WIRRAL COUNCIL

CABINET 15TH MARCH 2012

SUBJECT:	***PUBLIC HEALTH TRANSITION***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***CHIEF EXECUTIVE***
KEY DECISION	YES

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide The Cabinet with information regarding the implications of the transfer of part of the current public health system into the local authority in relation to roles and future structures.

While not currently a statutory duty, under the Health and Social Care Act, currently making its way through Parliament, local authorities will be statutorily responsible will be given new statutory duties across the three 'domains' of public health. These are:

- Health improvement – including reducing lifestyle related ill-health and inequalities in health, and addressing the underlying determinants of health
- Health protection – including ensuring that comprehensive plans are in place across the local authority, NHS and other agencies to respond to infectious disease outbreaks and other public health emergencies
- Health service improvement – by providing NHS Commissioners, including Clinical Commissioning Groups, with expert advice and support to improve and evaluate the quality and efficiency of health services.

In addition, each authority must, acting jointly with the Secretary of State for Health, appoint an individual to have responsibility for its new public health functions, known as the Director of Public Health.

2.0 BACKGROUND AND KEY ISSUES

National guidance

2.1 A number of guidance documents have now been issued in relation to the reform of the public health system. In particular,

- The public health outcomes framework.
- An operating model describing how PHE will work.
- Further details about implementing public health in local government and the role of the DPH.
- Public health funding – establishing the baseline for expenditure.
- An HR Concordat with local government on the transition process.

2.2 The HR Concordat was published on 17th November 2011 by the Local Government Association and the Department of Health. The Concordat provides guiding principles and Human Resource (HR) standards for the transfer of PCT public health commissioning activity and functions ("senders") to local authorities ("receivers"), and a fair and consistent approach to managing the related detailed HR processes in a

local context. The concordat also outlines the indicative timescales for change and the obligations on NHS and local government employers and trade unions on managing the change.

2.3 On 20th December the Department of Health published 'The new public health system', which has a summary document supported by two short 'fact-sheet' style documents on how Public Health will operate in Local Government (including the role of the Director of Public Health [Appendix 1], and the Operating Model for Public Health England. The details of the responsibilities that will transfer to the local authority are given in Appendix 2.

2.4 Public Health Outcomes Framework was published in January 2012and sets the context for the new system from local to national level. This identifies two overarching outcomes and four domains of indicators where improvement is sought. A summary of these is provided in the table below.

<table>
<tr><td colspan="4">Public Health Outcomes Framework</td></tr>
<tr><td colspan="4">Vision: To improve and protect the nation's health and wellbeing, and improve the health of the poorest, fastest

Outcome 1: Increased healthy life expectancy
Taking account of health quality as well as the length of life
(Note: this measure uses a self-reported health assessment, applied to life Expectancy)

Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities
Through greater improvements in more disadvantaged communities

(Note: these two measures would work as a package covering both morbidity and mortality, addressing within-area differences and between area differences)</td></tr>
<tr><td>DOMAIN 1:
Improving the wider determinants of health

Objective:
Improvements against wider factors that affect health and wellbeing, and health inequalities

(Indicators across the life course)</td><td>DOMAIN 2:
Health improvement

Objective:
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

(Indicators across the life course)</td><td>DOMAIN 3:
Improving the wider determinants of health

Objective:
The population's health is protected from major incidents and other threats while reducing health inequalities

(Indicators across the life course)</td><td>DOMAIN 4:
Healthcare public health and preventing premature mortality
Objective:
Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

(Indicators across the life course)</td></tr>
</table>

2.5 The baseline funding estimates for the new public health commissioning architecture were published on 7 February 2012. This provides the funding estimate for 2012-13. A further piece of work is being done by the Advisory Committee on Resource

Allocation and how resources should be distributed in the long-term, but we have been advised that this is unlikely to be available until December 2012. The document states that 'we would not expect the LA public health ring-fenced grants to fall in real terms from the values in Annex A, other than in exceptional circumstances such as a gross error or following a technical adjustment with major consequences for budgets, such as significant adjustment for NHS income, a change in planned responsibilities, or a large shift in the incentive payment for drugs treatment. In particular we may need to do further work to confirm the adjustment we have made to take account of abortion, sterilisation and vasectomy services initially being the responsibility of CCGs [Clinical Commissioning Groups] rather than LAs.' The baseline spend projected for 2012-13 for Wirral includes an uplift from the 2010 figures which it is based on, and for Wirral is estimated to be £22,264,000. Our current contracts and services provided for those areas which will transfer to local authority responsibility are within this figure.

Public Health Structure for Wirral

2.6 On 3 February 2012 a report providing an update on public health transition was taken to and it was recommended that

- the Chief Executive be instructed by to work with the Director of Public Health to bring back a proposal to on the future structure and operation of public health within the Council.

- subject to the satisfactory outcome of consultation, the Chief Executive ensures that a Memorandum of Understanding or other appropriate arrangements are put In place to allow the public health function to operate in shadow form during 2012/13.

- Cabinet endorses the membership and purpose for the Public Health Transition Steering Group

These recommendations were approved by Cabinet.

2.7 This report considers the steps that need to be undertaken to ensure that an appropriate structure is put in place to meet the local authority's future responsibilities, and to support the continued delivery of public health responsibilities during transition.

2.8 The LGA, in collaboration with the Department of Health has issued guidance on human resources issues associated with transition. This guidance notes that:

- All matters relating to the statutory transfer of public health functions and any staff transfers are of course subject to the passage of the Health and Social Care Bill 2011 and royal assent

- Staff identified as working in the public health functions that will transfer to local government on a statutory basis under the Health and Social Care Bill 2011 will do so on a TUPE or TUPE-like basis under COSOP

- Local authorities and PCTs are strongly encouraged to work together jointly with relevant trade unions to prepare for the transfer

- Arrangements should be agreed locally to help transferring staff to engage more closely with their eventual new employers in the transition year 2012-13

- However, no staff should transfer employment in advance of the due date of 1st April 2013 which is the date the statutory responsibilities transfer

- Councils are strongly encouraged to implement best employment practice, taking account of the need for future recruitment and retention of specialist public health staff

2.9 The bullet points above are being taken into account by the human resources workstream of the public health transition steering group.

2.10 A key element of transition planning will be to agree the functions and structure of the public health resource within the local authority. It will be important to ensure that this is done in a way that allows current public health responsibilities to be delivered until they are taken into their future system-wide locations. For example, the local DPH is still responsible for screening programmes until the NHS Commissioning Board and Public Health England are formed and start to commission them. Following that, the local responsibility will be to undertake monitoring and assurance that local people are benefiting adequately from those services.

2.11 It could be viewed that there are two main steps in agreeing a structure for the long-term.

(a) Agreeing a structure that allows delivery of current responsibilities until formal transition occurs in 2013 (or until the new arrangements for PHE and NHSCB are in place)

(b) Agreeing what functions will remain as a local responsibility, and how they will be delivered from April 2013 onwards.

Issues which might arise:

2.12 The NHS is currently running a voluntary redundancy process. Public Health staff may apply for this, and any agreement will need to be made on the assumption that we do not need the post, or that we will restructure to manage the work.

2.13 PHE and the NHS Commissioning Board have not yet published their detailed local structures. It is not clear whether specific roles would transfer into those structures from a local level; although if this were to be the case the numbers of roles in those organisations are likely to be small, and may be subject to competitive interview.

2.14 It is likely that more substantive arrangements will be required to be in place around October 2012. This is as a result of Clinical Commissioning Groups being authorised, NHSCB and PHE structures being defined, and the need for PCT Cluster oversight being reduced. In other words, the majority of the reformed system will be expected to be working in the six months before the formal transfer of responsibilities proposed in the Health & Social Care Bill.

Managing existing responsibilities

2.15 The structures attached to this report in Appendix 3 are the structures that are in place now to meet the needs of the next 12 months, however, this may change given 2.12 and 2.13 above. It would be expected that we would need to seek some shared service arrangements to manage the work with a reduced capacity of staff.

2.16 The Shadow arrangement proposed in the Cabinet paper of 2nd February is intended to enable public health staff to attend internal council meetings, understand council systems and to undertake a process of induction. However, this is on the understanding that the liability for those staff and budgets remains with the NHS until the end of March 2013. It may be that this liability may be dealt with through a secondment arrangement that could be put in place in October if the issue described in point 3 above arises. This could only happen if the local authority was happy to operate in this way.

Defining a future structure

2.17 There are significant opportunities arising from this reform which it would be valuable to work on during the period from now to October. The role of the Director of Public Health is defined by the guidance provided at Appendix 1, and the functions/responsibilities of local authorities at Appendix 2.

2.18 The guidance issued on the new public health system states 'While the organisation and structures of individual local authorities is a matter for local leadership, we are clear that these legal responsibilities should translate into the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business. This means that we would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.'

2.18 The work now required will be to (taking into consideration 2.12-2.14 above):

- Review the public health outcomes and functions aligned to the local authority
- Map existing resources within the public health function and across the authority that link to these functions
- Take into account how shared service models might be agreed or developed between local authorities on specific areas where resources are scarce or where there is value in a single approach.
- Drafting of a structure that meets these needs and which can then be consulted on
- Undertake any required consultation (particularly with staff and staff-side representatives).

3.0 RELEVANT RISKS

3.1 The risks are as described in the Cabinet report of 3rd February:

Risk	Potential Impact
Inadequate level of funding within local public health ring-fence to support local	Cuts in services currently provided

public health functions	
Failure to clarify public health responsibilities and organisational roles of the Local Authority, Public Health England and the NHS at a local level	Duplication/lack of coordination, potential to improve health outcomes is lost.
Public health responsibilities not embedded in all relevant parts of the new local system	Prevention not incorporated into care pathways Unable to maximise improvement and health inequality reduction opportunities.
New operating models do not provide for adequate public health support for local health emergency preparedness, resilience and response	Unable to respond effectively to major/public health incidents
Organisational barriers to access to information	Public health unable to access NHS data for health improvement, health protection and healthcare quality; thereby compromising the public health response
IM&T arrangements insufficient to support public health monitoring and service delivery	Inability to measure impact, uptake and outcomes.
Local authority does not embed public health action across all its functions	Duplication/lack of coordination, potential to improve health outcomes is lost.

4.0 OTHER OPTIONS CONSIDERED

4.1 This report sets out the steps to enable options to be considered.

5.0 CONSULTATION

5.1 Consultation on transition of staff

There will be a need to ensure meaningful consultation with staff affected by the transfer of functions.

5.2 Commissioned public health activity

Depending on the local public health budget, and on policy decisions made within the Council, there could be a need to consult. This could arise from a reduction in investment available, or a change in focus responding to understanding of needs through the Joint Strategic Needs Assessment.

6.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

6.1 *(Are there opportunities to involve voluntary, community and faith organisations? Is this report Compact compliant?)*

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

7.1 The public health function currently commissions a significant amount of voluntary and community sector activity. In 2010/11 this amounted to £3.7 million of investment.

There is an opportunity to ensure that this commissioning is integrated into any approach to commissioning from the VCF sector by the local authority.

8.0 LEGAL IMPLICATIONS

8.1 The local authority will be given statutory duties under the Health and Social Care Act (subject to Parliament). It has been indicated that, subject to the successful passage of the Bill the role of the Director of Public Health will be a statutory one, and that guidance would be issued describing this statutory role in the same way as guidance is produced for Directors of Adult Social Services and Directors of Children's Services.

9.0 EQUALITIES IMPLICATIONS

9.1 Has the potential impact of your proposal(s) been reviewed with regard to equality?

An impact review will need to be done in more detail since there is clearly potential for a workforce impact. An initial assessment is attached.

10.0 CARBON REDUCTION IMPLICATIONS

10.1 *n/a*

11.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

11.1 *n/a*

12.0 RECOMMENDATION/S

12.1 That the cabinet note the report.

12.2 That The Director of public Health reports directly to the Chief Executive on a shadow basis for 2012/13

12.3 That the additional skills and resources within the public health directorate, including the public health intelligence team are seen as a welcome addition to the Council workforce.

12.4 That the steps described in 2.18 are supported to allow for transition planning to take place on the basis of the reporting structure directly to the Chief Executive.

13.0 REASON/S FOR RECOMMENDATION/S

13.1 There are clear opportunities to create a robust structure for delivering public health functions, and to support the local authority in delivering its role as a public health organisation. These will be enhanced as further information becomes available on public health system reform, and assessment of internal opportunities is undertaken.

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APPENDICES

Appendix 1: Role of the Director of Public Health
Appendix 2: Local Authority Commissioning Responsibilities
Appendix 3: Current public health structure

REFERENCE MATERIAL

SUBJECT HISTORY (last 3 years)

Council Meeting	Date
Cabinet Report	3 February 2012
Cabinet Report	3 October 2011
Health & Wellbeing OSC	13 September 2011
Cabinet Report	17 March 2011
Health & Wellbeing OSC	18 January 2011

[Appendices 1 and 2 are taken directly from the document 'Public Health in Local Government: Factsheets' issued by the Department of Health in December 2011]

Appendix 1

The role of the Director of Public Health

In taking forward their leadership role for public health local authorities will rely heavily on the Director of Public Health and the specialist public health resources he or she has at their command. Indeed the Health and Social Care Bill makes clear that the Director of Public Health is responsible for exercising the local authority's new public health functions.

We have highlighted the duty on each unitary and upper tier authority to take such steps as it considers appropriate for improving the health of the people in its area.

The Health and Social Care Bill makes clear that each authority must, acting jointly with the Secretary of State for Health, appoint an individual to have responsibility for its new public health functions, known as the Director of Public Health. That individual could be shared with another local authority, where that makes sense (for example, where the senior management team is shared across more than one authority and the authorities are geographically contiguous). Below we cover key aspects of the function and scope of the role of Director of Public Health.

Appointments

We are working with local government and public health stakeholders to produce guidance, which will cover:

• appointments to existing Director of Public Health vacancies in a way that ensures they are fit for purpose for the future

• managing the transition of Director of Public Health posts to local government during 2012/13

• a process for local authorities and Public Health England (in the Secretary of State's behalf), acting jointly, to appoint new Directors of Public Health from 1 April 2013.

The guidance will build on the existing joint appointments process for Directors of Public Health and be consistent with Faculty of Public Health standards, including the use of appointments advisory committees and faculty assessors, and best practice in local government recruitment.

This will ensure Directors of Public Health in local government have the necessary technical, professional and strategic leadership skills to promote, improve and protect health and provide high-level, credible, peer-to-peer advice to the NHS about public health in relation to health services.

Reporting arrangements

We promised in Healthy Lives, Healthy People: update and way forward to discuss with stakeholders how best to ensure that that the Director of Public Health has an appropriate

status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services.

We have consulted local government and public health interests, and intend to bring forward amendments to the Health and Social Care Bill to reflect our desired policy position. Subject to Parliament, we will add Directors of Public Health to the list of statutory chief officers in the Local Government and Housing Act 1989.

After Royal Assent, we intend to issue statutory guidance on the responsibilities of the Directors of Public Health, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Services.

While the organisation and structures of individual local authorities is a matter for local leadership, we are clear that these legal responsibilities should translate into the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business.

This means that we would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.

Responsibilities

The Director of Public Health as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will in addition make it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. Directors of Public Health will also be statutory members of health and wellbeing boards, and will wish to use the boards as the key formal mechanism for promoting integrated, effective delivery of services.

What these legal responsibilities should translate into is the Director of Public Health acting as the lead officer in a local authority for health and championing health across the whole of the authority's business. Thus the Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services. Often the Director of Public Health will not be personally responsible for the problem, but he/she will know how to resolve it through engaging with the right people in the new system. He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing. In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality.

With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the local authority, but we would expect day-to-day responsibility for the grant to be delegated to the Director of Public Health.

Core skills

To deliver its new public health functions the local authority will need a specialist trained Director of Public Health and public health support with the full range of appropriate skills to deliver the functions we have described. That means we will need to ensure that job descriptions reflect the highest possible standards as set out by the Faculty of Public Health.

It is important to reaffirm that the Government believes the multidisciplinary nature of public health is a key strength of the profession. We believe that the transfer of new public health responsibilities to local authorities in no way changes this, and indeed reaffirms the importance of attracting to public health high-quality individuals from a wide range of disciplines including, but not limited to, medicine.

We will publish a Public Health Workforce Strategy, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a professional public health workforce, set out proposals for how learning and development will be taken forward in the reformed health system, and outline options for how public health knowledge can best be embedded across the wider workforce.

The new arrangements will provide opportunities and challenges for employers, including the wider local authority workforce.

Professional appraisal and support, and capacity building

Continuing professional development is a professional obligation for all public health professionals, both medical and non-medical. It ensures that public health professionals develop and maintain the necessary knowledge, skills and attributes to practise effectively and work towards improving the health of communities. Local authorities will wish to support this professional development.

Way forward

The Director of Public Health's new role offers a great opportunity to build healthier communities. But to make the most of this Directors of Public Health will need to:

• be fully engaged in the redesign of services that address the coming challenges

• influence and support colleagues who have a key role in creating better health, such as planning officers and housing officers

• facilitate innovation and new approaches to promoting and protecting health, while bringing a rigorous approach to evaluating what works, using the resources of Public Health England

• contribute to the work of NHS commissioners, thus ensuring a whole public sector approach.

Appendix 2

Commissioning responsibilities

Local authorities will be responsible for:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response

- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

We have undertaken a further check of where commissioning responsibilities for a range of services might sit in the future. As part of this work we have taken the opportunity to look again at where commissioning of abortion services might most appropriately be placed.

Given the highly clinical, and in most cases surgical, nature of abortion provision we have reconsidered our earlier decision to place these services with local authorities. We have provisionally concluded that abortion should remain within the NHS and be commissioned by clinical commissioning groups.

However, we are keen to seek a range of views on this revised commissioning route. A consultation on this revised recommendation will begin in due course.

In Healthy Lives, Healthy People: Update and way forward, we said we were still considering where to place responsibility for sexual assault referral centres (SARCs) and for campaigns to promote early diagnosis of, for example, cancer. We have decided that, subject to resolving some further points of detail, responsibility for sexual assault services, including SARCs, at least in the short to medium term, should rest with the NHS Commissioning Board. This is in our view the best way to ensure the delivery of uniformly high-quality services across the country. On early diagnosis we are committed to giving both Public Health England and the NHS Commissioning Board clear responsibility for delivery, based on a shared set of outcomes.

Only some of the above services are to be mandated. The commissioning of other services will be discretionary, guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy.

There was considerable comment during our consultation on commissioning responsibilities about the split of responsibilities for the public health of children and young people, including the Healthy Child Programme, with pregnancy to five services being commissioned by the NHS Commissioning Board. We accept the many benefits to be had from the integration of public health into the wider commissioning of children's and young people's public health, particularly in terms of the prevention and safeguarding agendas.

As we explained in Healthy Lives, Healthy People: Update and way forward, we believe that the NHS Commissioning Board will be best placed to lead the commissioning of public health funded services for children under five in the first instance, including health visiting, the Healthy Child Programme and Family Nurse Partnership, given the commitment to a 50% increase in the health visiting workforce and a transformation in the health visiting service by 2015, and to ensure associated improvements in support for families.

Our medium-term aim is to unify responsibility for these services within local government by 2015 when the increased health visiting workforce and new health visiting service model and the Healthy Child Programme offer to families should be in place. In line with this direction of travel, we are also transferring responsibility for commissioning effective Child Health Information Systems to the NHS Commissioning Board, also to be funded by the public health budget.

This decision will be reviewed in 2015 to determine longer-term plans. We will engage further on the detail of these proposals, particularly in respect of transition arrangements and the best way to begin to involve local authorities in local commissioning of these services in partnership with the NHS.

In the meantime, Public Health England will retain a close interest in the specification of Child Health Information Systems, to ensure public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.

The list of commissioning responsibilities above is of course not exclusive. Local authorities may choose to commission a wide variety of services under their health improvement duty, and indeed we would hope to see much innovation as local authorities embrace their new duties. This freedom is deliberately wide, to encourage the kind of locally-driven solutions that lie at the core of localism, underpinned by a robust analysis of the needs and assets of the local population. Public Health England will promote this local innovation through encouraging peer sharing of best practice and learning experiences, and through supporting rigorous evaluation of new approaches to improving and protecting public health.

Sexual health services

Local authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections (STIs) testing and treatment services, for the benefit of all persons of all ages present in the area. Transfer of these services offers great opportunities to integrate sexual health services and to link services to wider services, including alcohol and drugs, for particular target groups, such as young people, vulnerable people and other groups at risk of sexual ill-health.

We are going beyond merely transferring responsibility for sexual health services to local authorities and actually mandating hem for two reasons. First, STI testing and treatment services are a central part of protecting health. The Government therefore believes that high-quality services must be available in all areas, although the services provided will be tailored to meet local needs.

Second, the Secretary of State for Health currently has a duty, reiterated in the Health and Social Care Bill, to provide advice on contraception, medical examination of people seeking advice on contraception, the treatment of these people, and the supply of any contraceptive substances and appliances. This duty is currently delegated to primary care trusts, who are required to provide open-access services which are not limited to their own residents. Mandating these services of local authorities in the future will allow the Secretary of State for Health to meet this duty fully, over and above what is provided for via current GP provision.

Health protection plans

At present Directors of Public Health in primary care trusts play a key leadership role in planning for, and responding to, health protection incidents, supported by local Health Protection Agency health protection units. Subject to Parliamentary approval, the Health and Social Care Bill will provide that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population. However, we want

the Director of Public Health to continue to provide a coordination role to protect the health of the local population when transferred to local authorities. Our vision is that the local authority, and the Director of Public Health acting on its behalf, should have a pivotal place in protecting the health of its population. We therefore propose to use a regulation-making power in the Bill to require local authorities to take steps to ensure that plans are in place to protect the local population.

Under this duty, local authorities (and Directors of Public Health on their behalf) would be required to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated.

Where the Director of Public Health identifies issues it will be his or her role to highlight them, and escalate issues as necessary, providing advice, challenge and advocacy to protect the local population, working with Public Health England which will provide specialist health protection services including, for instance, coordination of outbreak control, and access to national expert infrastructure as and when necessary. His or her role in delivering these functions will be supported by the transparency in the system that will allow the Director of Public Health and others rapid access to routine monitoring data.

Below we set out in brief how we envisage this health protection role working.

With regard to emergencies, we plan the following. At the Local Resilience Forum (LRF) level, a lead Director of Public Health from a local authority within the LRF area will be agreed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.

Public Health England will continue to provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.

The NHS Commissioning Board will appoint a lead director for NHS emergency preparedness and response at the LRF level, and provide necessary support to enable planning and response to emergencies that require NHS resources.

Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. LHRPs will consist of emergency planning leads from health organisations in the LRF area and will ensure effective planning, testing and response for emergencies.

LHRPs are a formalisation of existing health subgroups found in the majority of LRF areas. They will enable all health partners to input to the LRF and in turn provide the LRF with a clear, robust view of the health economy and the best way to support LRFs to plan for and respond to health threats. Further work will be done over the coming months to pilot and plan the resourcing and operation of LHRPs.

The lead director appointed by the NHS Commissioning Board and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning. Resources will be required to support the LHRP to provide continuous readiness.

More work will take place in the coming months to develop operational guidance for the system-wide emergency preparedness, resilience and response model.

The NHS lead director will represent the LHRP on the LRF, as now, since most emergencies require readiness and input of NHS resources. The lead Director of Public Health should also attend, and Public Health England will attend where the emergency requires its presence.

In terms of plans for screening and immunising the local population we envisage a process as follows. The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes in accordance with an agreement between the Secretary of State for Health and the Board which will set out the terms in which the Board will exercise a Secretary of State function. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening.

Directors of Public Health will advise, for example, on whether screening or immunisation programmes in their area are meeting the needs of the population, and whether there is equitable access. They will provide challenge and advice to the NHS Commissioning Board on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board on issues such as raising uptake of immunisations and screening, and how outcomes might be improved by addressing local factors. They will also have a role in championing screening and immunisation, using their relationships with local clinicians and clinical commissioning groups, and in contributing to the management of serious incidents.

Directors of Public Health will play a role in ensuring that immunisation care pathways for programmes such as neonatal hepatitis B are robust. The Board will remain accountable for responding appropriately to that challenge from local public health teams, and for driving improvement.

This local authority role in health protection planning is not a managerial, but a local leadership function. It rests on the personal capability and skills of the local authority Director of Public Health and his or her team to identify any issues and advise appropriately. But it will be underpinned by legal duties of cooperation, contractual arrangements, clear escalation routes and transparency.

Thus clinical commissioning groups will have a duty of cooperation with local authorities; NHS-funded providers can be required through contracts to share plans and appropriate information; Directors of Public Health can use their annual report and membership of the health and wellbeing board to raise concerns more formally; and the Secretary of State for Health can use the Mandate and his agreement with the Board to ensure that the NHS Commissioning Board takes appropriate account of the advice of Directors of Public Health.

Finally, there will be a professional relationship between Directors of Public Health and Public Health England, and the Chief Medical Officer as professional lead for public health, which will give directors and their teams a route for contributing to national thinking about what is needed.

The system ensures that accountability is focused where it needs to be. The Director of Public Health will be responsible as the public health lead in each local authority for advising on plans that are in place and identifying any problems, using his or her public health expertise. NHS and other partner colleagues will be accountable for taking appropriate account of that advice.

This is in line with the design of the new system overall: Public Health England and Directors of Public Health are accountable for the provision of high-quality public health advice; the NHS Commissioning Board, clinical commissioning groups and others are accountable for making the appropriate use of that advice.

The Secretary of State for Health will retain a central interest in health protection even where he has delegated functions to the local level. To this end we will publish further details as we develop policy on the new system. In particular we will develop a statement on how we will promote high performance and support performance improvement.

We also intend to produce operational guidance to support incident management at a local level, which will cover the working relationship between the NHS, Public Health England and the local authority. The guidance will recognise the need for flexibility to enable each area to make plans most appropriate to protect the health of its population.

Population healthcare advice to the NHS

We will also mandate local authorities to provide population healthcare advice to the NHS. Good population health outcomes, including reducing health inequalities, rely not just on health protection and health improvement, but on the quality of healthcare services provided by the NHS. That is why we are preserving a key role for local authority public health teams in providing public health expertise for the NHS commissioners of these services.

The need to secure provision of public health expertise for healthcare commissioners (and to support health and wellbeing boards in producing the joint strategic needs assessment and joint health and wellbeing strategy) was a key theme of the consultation on the public health white paper Healthy Lives, Healthy People.

We have consulted a group of public health and other experts who have developed a draft model for what such a public health advice service might look like, building on existing work across the country. Appendix 1 sets out the group's recommendations, aligned against the stages of the commissioning cycle.

Clinical commissioning groups will require a range of information and intelligence support via both the population healthcare advice service based in local authorities and other commissioning support services such as from Public Health England where appropriate. It is important to note that although there are some similarities in the nature of these services (ie public health population healthcare advice and the work of commissioning support organisations (CSOs) in the future), they will have a different focus.

We envisage that public health teams will provide largely a strategic population focus, synthesizing data from a wide variety of sources and applying their public health skills to draw the implications of that data for the local population. CSOs will focus more on commissioning processes and clinical systems, including detailed analysis of referrals and

activity, procurement and business processes. Both are essential for driving improvements in services.

There would be nothing to stop local authorities from agreeing locally to offer a wider range of services. Local authorities will also be free to meet this obligation in a variety of ways, for example in relatively small authorities it may make sense to locate a team in a single authority, acting on behalf of several. In addition, Public Health England will have a role through its information and intelligence service to support local authorities on this mandatory duty. This could include, for example, providing baseline data and analysis that local public health teams would need to share with the local NHS to inform discussions about relative needs and priorities.

Given close working and responsiveness between public health teams and clinical commissioners we would expect clinical commissioners to make full use of the expertise of local public health teams (as well as public health expertise in clinical senates). Indeed we are confident that as fully integrated commissioning teams are put in place throughout the country, the nature and extent of such assistance will be an accepted and automatic core element of local commissioning practice. This will be another means of taking forward the underpinning localism ambitions of this policy approach.

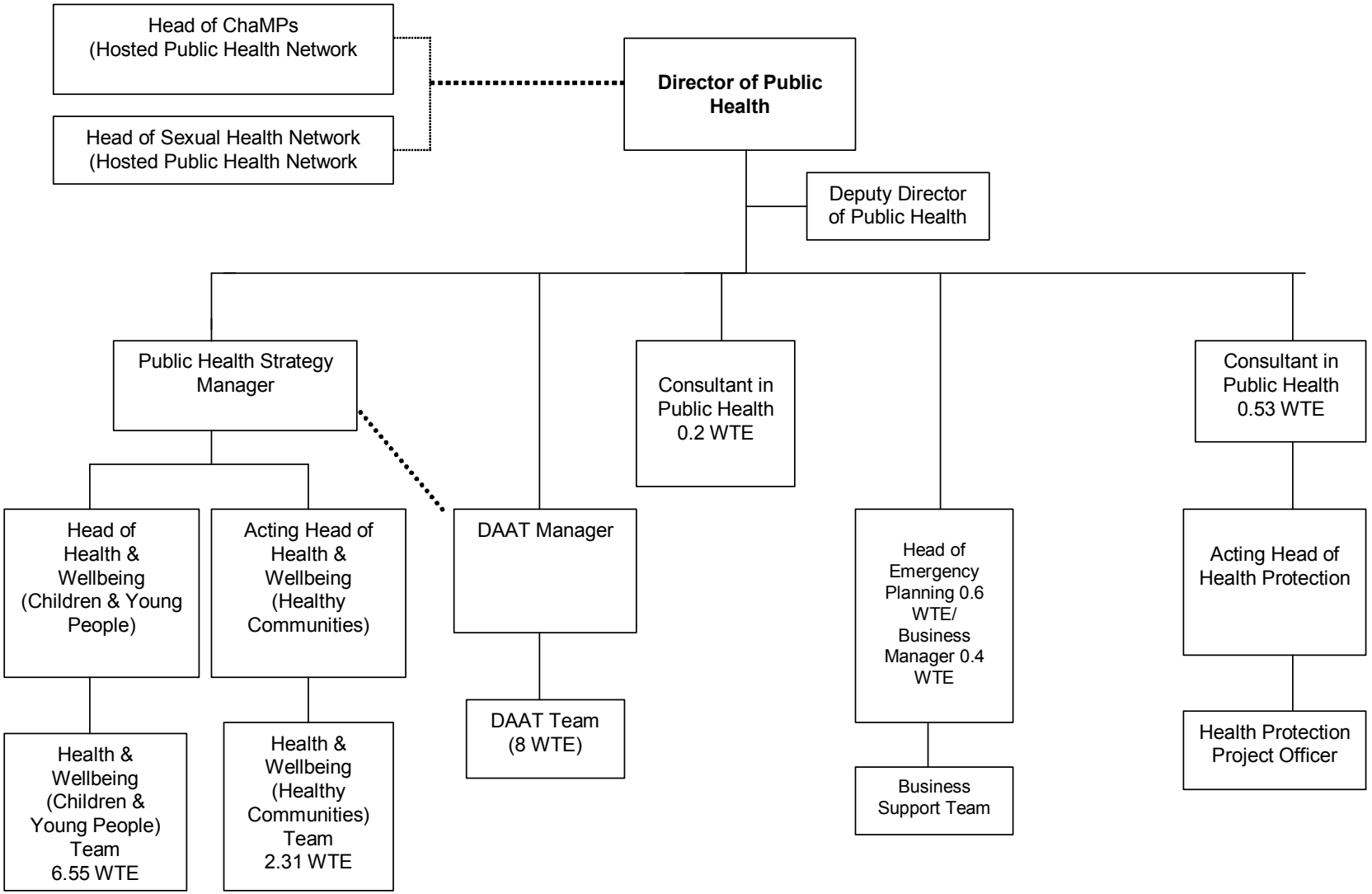
Where there are concerns about the quality of the advice received we would expect this to be raised at the local level initially with the local authority. There may be an issue of professional development, in which case we would envisage clinical commissioning groups involving Public Health England in discussions.

We are considering further what role local public health advice may play in supporting the NHS Commissioning Board in its core responsibilities, for example with respect to the quality of local primary care commissioning.

The group of public health experts and GPs who have advised us on the development of the population healthcare advice service are also working with us to consider how best to ensure that the provision of population healthcare advice meets the needs of clinical commissioning groups. This will help ensure that clinical commissioning groups can be confident that they will receive the kind of high-quality, responsive service they need.

Appendix 3

Public Health Directorate – Health Improvement, Health Protection and Healthcare-related Public Health

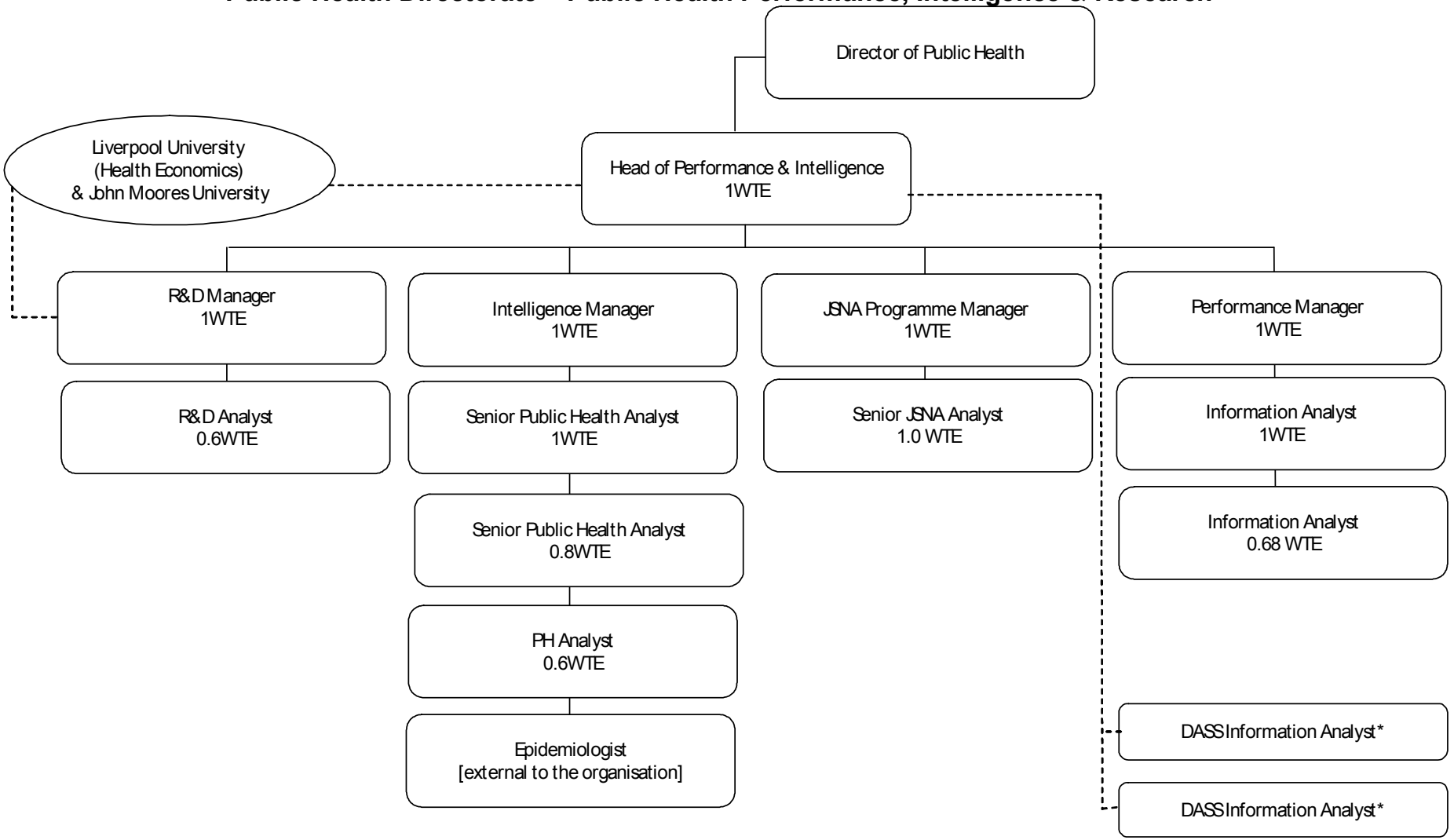


Public Health Directorate – Health Improvement, Health Protection and Healthcare-related Public Health Work Activities and functions

Commissioning and Managing
Teenage pregnancy, sexual health and contraception; weight management; breastfeeding; curriculum development for SRE; the health of looked after children; the healthy child programme; safeguarding; physical activity programmes; contract management; health inequality programmes, health trainer services; smoking cessation programmes; mental health and wellbeing; health improvement for vulnerable and minority communities; drug treatment and recovery services; alcohol education, prevention and treatment services; hepatitis testing and treatment programme; drug and alcohol services in criminal justice; offender health; community asset development

Commissioning and Managing
Health protection and major incident planning
Immunisation (multiple programmes childhood through to older age)
Screening programmes (12 programmes currently running – cancer, non-cancer, maternal and child health)
Support for secondary care health services (e.g. heart disease, cancers, mental health, respiratory disease etc)
Business Planning
Performance Management

Public Health Directorate – Public Health Performance, Intelligence & Research



*Current management arrangements
to be reviewed with Director of ASS

Public Health Directorate – Public Health Performance, Intelligence & Research
- Work activities and functions
(Built around the commissioning cycle)

PLAN	DO	REVIEW	REVISE
-Joint Strategic Needs Assessment -**Health needs/impact assessment** -**Risk profiling & prediction** -**Demographic forecasting and disease trends** -**Geographic analysis and mapping, socio-demographic analysis** -**Identification of risk groups (e.g. communities)** -**Research, evaluation, surveys, audits, peer reviews** -**Trend and statistical analysis** -**Geographic (e.g. ward), practice, regional and national benchmarking of disease prevalence, activity, productivity and cost**	-Analysis and presentation of productivity indicators -Clinical pathway mapping/ modelling & cost comparators -Providing evidence and information on comparative health outcomes -Statistical analysis of variation and correlations -KPI benchmarking -Development, implementation & management of a performance management framework (at all levels of organisation from strategy to individual performance) -Analytical support for contract monitoring/analysis -Provider activity, validation & data quality review	-Contract development (e.g. KPI specification) -Performance management and support for service improvement -Contract validation and challenge -Pathway and scenario modelling (e.g. dementia) -Providing comparative cost and activity monitoring -Metrics reporting -Performance reporting -Providing comparative outcome monitoring (inc. patient and public health data) -Production of Board level reports, presentations and profiles.	-Demographic forecasting and disease trends -Forecasting and future projections of expected activity -Cost benefit analysis of current activity versus alternatives (Health Economics) -Programme budgeting (comparative spend on disease conditions [Health Economics])

WIRRAL

EQUALITY FRAMEWORK FOR LOCAL GOVERNMENT ACHIEVING

Equality Impact Toolkit (new version February 2012)

Section 1: Your details

Council officer:

Email address:

Head of Service:

Chief Officer: **Fiona Johnstone**

Department: Public Health

Date: 24 February 2012

Section 2: What Council function / proposal is being assessed?

The transfer of public health functions and responsibilities to the local authority.

Section 2b: Is this EIA being submitted to Cabinet or Overview & Scrutiny Committee?

No

Section 3: Will the Council function / proposal affect equality in ……? (please tick relevant boxes)

☐ **Services**

☐ **The workforce** ✓

☐ **Communities**

☐ **Other** (please state)

If you have ticked one or more of above, please go to section 4.

☐ **None** (please stop here and email this form to your Chief Officer who needs to email it to equalitywatch@wirral.gov.uk for publishing)

Section 4: **Within the Equality Duty 2010, there are 3 legal requirements.**
Will the Council function / proposal support the way the Council
……(please tick relevant boxes)

☐ Eliminates unlawful discrimination, harassment and victimisation ✓

☐ Advances equality of opportunity ✓

☐ Fosters good relations between groups of people ✓

If you have ticked one or more of above, please go to section 5.

☐ **None** (please stop here and email this form to your Chief Officer who needs to email it to equalitywatch@wirral.gov.uk for publishing)

Section 5: **Will the function / proposal have a positive or negative impact on any of the protected groups (race, gender, disability, gender reassignment, age, pregnancy and maternity, religion and belief, sexual orientation, marriage and civil partnership)?**

You may also want to consider socio-economic status of individuals.

Please list in the table below and include actions required to mitigate any negative impact.

Protected characteristic	Positive or negative impact	Action required to mitigate any negative impact	Lead person	Timescale	Resource implications
Disability	May be a negative impact if staff move location and need reasonable adjustments to be made Accessibility	Assessment of needs would be undertaken	Business Manager	n/a – will only apply if staff move location	Funding for any reasonable adjustments required
Gender	Carers may need flexible working arrangements	Assessment of needs undertaken Use of flexible working policy	Business Manager	Transition period and beyond	Will need to be considered depending on the flexibility required.

Section 5a: Where and how will the above actions be monitored?

Through the Public Health Transition Steering Group

Section 5b: **If you think there is no negative impact, what is your reasoning behind this?**

Section 6: **What research / data / information have you used in support of this process?**

n/a

Section 7: **Are you intending to carry out any consultation with regard to this Council function / policy?**

Yes

(please stop here and email this form to your Chief Officer who needs to email it to equalitywatch@wirral.gov.uk for publishing)

Section 8: **How will consultation take place?**

Consultation will take place through the Human Resources Workstream of the Public Health Transition Steering Group. There are staff representatives on the steering group, and staff-side representatives have been invited to be on the workstream group.

Before you complete your consultation, please email your 'incomplete' EIA to equalitywatch@wirral.gov.uk via your Chief Officer in order for the Council to ensure it is meeting it's legal requirements. The EIA will be published with a note saying we are awaiting outcomes from a consultation exercise.

Once you have completed your consultation, please review your actions in section 5. Then email this form to your Chief Officer who needs to email it to equalitywatch@wirral.gov.uk for re-publishing.