions, policies and protocols to provide a comprehensive governance framework.*

Objective 22: *Explore future long-term governance models for the Association including potential closer alignment with other organisations (eg NHS Confederation, LGA) or charitable status.*

Objective 23: *Conduct the business of the Association following the governance framework regulations and through monthly Executive meetings, electronic executive discussions and the AGM.*

A major part of the early work for staff is to set up a robust governance framework that will carry the Association forward. This framework should be sufficiently adaptable so that changes in infrastructure and partnership working would not require another complete overhaul. It should be comprehensive enough to assure subscribers and potential funders of the Association's sound basis.

The current constitution was written in 2005 before the opportunity to employ staff came about. It was also before the new more representative structure was decided upon. Whilst it is robust enough to be followed for the year 2007-8 it is in urgent need of review and update to reflect these changes and add further detail to make it a more complete document. It will therefore be re-drafted for approval by members at the 2008 AGM.

The framework should also include more detailed descriptions of roles and responsibilities (for the staff and Executive), policies (such as conflict of interest; representation etc) and protocols (such as for elections, meetings etc) to ensure probity and accountability. Some of these will be ready for the 2008 AGM and others later that year.

Whatever longer-term vision the ADPH decides upon it will require strong governance. Options for the future will include charitable status and more formal partnership arrangements as well as the status quo. The exploration of these options will be part of the 2009 review.

In advance of this work some clarification has been agreed in order to progress a broader based and representative association as quickly as possible. A constituency based executive has already been put in place to ensure that further decisions have a sound membership input. Agreed structural parameters are summarised as follows.

Membership categories

- Full members - all DsPH and equivalent across the UK are members of the ADPH by right.
- Associate members – former DsPH and Deputy DsPH can be associate members by registering their interest.
- Honorary members – people may be invited to become honorary members.

Executive

- The five honorary executive (President, Vice-President, Treasurer, Secretary, Membership Secretary) must be full members and will be elected by all full members for a term of three years.
- Constituency representatives to the executive will be sought from the ten English regions, Scotland, Wales and Northern Ireland as well as the regional DPH group.
- Executive members who can be full or Associate members, will be elected by and represent their constituencies for a term of three years. There may be some Observers and appointed members of the Executive.

Finance

Objective 24: *Set up robust financial accounting and monitoring systems to ensure probity and accountability.*

Objective 25: *Risk assessment and controls assurance document to be developed and employed.*

Objective 26: *Develop and initiate a system for subscriptions to ensure sufficient sustainable income.*

Objective 27: *Develop and submit bids for specific development programmes for DsPH.*

Objective 28: *Hold sufficient reserves and achieve a balanced budget in year.*

Systems and risks

Currently the budget is managed by Cambridgeshire PCT as host. This means that the NHS systems and policies apply to all transactions. Whilst this offers an overall level of confidence in the finance of the Association it only provides broad assurance. It is necessary to internally monitor transactions and undertake regular reporting to the Treasurer in order to ensure a sound financial base.

Risk management

In order to put the ADPH on a longer-term sound economic basis the finances must be assured and any risks to the future of the Association documented, reported to the executive and managed. To that end, risk assessment and controls assurance will be maintained and regularly reported on.

One of the major issues will be the preservation of sufficient reserves to guarantee wind-down and staff notice payments. If in the longer-term staff are employed directly rather than seconded then the issues of pensions, sick benefits and redundancy will need to be accounted for.

Income

In order to provide membership, policy and development services an annual income of around £250,000 is needed. Deliverables will include one major annual conference, policy workshops, regular newsletters and other membership services (such as the website) and the staff time to undertake initiation and management of policy work, surveys etc. It will alos include co-ordination of the executive and their work.

To be sustainable this money must come from subscriptions. Our members are there because of their roles and the benefits received will support that role; this is not a society for interested individuals. In order to reflect this and also to be inclusive with basic benefits it has been agreed to require an organisational subscription from DPH employers.

The four countries of the UK have different NHS and public health structures and therefore different approaches will be necessary. A scheme will be developed whereby those members whose organisations pay full subscriptions will receive over and above the basic benefits that all members will expect.

Extra funding will be required for specialised development work such as that suggested below and the intention is to apply to the Department of Health and others where appropriate for funds for specific programmes as required.

Budget

A budget profile will be agreed between the Chief Executive and the Treasurer annually. Monthly statements will be produced by the PCT and monitored in-house with regular queries and oversight by the Treasurer. An annual statement will be delivered at the AGM.

Annual budget details and forward projections will be attached as appendices to this Plan and updated regularly.

Forward plan

Objective 29: *Review the Business Plan annually and set more detailed objectives for the year updating the appendices at least quarterly.*

Objective 30: *Undertake a major review in 2009 as a basis for the next three-year plan to include the forward vision and sustainable options for the infrastructure, communications and funding.*

Objective 31: *Ensure continuity for the Association during changes in staffing and Executive positions and ensure support for members during NHS structural changes.*

Overall aims

By 2010 the ADPH will have achieved the following.

- **A full representative structure and robust governance framework will have been set up and there will be systems in place to ensure that this is actively followed at all times.**
- **Membership services will be such that employing organisations value the support for their DPH and pay the corporate subscription as a matter of course.**
- **The ADPH voice will be well-known and valued as an expert and honest advocate for the improvement and protection of health and care and the reduction of inequalities.**
- **Other public health organisations will value us as a partner and collaborator and will look to include the ADPH in collaborative initiatives as a matter of course.**

Nicola Close
Chief Executive, ADPH
May 2008