WIRRAL COUNCIL

CABINET

17 MARCH 2011

SUBJECT:	***NHS REFORM AND PUBLIC HEALTH***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***INTERIM CHIEF EXECUTIVE***
RESPONSIBLE PORTFOLIO HOLDER:	***COUNCILLOR JEFF GREEN***
KEY DECISION?	NO

1.0 EXECUTIVE SUMMARY

1.1 This report considers the implications of significant national NHS reform and identifies a number of issues on which Wirral Council will wish to determine the local approach. These include the introduction of General Practice Commissioning Consortia, the transfer of public health into local authorities and the establishment of Public Health England, and the establishment of local Health and Wellbeing Boards.

The Council's Corporate priorities include a commitment to improving health and wellbeing, and to tackling inequalities. These reforms will reinforce and build upon the existing duty of wellbeing by transferring specific additional responsibilities to local authorities.

The Council has responded with pace to the need to understand the new architecture of the NHS, and the changed relationships that will come into place during the next two years. The recommendations contained in this paper will allow the Council to continue to build on this to ensure effective and robust partnerships for health on Wirral in the future.

A number of the implications are dependent on the outcome of consultation (for example the White Paper on Public Health, Healthy Lives, Healthy People) and on the Health & Social Care Bill which is currently in passage through Parliament. Within the Health & Social Care bill there are a number of statutory duties which will pass from the NHS to local government. The Bill contains provisions covering five themes: 1) strengthening commissioning of NHS services, 2) increasing democratic accountability and public voice, 3) liberating provision of NHS services, 4) strengthening public health services and 5) reforming health and care arms-length bodies.

2.0 RECOMMENDATIONS

2.1 That because of the progress made to date it is recommended that the local authority moves to creating a shadow public health function at the earliest opportunity. It is recommended that the Interim Chief Executive be instructed to bring forward a report to Cabinet with proposals for appropriate milestones to be put in place, and consideration of the functions for public health in the Council.

2.2 That since the transfer of public health into the local authority from the NHS is a significant change it should be considered as part of the Strategic Change Programme and that the Interim Chief Executive be instructed to put in place appropriate seminars and briefings to ensure that all Members are aware of these changes and their implications for the Council.

2.3 That as the Council has already expressed a strong interest in becoming an early implementer for Health and Wellbeing Boards at its meeting on 4th February, the Interim Chief Executive should be instructed to bring a report to a future Cabinet on proposals for how the Health and Wellbeing Board could be established at the earliest opportunity, and at the latest by October2011. This should include consideration of how the Health and Wellbeing Board will align with the Council's other governance arrangements. It is important that the Health and Wellbeing Board is established at the earliest opportunity so that progress can be made on the Joint Strategic Needs Assessment.

2.4 That the Interim Chief Executive should be instructed to build on the relationships he has already established with the GP Commissioning Consortia, and with other NHS partners to ensure that the Council is able to continue to work well on issues of shared interest in a changing environment.

3.0 REASON/S FOR RECOMMENDATION/S

Transfer of Public Health

3.1 The consultation on the public health White Paper is due to close on 31st March 2011. A response to the feedback is likely to be published in early summer giving a final view on the proposals contained within it. This will include clarification of future funding and commissioning streams, and which public health activities will transfer to local authorities from 2013. Understanding of these functions will allow the Council to determine how it might deliver them at a local level. It is recommended that enough time is given to Council members to gain a clear view of the range of responsibilities which will transfer to them so that they are able to take informed decisions, including any appropriate consultation that they may wish to undertake.

3.2 Within the timeline for the public health white paper it identifies that the setup of working arrangements with local authorities will take place during 2011. The current Director of Public Health role is a joint appointment between the Council and NHS Wirral. The future role of the Director of Public Health will need to be determined in the context of the Councils requirements of the role and where it will sit within the future structure of Wirral Council. The post is a statutory role and will, in future, be a joint appointment with the new public health service,

Public Health England which is being developed during 2011, and which will be in place in 2012. A description of how the role of a director of public health might operate is provided within the White Paper, and is attached as appendix A to this report

3.3 All transition plans for public health will be reviewed and signed off by Regional Directors of Public Health at the point when Public Health England is established in 2012, and the legislation has gone through parliament. Because this is a significant transfer of responsibilities and, therefore, an area of change for Wirral Council, it is recommended that a local transition plan be developed as part of the Strategic Change Programme, with appropriate milestones and governance. A guidance paper has been produced by the Regional Director of Public Health on the issues that will be considered when reviewing transition plans. This could be used as a framework for the development of Wirral's public health change programme.

3.3 Shadow budgets for public health for local authorities will be published in 2012 according to a national formula. It is recommended that the provision of Member seminars and other appropriate briefings on community needs, the evidence base for action, and currently commissioned services will create a strong basis for decisions on Council priorities for public health to be taken during 2012-13.

3.4 Governance and accountability for delivery of public health responsibilities within the Council currently is not formalised. The current director of public health is a joint appointment between Wirral Council and NHS Wirral and it is recommended that the period of transition is used to strengthen the existing responsibility held by that post by use of Council reporting through the corporate plan so that existing progress on public health issues is reported into Council performance processes.

3.5 The White Paper, Healthy Lives Healthy People, ends its consultation period on 31st March. A draft response to the White Paper is attached at Appendix B for consideration by Members so that a response from Wirral Council can be submitted by the consultation deadline.

Establishment of Health and Wellbeing Boards

3.6 The Council has already submitted an expression of interest in becoming an early implementer for Health and Wellbeing Boards. Within a recent presentation by Andrew Larter, Deputy Director Local Government and Regional Policy at the Department of Health, he stated that the 'Majority of places will have shadow Health & Wellbeing Boards in place, by October 2011'. It is recommended that to meet this timeline, responsibilities are allocated to the Interim Chief Executive to bring a report to Cabinet in the future which will incorporate a development plan, and which will allow the Council to consider the scope of the Health and Wellbeing Board, membership, governance issues, and any supporting structures or workstreams that it would wish to have in place.

3.7 There is an existing responsibility for the directors of children and young people, the director of adult social services and the director of public health to produce a Joint Strategic Needs Assessment which is refreshed on an on-going basis. This responsibility is being proposed to be enacted within the responsibilities outline for Health and Wellbeing Boards within the Health and Social Care Bill. It also widens the duty to GP Commissioning Consortia to take part in developing the JSNA. Recognising that this is subject to the passage of the Bill through parliament; it would seem appropriate to recommend that those who have an existing duty to produce a JSNA undertake work to engage with the pathfinder GP Commissioning Consortia, to ensure that a refreshed and revised Joint Strategic Needs Assessment could be presented to the membership of the shadow Health & Wellbeing Board towards the end of the year.

Collaborative Commissioning Approach

3.8 The local GP Commissioning Consortia will be responsible for the commissioning of services which currently have a value of approximately £450 million. Many of the areas of commissioning activity that they will take formal ownership of in 2013, have significant opportunities for collaborative commissioning and the development of integrated models of care. The Interim Chief Executive has already established good relationships with the new GP pathfinder consortia, and it will be important that this continues. It is recommended that the Council continue to enable good relationships between local health commissioners, which support close working between the consortia, public health, adult and children's care leadership. Over time (subject to parliamentary approval), the forum for this engagement will be in the Health and Wellbeing Board.

4.0 BACKGROUND AND KEY ISSUES

4.1 The return of public health to the local authority

Birkenhead was at the forefront of the early municipal response to the twin challenges of improving population health and supporting conditions for economic development. An Act was passed in 1833 to appoint 'Commissioners for the Improvement of Birkenhead, which led to the paving and cleaning of the town, the development of parks and the first docks being opened in 1847. Public health has been a central function of the core mission of Wirral Council since its incorporation in 1877, when the Medical Officer for Health was a Dr Francis Vacher. The earliest reports of the Medical Officer for Health are held in the Archives Service and make fascinating reading. The proposed transition of public health back to local authorities is linked very closely to the acknowledgement that local authorities have always played a significant role in health, both in terms of the wider determinants of health and environmental health responsibilities.

The publication of the White Paper on Healthy Lives, Healthy People, and two other consultation papers: one on public health outcomes, the other on funding and commissioning routes for public health outline the intention to create a public health system where:

- Local authorities assume responsibility for local public health improvements
- Public Health England, a department within the Department of Health will be set up to bring together all health protection and improvement functions under one body.
- The budget for public health will be ring-fenced from within the overall NHS budget.

The intention is to strengthen the role of communities, ensure the effective use of good evidence and to strengthen health protection. Reducing health inequalities, improving health at different stages of life and working in partnership with business and the voluntary sector are all key features of the white paper proposals. Proposed outcomes for public health are considered under five 'domains': health protection and resilience; tackling the wider determinants of health; health improvement; prevention of ill health; and healthy life expectancy and preventable mortality. The proposed funding and commissioning streams for public health activities are outlined in the table in Appendix C.

The legislation which would enable the delivery of these intentions, is contained within the Health and Social Care Bill currently making its passage through parliament. It transfers responsibility for public health activities from Primary Care Trusts to local authorities and to the Department of Health, which will exercise its functions through a new dedicated public health service within the department to be known as "Public Health England".

Duties placed directly on local authorities

The Bill sets out a new duty on local authorities, to "**take such steps as it considers appropriate for improving the health of the people in its area"**.

The steps that may be taken by the local authority under the section 2B duty (or by the Secretary of State under his identical duty) are specified in the Bill as including:

Providing information and advice

- Providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way)

- Providing services or facilities for the prevention, diagnosis or treatment of illness

- Providing financial incentives to encourage individuals to adopt healthier lifestyles

- Providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment

- Providing or participating in the provision of training for persons working or seeking to work in the field of health improvement

- Making available the services of any person or any facilities

- Providing grants or loans on such terms as the local authority considers appropriate

Other specific duties are also being passed to local authorities from PCTs and central government, including:

- The Secretary of State's existing responsibilities for the medical inspection and treatment, dental inspection and treatment, and the weighing and measuring of school children, including school nursing services (at present usually commissioned or performed by PCTs)

- PCTs' duties in respect of dental public health

- Responsibility to co-operate with health bodies and the prison service in relation to securing and maintaining the health of prisoners

Authorities will retain existing statutory duties under the Public Health (Control of Disease) Act 1984.

The stated rationale for the shift in functions is that "Local government is best placed to influence many of the wider factors that affect health and wellbeing". The government describes the changes as being about "significantly empowering local government to do more" through giving it "real freedoms, dedicated resources and clear responsibilities".

Delegation of additional public health duties to local authorities by the Secretary of State

The Bill imposes on the Secretary of State a "health improvement" duty in relation to the people of England, which is identical to the new local authority health improvement duty described above. The Bill also places another public health duty on the Secretary of State to take steps to protect the public from disease or other dangers to health. The Bill gives the Secretary of State powers to delegate the performance of these functions to local authorities. The true extent of the role to be played by local authorities in this area is, therefore, as yet unknown, but it could certainly be much greater than just the duties given directly to them in the Bill.

Guidance and directions from the Secretary of State

The Secretary of State will retain considerable overview and control of those public health functions which are to be performed by local authorities including the power to set out prescribed steps that authorities must take to fulfil either their own duties or any of the Secretary of State's functions which have been delegated to them. In addition, when performing their public health functions authorities would be required to have regard to Secretary of State guidance – this appears to be linked to requiring local authorities to have regard to the Department's public health outcomes framework, which is also the subject of consultation.

Funding

Overall, funding for public health is to be funded by a new public health budget, ring-fenced within the overall NHS budget. As regards funding for local authorities, in the current consultations on the proposed arrangements, the government has given two assurances.

First, the government has stated that ring-fenced funding will be provided to cover local authorities' new duties. This is not reflected in the Bill itself, as the funding would come in the form of a grant under the general grant-making powers in section 31 of the Local Government Act 2003. This additional funding will only cover new duties imposed by the Bill. The government acknowledges that local authorities are already carrying out a number of activities which could be regarded as falling under a "public health" banner, and indicates that there is no barrier to integrating the operational management of these existing activities with the new duties. However the funding will be ring-fenced and only apply to the new duties. The level of funding provided within the ring-fence will be determined by a nationally applied formula, and may result in variation to the current local spend on the activities described in the funding and commissioning consultation document. Work is ongoing to describe the current funding flows locally, and the associated activity resulting from these investments.

Second, the government has stated that any additional public health duties delegated by the Secretary of State to authorities under the Bill will be covered by additional funding. This assurance is reflected in clause 18 of the Bill, which provides for payment to be agreed for any arrangement under which a local authority is to perform the Secretary of State's duties.

In addition to the ring-fenced funding, the Department also proposes a new public health premium payable to local authorities on top of their public health budget allocation "to incentivise action to reduce health inequalities". This premium would be weighted towards areas with the worst health outcomes and would refer to the Department's public health outcomes framework to identify progress made in improving the health of the local population.

The DH consultation on funding for public health (Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health) is open until 31 March.

Directors of Public Health

To ensure appropriate performance of local authorities' new public health duties, the Bill requires each local authority to appoint a Director of Public Health [DPH]. This will replace the existing requirement on PCTs to employ a person as director of public health to provide local leadership and co-ordination of public health activity. The director will have responsibility for all of the local authorities' public health duties under the Bill and other legislation. DsPH will also be required to publish annual reports on the health of their local population – the explanatory notes to the Bill state that these reports "are intended to help DsPH account for their activity and to chart progress over time".

The Secretary of State will have considerable powers to influence and intervene in the work of the DPH. The authority must consult with the Secretary of State about both appointment and termination of appointments to the post, and the Secretary of State can ask the authority to review/investigate the director's performance if it appears that they are not properly performing their duties.

Concepts and practice relating to public health is given in Appendix D which provides a description of the various domains of public health, the skills and compentencies required in carrying out public health duties and examples of public health activities.

4.2 **Development of Health and Wellbeing Boards.**

The Health and Wellbeing Bill will expand local authorities' responsibilities for ensuring integration in the approach to health and social care provision in its area, and (subject to legislation) will require the establishment of a formal Board.

The Bill would transfer to local authorities and the commissioning consortia in their area the existing duty in the NHS Act 2006 requiring local authorities and PCTs to produce a Joint Strategic Needs Assessment. To this is added a further duty requiring the local authority and the commissioning consortia to prepare a joint health and wellbeing strategy, which is a "strategy for meeting the needs included in the [JSNA] by the exercise of functions of the authority, the NHS Commissioning Board or the consortia". In preparing this strategy consideration must be given to the extent to which the needs could be met more effectively by arrangements under s.75 of the NHS Act 2006 [arrangements between local authorities and NHS bodies] rather than in any other way.

The JSNA and the joint health and wellbeing strategy are then given effect by another new requirement that local authorities and the commissioning consortia must have regard to the JSNA and the strategy when exercising any relevant functions and by a power on local authority Health and Wellbeing Boards to give their local authority an "opinion" on whether the authority is fulfilling the requirement to have regard to the JSNA and the strategy when performing its functions.

The Health and Wellbeing Board [HWB] is the new body which will carry out the local authority functions in relation to the JSNA and the joint health and wellbeing strategy. It will be a committee of the local authority, but its membership is broad and determined in the Bill.

In addition to the functions already described, HWBs will have further functions in relation to encouraging integrated working, including a duty to encourage those arranging for the provision of health or social care services in their area to work in an integrated manner, and in particular provide advice, assistance etc. to encourage the making of arrangements under section 75 of the NHS Act 2006.

In addition the local authority would have power to pass other functions to the HWB. This reflects the message from the government that, while the HWB functions expressly set out in the Bill are reasonably limited and largely strategic in nature, it is anticipated that they will develop a wider key role in the area in relation to health and

social care. The Healthy Lives, Healthy People white paper states that the Bill gives "sufficient flexibility... for health and wellbeing boards to go beyond their minimum statutory duties to promote joining-up of a much broader range of local services for the benefit of their local populations' health and wellbeing". It refers to the wider localism agenda in setting out a vision of local government taking "innovative approaches to public health by involving new partners", which might put HWBs as the central co-ordinating point of a network of services commissioned from different types of provider.

The accountability arrangements for HWBs will need to be clarified. For example there is no means to formally require consortia or the local authority to comply with the joint strategy, and their other powers are framed as being to encourage, advise etc. If the authority were to pass additional powers to them, as a committee of the local authority then accordingly they may exercise wider powers than are set out in the Bill.

The membership of the HWB reflects the breadth of perspective needed for the preparation of the JSNA and the strategy, and to facilitate integrated working. In addition to at least one councillor of the local authority (Cabinet at its meeting on 4th February agreed that the Wirral HWB would include all three party leaders) and its directors of public health, adult social services and children's services, it must include a representative of each commissioning consortia and a representative of the Local Healthwatch organisation (see section 3 of this report). In addition the HWB itself and the local authority (in consultation with the HWB) will have powers to include additional members. Authorities will need to think carefully about the composition of their HWB to ensure that it balances the need for other perspectives with ensuring appropriate levels of control over the body's activities. The role of provider organisations will be one area where, as a commissioning-focussed body, the HWB will need to ensure transparency and appropriate methods of inclusion.

4.3 **Development of GP Commissioning Consortia**

In Wirral, at the time of writing this report, there are three GP Commissioning Consortia which have formed, all three of which have been recognised nationally as ‘pathfinders’ for GP commissioning. The three consortia are:

- Wirral Health Commissioning Consortium (population covered 153,233)
- Wirral GP Commissioning Consortium (population covered 134,899)
- Wirral NHS Alliance (population covered 36,629)
- Practices not yet in a consortia (population covered 8,071)

(Note: the population figures for the consortia are built from the practice list sizes and will not equate to the resident population figures)

The GP consortia are in the process of agreeing appropriate transitional governance arrangements. At the same time, PCTs are required to form cluster arrangements, and NHS Wirral has proposed that it should form part of a cluster with Central and Eastern Cheshire, Western Cheshire and Warrington PCTs. The cluster will be in place by June, and GP consortia will be accountable for the activity to the Cluster board.

4.4 Formation of Wirral Community NHS Trust

Members might wish to note that progress is being made on establishment of the new community NHS Trust. Details to facilitate the production of the Establishment Order have been submitted to the Department of Health on 7 February 2011. This includes the property and contracts to be transferred to the Trust. The shadow Board is in place – with the exception of the Director of Finance post which is out to advertisement. All staff who are transferring have been notified. The Trust is ready to become operational from 1st April 2011. Work is already in hand regarding preparation of financial, workforce and activity information for the Foundation Trust application.

5.0 RELEVANT RISKS

5.1 If the Council does not effectively create a means of delivering it's public health functions it will potentially create harm through failure to deliver activities which reduce risks to ill-health.

5.2 Failure to gain a clear understanding of the responsibilities and budgets transferred may mean that the Council is not in a position to deliver value for money health improvement programmes.

5.3 If the Health and Wellbeing Board is not established early, the local commissioning arrangements could lose synergy and opportunities to work in partnership may be lost.

6.0 OTHER OPTIONS CONSIDERED

6.1 Not relevant to this report, however a number of options would be proposed for Cabinet decision in future reports subject to the agreement of the recommendations in section 2.0.

7.0 CONSULTATION

7.1 None required for this report

8.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

8.1 Currently there is good involvement of the voluntary, community and faith sectors in existing public health programmes. This could be enhanced under the proposals in the White Paper.

9.0 RESOURCE IMPLICATIONS: FINANCIAL; IT; STAFFING; AND ASSETS

9.1 There are no immediate financial, IT, staffing or assets resource implications. However these issues will need to be addressed within arrangements put in place in relation to the transfer of public health responsibilities to the local authority.

10.0 LEGAL IMPLICATIONS

10.1 There are a number of statutory functions which will transfer to Local Authorities subject to the passage of the Health and Social Care Bill.

11.0 EQUALITIES IMPLICATIONS

11.1 None identified in this report.

11.2 Equality Impact Assessment (EIA)

(a) Is an EIA required?	No
(b) If 'yes', has one been completed?	Yes (specify date) / No *(delete as applicable)*

12.0 CARBON REDUCTION IMPLICATIONS

12.1 Not directly applicable

13.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

13.1 Not applicable

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APPENDICES

Appendix A: Suggested role of the Director of Public Health (from the Public Health White Paper
Appendix B: Suggested response to the White Paper
Appendix C: Proposed funding and commissioning routes (from the PH consultation paper)
Appendix D: Public Health: Concepts and Practice

REFERENCE MATERIAL

Healthy Lives, Healthy People: Our strategy for public health in England. Department of Health 2010.
Healthy Lives, Healthy People, Transparency in Outcomes. Proposals for a Public Health Outcomes Framework, Department of Health 2010.
Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health. Department of Health 2010.

(Include background information referred to or relied upon when drafting this report, together with details of where the information can be found. There is no need to refer to publicly available material: e.g. Acts of Parliament or Government guidance.)

SUBJECT HISTORY (last 3 years)

Council Meeting	**Date**

Appendix A: Taken from the White Paper: Healthy Lives, Healthy People

This is offered as a framework for exploring what role is required on Wirral and how it should be delivered.

Annex: A vision of the role of the Director of Public Health

1. This Annex sets out a vision for the role of the Director of Public Health (DPH) developed in discussions between the Department of Health and public health professionals, local government and the NHS over recent months. DsPH have a critical leadership role in the new system – at the centre of improving the health and wellbeing of local communities across England.[i] This role is subject to passage of the Health and Social Care Bill.

Principal adviser

2. We envisage that the DPH will be the principal adviser on all health matters to the local authority, its elected members and officers, on the full range of local authority functions and their impact on the health of the local population, including identifying health inequalities and developing and implementing local strategies to reduce them.

3. He or she will be play a key role in the proposed new functions of local authorities in promoting integrated working; contribute to the development of the local Joint Strategic Needs Assessment (JSNA) and the joint health and wellbeing strategy; be an advocate for the public's health within the community; and produce an authoritative independent annual report on the health of their local population.

Provision and use of evidence

4. The DPH will be responsible for ensuring that the local authority, and its key partners, have access to the high-quality analysis and evidence needed to inform the JSNA, the Annual Health Report, emergency preparation and response, and all public health services for which they are responsible. In tight financial times, it will be incumbent only to support effective interventions that deliver proven benefits, and to evaluate innovative approaches.

Population healthcare

5. Although the DPH will be employed by local authorities, it will be vital to ensure a high-quality public health input into NHS services. DsPH will need to work closely with GP consortia to help identify, prevent and manage a range of conditions, such as mental ill health, cardiovascular disease, diabetes and cancer, across the population, to support people to take care of their own health. This includes Service personnel, their families and veterans. DsPH will also need to have input into commissioning services for people with established diseases and long-term conditions, supported by high-quality community services provided by a wide range of health professionals.

6. In addition to offering support to GP commissioners, the DPH will wish to engage in a range of regular informal and formal mechanisms for public health experts to advise other NHS colleagues. The DPH will work with NHS colleagues locally in:
   - advising on commissioning and effective operation of population health services;
   - ensuring the provision of services for diverse and potentially excluded groups (for example, people with mental health problems and with learning disabilities; the homeless; people in prisons and ex-offenders; children with special educational needs or disability and looked after children; and travellers);
   - advising on how to ensure equal access and equity of outcome across the population; and
   - working with and supporting health and social care colleagues to increase opportunities for using contacts with the public and service users to influence behaviours positively and thereby improve health.

Health protection and emergency preparedness and response

7. Where the Secretary of State enters into arrangements with local authorities in relation to health protection and emergency preparedness, we envisage that the DPH will play an important role in local emergency planning and response to public health threats that affect their communities. They will be supported in this by the Health Protection Units (HPUs), which will provide specialist advice and access to the national resources of the public health service.

8. DsPH will work closely with local HPUs across the full range of health protection issues and ensure they are appropriately reflected in the Annual Health Report and the JSNA and that co-ordinated action can be taken where necessary.

9. The 'proper officer' for the purposes of the Public Health (Control of Disease) Act 1984 will continue to be appointed by the local authority (at the lower tier in a two-tier regime).

10. Authorities (including port health authorities) will continue to provide health protection interventions according to existing legislation such as the Public Health (Control of Disease) Act 1984, Food Safety Act 1990, Environmental Protection Act 1990 and others.

11. DsPH and HPUs will contribute to Local Resilience Forums according to local need and expertise. DsPH will ensure that there are sufficient qualified and appropriately trained public health staff to maintain a robust and resilient on-call rota for major incidents, infectious disease outbreaks and port health at the local level.

12. DsPH and HPUs will work together to undertake local horizon scanning and risk management, health surveillance and, working with local partners, will develop plans and mitigation strategies for the threats and hazards that might affect health – supported by Public Health England as appropriate.

13. Local and National Resilience Forums will continue to play a vital role, working together with a range of organisations to ensure that we are prepared for and can respond to significant threats and emergencies.

Health improvement and inequalities

14. The DPH will be responsible for health improvement, addressing local inequalities in health outcomes, and addressing the wider determinants of health. He or she will work in partnership with other local government colleagues, and partners such as GP consortia, the wider NHS, early years services, schools, business, voluntary organisations and the police, to achieve better public health outcomes for the whole of their local population. This may also include working with other DsPH and Public Health England across a wider geographical area as appropriate. We would expect this to include personal public health services such as smoking cessation, alcohol brief interventions, weight management and work to address the wider determinants of health.

Accountability

15. DsPH will have a professional duty to keep their skills up to date and to ensure their staff are similarly well trained. This is to ensure there is a competent local multi-disciplinary public health workforce, with strong professional leadership at its heart.

16. The primary accountability for local government will be to their local populations through transparency of progress against outcomes and their local strategy. There will also be a relationship between Public Health England and local councils through the allocation of the ring-fenced budget, for which the Chief Executive will be the Accountable Officer; through transparency of progress against the outcomes framework; and through the incentives available to reward progress against health improvement outcomes.

17. DsPH will be jointly appointed by the relevant local authority and Public Health England. While councils will have the power to dismiss DsPHs for serious failings across the full spectrum of their responsibilities, the Secretary of State for Health will have the power to dismiss them for serious failings in the discharge of their health protection functions. They will be accountable to the Secretary of State for Health and professionally accountable to the Chief Medical Officer.

Appendix B: Suggested response to the White Paper

1. Introduction and context

The launch of the NHS White Paper Equity and Excellence: Liberating the NHS issued in July 2010 signalled major changes for public health. These changes are set out in more detail in the Public Health White Paper, "Healthy Lives, Healthy People" published on the 30th of November 2010. The consultation period for the Public Health White Paper has been extended to the 31st of March 2011. This date coincides with the end of the consultation period for related documents, i.e. "Healthy Lives, Healthy People: Transparency in outcomes" (outlining the proposals for a public health outcomes framework); and "Healthy Lives, Healthy People: consultation on the funding and commissioning route for public health".

2. Summary of the White Paper

The Government has expressed a commitment to achieve a high standard in public health. At the centre of this commitment is the Health and Social Care Bill which was presented to Parliament on the 19th of January 2011. The Bill describes a reformed public health service, embedded within a system of local democratic accountability, working alongside a newly formed body called "Public Health England".

There are many welcome assertions contained within the White Paper, particularly:

- the recognition that health is determined by wider social influences which have an impact throughout the 'life course'
- the commitment of the Government to improving the health and wellbeing of the population, to protect the population from serious threats to their health and the emphasise on improving the health of the poorest at the fastest rate
- local government becoming the responsible body for the health and wellbeing of their local population
- the creation of Health and Wellbeing Boards to ensure all partners are delivering their organisation's contribution to health and wellbeing
- the creation of Public Health England (PHE) to bring together the health protection functions of the Health Protection Agency, the National Treatment Agency and other arms length bodies
- that there is to be a Director of Public Health for each top tier local authority – accountable to their local authority and to Public Health England

3. Response to the Consultation

The Public Health White Paper contains a number of consultation questions and our response to these is given below.

Question 1: Are there additional ways in which we can ensure that GPs and GP practices will continue to play a key role in areas for which Public Health England will take responsibility?

GPs have a particular responsibility for the needs of their registered population. Strong working relationships between the local public health system and GP

Consortia will be crucial to addressing these population needs and may be achieved by:

- Providing incentives for GP practices who promote primary prevention and who actively seek patients who are most at risk of poor health
- Investing resource to achieve wellbeing outcomes that are equally shared and delivered by the NHS and the local public health system
- Supporting GP commissioners with public health data and intelligence accessible at practice, neighbourhood and super-output area level – for both health needs and healthcare.
- Directors of Public Health collaborating with GP Consortia to ensure that local commissioning plans, primary care strategies, specific needs assessments, care pathway redesign, etc are consistent with local health and wellbeing priorities as identified in the Joint Strategic Needs Assessment (JSNA)
- Directors of Public Health working in partnership with GP Consortia to develop forms of community-oriented primary care appropriate to under-served communities with poor health outcomes

Question 2: What are the best opportunities to develop and enhance the availability, accessibility and utility of public health information and intelligence?

We need to measure and so address what is important to the population we serve, taking account of existing resources, capacity and assets within the population. At the core of the new local public service will be the need for more efficient and effective use of evidence and evaluation.

- The Joint Strategic Needs Assessment (JSNA) needs to be driven by the various functions of local government in order to give a more comprehensive picture of the local community. The JSNA must augment the Health and Wellbeing Strategy and the annual report of the Director of Public Health
- Evidence needs to focus upon what is effective and what is cost effective, drawing on nationally disseminated best practice as well as local insight. The current (often disparate) body of evidence around the impact of early intervention (e.g. from specific pilots, models and evaluations) should be reviewed, extended and applied to the new system – we need to avoid starting from square one
- Wherever possible, evidence should include principles of co-production, that is, the population as partners in evidence generation and application. This requires clear public accessibility and understanding of information collected
- A relevant level of transparent evaluation for programmes and services should be built in at the outset
- Surveillance and monitoring of environmental hazards, risk factors and communicable and non-communicable diseases needs to be included in the assessment of need
- Health impact assessments and health equity audits are essential components of any health and wellbeing strategy.

The establishment of the local Public Health Service provides the opportunity to effectively collate, appraise, present and disseminate local intelligence, evidence

and data to support the development of local networks to improve the efficient use of skills and resources. It also allows the interpretation and application of evidence from elsewhere to the local context.

Question 3: How can Public Health England address current gaps such as using the insights of behavioural science, tackling wider determinants of health, achieving cost effectiveness, and tackling inequalities?

We support the creation of a new National Institute for Health Research (NIHR) and the School for Public Health Research and a Policy Research Unit of Behaviour and Health recently announced by the Minister for Public Health.

In the recent past, Wirral has benefited from the evidence based support tools and effective approaches used by the National Support Team on health inequalities and the lessons learnt from the assistance offered by the NST should be maintained

It would be beneficial to understand how Public Health England and Local Government will share responsibility for defining and monitoring public health outcomes and over what timescale will the successes of the local public health service be measured?

Question 4: What can wider partners nationally and locally contribute to improving the use of evidence in public health?

We would wish to see effective networks and dissemination of the evidence base for public health from all partners. We would support the need for consistent and continued investment to build a strong evidence-base for public health. This requires building in of evaluative research for all new innovative interventions. The evidence-base should be able to capture local innovation, research and evaluation.

Question 5: We would welcome views on Dr Gabriel Scally's report. If we were to pursue voluntary registration, which organisation would be best suited to provide a system of voluntary regulation for public health specialists?

We welcome the intention of the Government to build on the achievements and skills of the current public health workforce. Maintaining a well trained public health workforce will be critical to the success of the public health system. We understand that there are divergent views in the public health community as how best this should be delivered. In principle, we believe that standards and processes for regulation must be made consistent across all registering bodies.

Cross cutting issues

Additionally we would wish to comment on a number of issues not directly addressed in the consultation questions.

We believe the success of the proposed reforms for public health will be dependent to a large extent on the clarity of guidance provided on the division of functions between Local Government, Public Health England, the NHS Commissioning Board and the GP Commissioning Consortia.

We are concerned that the commissioning of the health visitor services are not being devolved to local public health services sooner. The Health Visitor service is a local service and is pivotal for the management of services for children and families in accordance with the life-course approach described by the White Paper.

A key concern with the fragmentation of public health funding and about what level of funding will ultimately be with local authorities especially if local authorities are held to account for some of the public health indicators proposed in the public health outcomes paper.

It will be beneficial to understand how the inequality premium will be allocated and whether there is any intention to ring-fence any aspect of it.

The division of commissioning responsibility may inadvertently allow public health and general practice commissioning consortiums to commission the appropriate services but in an inconsistent manner. For example splitting the commissioning of the Healthy Child Programme between the NHS Commissioning Board (0 to 5 years) and the local authority (5-19 years) may generate some risks concerning the provision of the correct service in the correct place at the correct time. This may also have implications for children who are looked after and our safeguarding procedures.

Council would welcome further clarity regarding the development of 'Healthwatch' and its relationship with the overview and scrutiny functions of the within the Council.

Appendix C
Extracted from Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health.

Public health funded activity	Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	Proposed commissioning route/s for this activity (including direct provision in some cases)	Examples of proposed associated activity to be funded by the NHS budget (including from all providers)
Accidental injury prevention	Local initiatives such as falls prevention services	Local authority	-
Public mental health	Mental health promotion, mental illness prevention and suicide prevention	Local authority	Treatment for mental ill health
Physical activity	Local programmes to address inactivity and other interventions to promote physical activity, such as improving the built environment, and maximising the physical activity opportunities offered by the natural environment	Local authority	Provision of brief advice during a primary care consultation e.g. Lets Get Moving
Obesity programmes	Local programmes to prevent and address obesity, e.g. delivering the Naitonal Child Measurement Programme and commissioning of weight management services	Local authority	NHS treatment of overweight and obese patients, e.g. provision of brief advice during a primary care consultation, dietary advice in a healthcare setting or bariatric surgery.
Drug misuse	Drug misuse services, prevention and treatment	Local authority	Brief interventions
Alcohol misuse	Alcohol misuse services, prevention and treatment	Local authority	Alcohol health workers in a variety of healthcare settings
Tobacco control	Tobacco control local activity, inclulding stop smoking services, prevention activity, enforcement and communications	Local authority	Brief interventions in primary care, secondary, dental and maternity care
NHS Health Check Programme	Assessment and lifestyle interventions	Local authority	NHS treatment following NHS Health Check assessments and ongoing risk management
Health at work	Any local initiatives on workplace health	Local authority	NHS occupational health
Prevention and early presentation	Behavioural/lifestyle campaigns/services to prevent cancer, long-term conditions, campaights to prompt early diagnosis via awareness of symptoms	Local authority	Integral part of cancer services, outpatient services and primary care. Majority of work to promote early diagnosis in primary care

Public health funded activity	Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	Proposed commissioning route/s for this activity (including direct provision in some cases)	Examples of proposed associated activity to be funded by the NHS budget (including from all providers)
Children's public health for 5-19s	The Healthy Child Programme for school-age children, including school nurses and including health promotion and prevention interventions by the multiprofessional team	Local authority	All treatment services for children (other than those listed above as public health funded, e.g. sexual health services or alcohol misuse)
Community safety and violence prevention and response	Specialist domestic violence services in hospital settings and voluntary and community sector organisations that provide counselling and support services for victims of violence including sexual violence, and non-confidential information sharing activity	Local authority	Non-confidential information sharing
Social exclusion	Support for families with multiple problems, such as intensive family interventions	Local authority	Responsibility for ensuring that socially excluded groups have good access to healthcare
Seasonal mortality	Local initiatives to reduce excess deaths	Local authority	-
Sexual health	Contraception, testing and treatment of sexually transmitted infections, fully integrated termination of pregnancy services, all outreach and prevention	Local authority to commission all sexual health services apart from contraceptive services commissioned by the NHS Commissioning Board (via GP contract)	HIV treatment and promotion of opportunistic testing and treatment
Reduction and preventing birth defects	Poopulation level interventions to reduce and prevent birth defects	Local authority and Public Health England	Interventions in primary care such as pre-pregnancy counselling or smoking cessation programmes and secondary care services such as specialist genetic services.
Dental public health	Epidemiology, and oral health promotion (including fluoridation)	Local authority supported by Public Health England in terms of the coordination of surveys	All dental contracts

Public health funded activity	Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	Proposed commissioning route/s for this activity (including direct provision in some cases)	Examples of proposed associated activity to be funded by the NHS budget (including from all providers)
Children's public health for under 5s	Health Visiting Services including leadership and delivery of the Healthy Child Programme for under 5s, prevention interventions by the multiprofessional team, and the Family Nurse Partnership	NHS Commissioning Board	All treatment services for children (other than those listed above as public health funded)
Public health care for those in prison or custody	e.g. all of the above	NHS Commissioning Board	Prison healthcare
All screening	Public Health England will design, and provide the quality assurance and monitoring for all screening programmes	NHS commissioning Board (cervical screening is included in GP contract)	-
Immunisation against infectious disease	Universal immunisation programmes and targeted neonatal immunisations	Vaccine programmes for children and flu and pneumococcal vaccines for older people, via NHS Commissioning Board (including via GP contract). Targeted neonatal immunisations via NHS. Local authority to commission school programmes such as HPV and teenage booster	Vaccines given for clinical need following referral or opportunistically by GPs
Standardisation and control of biological medicines	Current functions of the HPA in this area	Public Health England	-
Infectious disease	Current functions of the Health Protection Activity in this area, and public health oversight of prevention and control, including co-ordination of outbreak management	Public Health England with supporting role for Local Authorities	Treatment of infectious disease (see sexual health below) Co-operation with Public Health England on outbreak control and related activity
Radiation, chemical and environmental hazards, including the public health impact of climate change	Current functions of the HPA in this area, and public health oversight of prevention and control, including coordination of outbreak management	Public Health England supported by local authorities	-

Public health funded activity	Proposed activity to be funded from the new public health budget (provided across all sectors including NHS)	Proposed commissioning route/s for this activity (including direct provision in some cases)	Examples of proposed associated activity to be funded by the NHS budget (including from all providers)
Nutrition	Running national nutrition programmes including Healthy Start. Any locally-led initiatives.	Public Health England, some local authority activity	Nutrition as part of treatment services, dietary advice in a healthcare setting, and brief interventions in primary care
Emergency preparedness and response and pandemic influenza preparedness	Emergency preparedness including pandemic influenza preparedness and the current functions of the HPA in this area	Public Health England, supported by local authorities	Emergency planning and resilience remains part of core business for the NHS. NHS Commissioning Board will have the responsibility for mobilising the NHS in the event of an emergency.
Health intelligence and information	Health improvement and protection intelligence and information, including: data collection and management; analysing, evaluating and interpreting data; modelling; and using and communicating data. This includes many existing functions of the Public Health Observatories, Cancer Registries and the Health Protection Agency	Public Health England and local authority	NHS data collection and information reporting systems (for example, Secondary Uses Service)

Appendix D: Public health: concepts and practice

Health*:* Health is defined by the World Health Organisation as "a state of complete physical, mental and social wellbeing not merely the absence of disease or infirmity (WHO 1946). **Public Health**: Public Health has been defined as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society, organisations public and private, communities and individuals." (Acheson Report quoted in Wanless Report 2003).

Function/System/Service: Resources to improve public health outcomes can be defined as 'public health relevant' such as early years spending, housing improvement etc and 'public health directed' such as the Public Health Service or NHS prevention spend. Thus, in making the broad concept of public health operational, it is helpful to separate out the concepts of public health function, system and service as follows:

Public Health	Descriptor	Includes
Public Health Function	The 'distributed' capacity to deliver improved health outcomes for the population	All those services , agencies, systems , networks, institutions, professionals, organisations and communities that have a role to play in improving health outcomes within a given population.
Public Health System	The organisational arrangements through which the public health function is mobilised	Systematic and specific collaborative duties placed on the 'public health relevant' capacities of all partners in the public health function. In practice this will mean management, governance and accountability arrangements for all public sector investment will need to have their contribution to health outcomes defined and specified.
Public Health Service	The directly managed unit with the skills, knowledge and responsibility to direct the public health function and system.	The Specialist Public Health Service under the statutory direction of a Director of Public Health accountable to the Chief Executive and elected members of a specific Local Authority. This service is established jointly with the National Public Health Service accountable to the Secretary of State for Health

		and will work collaboratively with a professional public health network.

Domains*:* Delivering the public health function is traditionally defined in three key domains of focus:

Domain	**Exemplified by:**
Health Protection	Emergency Planning, Communicable Disease Control (Health Protection Agency/Food Standards Agency functions etc), health surveillance, epidemiology
Health Improvement	Prevention spend, public health partnerships, investment for health approaches, early detection, screening, public engagement, social marketing.
Health Services	Evaluating the effectiveness and efficiency of health care system expenditure, evidence based practice and application of NICE guidance, health care system policy and strategy, ethics, secondary prevention (chronic diseases management etc), patient safety, Serious Untoward Incidents management, improved treatment outcomes etc.

4.1.2 **Public Health Service**:

A systematic classification of the functions of a Public Health Service can be defined as follows:

1. health surveillance, monitoring and analysis
2. investigation of disease outbreaks, epidemics and risks to health
3. Establishing designing and managing health promotion and disease prevention programmes
4. Enabling and empowering communities and citizens to promote health and reduce inequalities
5. Creating and sustaining cross-governmental and inter-sectoral partnerships to improve health and reduce inequalities
6. Ensuring compliance with regulations and laws to protect and promote health
7. Developing and maintaining a well-educated and trained multi-disciplinary workforce
8. Ensuring the effective performance of NHS Services to meet goals in improving health, preventing disease and reducing inequalities
9. Research, development. Evaluation, innovation
10. Quality assuring the public health function

4.1.3 Professional Competencies:

Professional public health competencies for specialists and consultants in Public Health who are required to be accredited by the Faculty of Public Health include the following key areas (required for safe public health practice).

Summary of the key areas for public health competence

(defined by the FPH Standards Committee and agreed by the Board)

Key areas of public health competence	
1	Surveillance and assessment of the population's health and well-being
2	Assessing the evidence of effectiveness of health and healthcare interventions, programmes and services
3	Policy and strategy development and implementation
4	Strategic leadership and collaborative working for health
5	Health improvement
6	Health protection
7	Health and social service quality
8	Public health intelligence
9	Academic public health
10	Ethical management of self/others/resources

4.1.4 Wellbeing and Quality of Life

In recent years, the concepts of wellbeing and quality of life have gained importance in public health practice. The determinants of health and wellbeing in communities can be defined as in the diagram below. Public health services, along with others, have a central role to play in directing both the societal resources and political debate required to deliver improved community wellbeing.

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4.1.5 Prevention Services

Before 1974, the Director of Public Health had a direct role in commissioning and managing 'prevention services'. Since 1974 many of these functions transferred from Local Government to community health services systems within the NHS where the DPH role has ranged from direct responsibility for commissioning to a professional influence on other commissioners. These services can include budgets and programmes commissioned from a range of providers such as those identified below:

Affordable warmth	public health intelligence
prevention of communicable disease	infection control

on-call rota	infection control
blood-bourne viruses services	sexual health services
contraception services	mental wellbeing
health at work	healthy eating/nutrition
physical activity	breastfeeding support
alcohol (tier 1 and 2)	tobacco control
smoking cessation	drugs
falls prevention	healthy child programme e.g. sure start
healthy schools	prison health promotion
health development	health emergency planning
Screening (including: breast screening, chlamydia screening, vascular checks, cervical screening, bowel cancer screening, ante-natal screening, newborn blood spot, neo-natal hearing, diabetic retinopathy	cancer awareness
school nursing	health visiting
health trainers	self care
immunisation	community dental services
oral health promotion	prison health service

[note: this list is illustrative and not exhaustive]

4.1.7 Primary Care

Primary care is a major setting for public health action and a key part of the wider public health function. In its 2008 World Health Report 'Primary Health Care: Now More Than Ever'
the World Health Organisation has identified five key elements of reform essential to achieving the public health focussed goal of "better health for all". These are identified as:

- Reducing exclusion and social disparities in health (reforms to achieve universal coverage)
- Organising health services around peoples needs and expectations (service delivery reforms)
- Integrating health into all sectors (public policy reforms)
- Perusing collaborative models of policy dialogue (public policy reforms)
- Increasing stakeholder participation

Various recent reviews of primary care models show that the Community Oriented Primary Care Model (COPC) is particularly appropriate for underserved communities with poor health outcomes such as those experienced in parts of Wirral. One of the key criticisms of the model is that although it does deliver improved and accelerated health outcomes by addressing wider social determinants
this has caused significant implementation and uptake problems because of the increased costs involved. This barrier could be overcome through taking a place based budgeting approach to integration of primary care services with existing Council (and third sector) neighbourhood service delivery. The interventions of the latter are already funded and designed to meet non clinical social and economic needs of communities.