WIRRAL COUNCIL

CABINET 21 JUNE 2012

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

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide Cabinet with an update on national policy and guidance for public health reform; an update on the local transition, and to seek agreement on the proposed role of the Director of Public Health and structure within the Council.

Under the Health and Social Care Act, local authorities have been 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 (DPH).

2.0 BACKGROUND AND KEY ISSUES

National guidance

2.1 The Health and Social Care Act 2012, states that Public health is part of the health service and will remain so even after transfer to the Local Authority. Not since 1974 have local authorities had health service functions and it is important that some consideration be given to the difference between this situation and other local authority functions.

2.2 Constitutionally the responsibility for most local authority functions lies with the local authority. DCLG's responsibility is that of a regulator and a mediator of relationships. DCLG is not accountable to Parliament for local government services. Its role in finance is as the custodian of its distribution. Responsibility for the health service lies with the Secretary of State directly. He is accountable to Parliament and must write an annual report to Parliament on the health service in England. The financial allocations are made out of NHS money for which the Secretary of State is responsible. His function is then devolved to NHS bodies and also now to local authorities.

2.3 How much this constitutional difference will matter in practice is unclear but there will be some differences

- DH will have wider powers of direction and intervention than DCLG
- It will also be more accustomed to using them
- It is unlikely that ring fencing will be removed from the public health grant without replacing it with some other method for the Secretary of State to account for its value e.g. outcome-based funding
- Certain legal constraints will apply e.g. local authorities will not be permitted to charge
- Certain NHS systems will apply (although not all because the Government is now drawing a new distinction between "the health service" and "the NHS" – this distinction is not entirely clear as yet)
- It will be possible to raise questions about public health in Parliament

2.4 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.

2.5 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. A consultation document has now been received, which on a crude analysis could mean that over time Wirral's allocation reduces by a figure which could be between £6 million - £7 million. This would have a significant impact on long-term investments in prevention. The problem is that the calculation is being made from an overall pot of £2.2 million which is the estimated amount spent on public health across the country in local authorities. For those local authority areas where there has been little sustained investment, it is likely that they will gain funding. The issue is that the overall pot is not enough to allow those areas to benefit, without a resulting disbenefit for areas that have invested in public health interventions. A final decision on the allocation 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 will need to be managed within

this figure. However, an additional £2,123,000 has been requested in addition to this to cover further expenditure which it has now become clear will transfer to the local authority. If this is not received, then there will be a potential further pressure on the budget which will have to be addressed.

Public Health Structure for Wirral

2.6 On 3 February 2012 a report providing an update on public health transition was taken to Cabinet 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 The transition plans submitted to the Strategic Health Authority and to the Department of Health have been assessed as meeting their requirements. A transition group is in place and providing oversight of the activities which will need to be delivered during the next period to April 2013.

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:

- 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

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

Issues which might arise during transition:

2.10 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.

2.11 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.

2.12 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 detailed in the Health and Social Care Act 2012.

Managing existing responsibilities

2.13 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.

2.14 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

2.15 Over the past two months, a number of discussions have taken place regarding the future responsibilities of the Director of Public Health and the relevant supporting functions. The core 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.

2.16 The proposed responsibilities are as follows:

2.16.1 The Director of Public Health will continue to be responsible for the public health functions and staff that currently form part of the public health resource on Wirral, and which will transfer to the local authority formally from April 2013.

2.16.2 That the Director of Public Health will take responsibility for Performance Management across the Council and that the line management for this

function will transfer from the Finance Directorate into the Public Health Directorate.

2.16.3 That the Director of Public Health will take responsibility for a consistent approach to Commissioning and Procurement within the Council.

2.17 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 If this recommendation is approved, the next steps will be to:

- Understand the Performance Management and Commissioning and procurement needs of the Council to support any service redesign
- Map existing resources within the public health function and across the authority that link to these functions
- Undertake any required consultation (particularly with staff and staff-side representatives).

2.19 It has also been proposed that the Director of Public Health could have a role in respect of Environmental Health. As this currently falls within the remit of the Director of Law, HR and Asset Management, it is suggested that a decision on this aspect of the role is deferred until a later date to allow for appropriate discussions to take place.

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 public health functions	Cuts in services currently provided
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 It is recommended that the Director of Public Health should also have a leadership role in supporting partnerships to improve health outcomes for people in Wirral. The nature of this role can be considered as part of the Council's approach to partnership working.

5.0 CONSULTATION

5.1 Staff Consultation

There will be a need to ensure meaningful consultation with staff affected by the transfer of functions, and by the allocation of staff within the Council to the Directorate.

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 Voluntary, community and faith groups are currently commissioned through both the NHS public health function and through the Council. The Council will be determining priorities on public health activity through its normal consultation processes, in tandem with any consultation on the Health & Wellbeing Strategy.

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, and that a secondment arrangement is put in place to enable her to directly manage Council staff.

12.3 That under the secondment agreement, the Director of Public Health takes responsibility for Public Health, Performance Management, and the council's approach to Commissioning within the local authority with immediate effect.

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 3.1	*Proposed structure for the Director of Public Health:*
Appendix 3.2	*Current public health structures which will transfer*

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

Appendix 1

RESPONSIBILITIES OF THE DIRECTOR OF PUBLIC HEALTH

Also see Department of Health Guidance Note:
Public Health in Local Government *"The Role of Director of Public Health".*

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 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.

Statutory responsibilities

- produce an annual report on the health of the local population, and for the local authority to publish it.
- statutory members of the Health and Wellbeing Boards
- lead officer in a local authority for health and championing health across the whole of the local authority's business

Delivery responsibilities

- Lead officer for health and championing health across the whole of the local authority's business.
- Produce a JSNA that sets out the current health and wellbeing needs of the local population.
- Support the HWBB to produce and implement a Health and Wellbeing Strategy.
- promote opportunities for action across the "life course",
- work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities.
- engage with wider civil society to enlist them in fostering health and wellbeing.
- day-to-day responsibility for the ring fenced public health grant to be delegated to the DPH.
- Undertake personal Continuing Professional Development and that of staff for whom accountable.
- Undertake appraisal in accordance with professional code of conduct.
- 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 PHE.
- contribute to the work of NHS commissioners, thus ensuring a whole public sector approach.

Appendix 2

PUBLIC HEALTH SERVICES

Also see Department of Health Guidance Notes:
Public Health in Local Government "*Commissioning Responsibilities"*
Public Health in Local Government *"Public Health Advice to NHS Commissioners"*

Locally Specified Services (i.e. Local Authority)

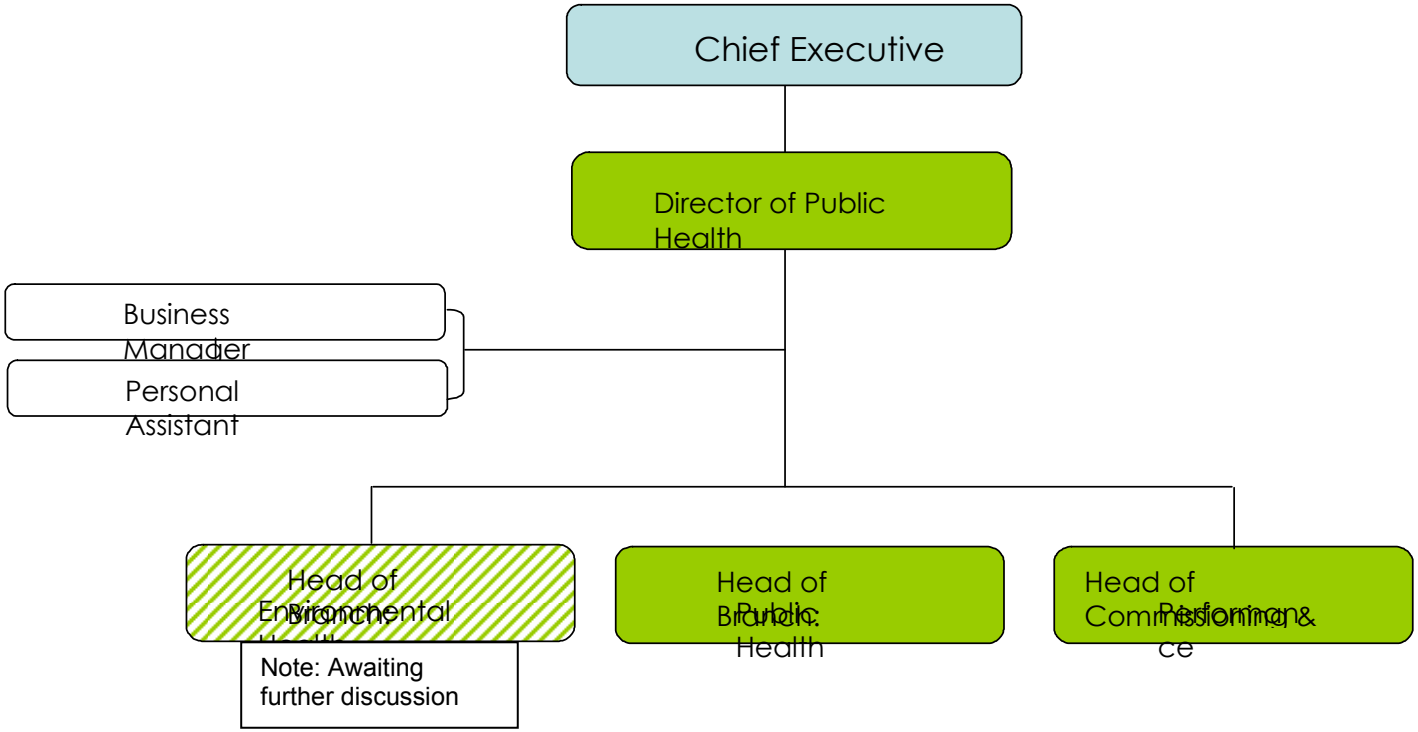
- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public Health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population
- 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
- 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.

Nationally Mandated Services

- The National Child Measurement Programme
- NHS Health Check assessments
- 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)
- Population healthcare advice to the NHS
- Protecting the health of the population.

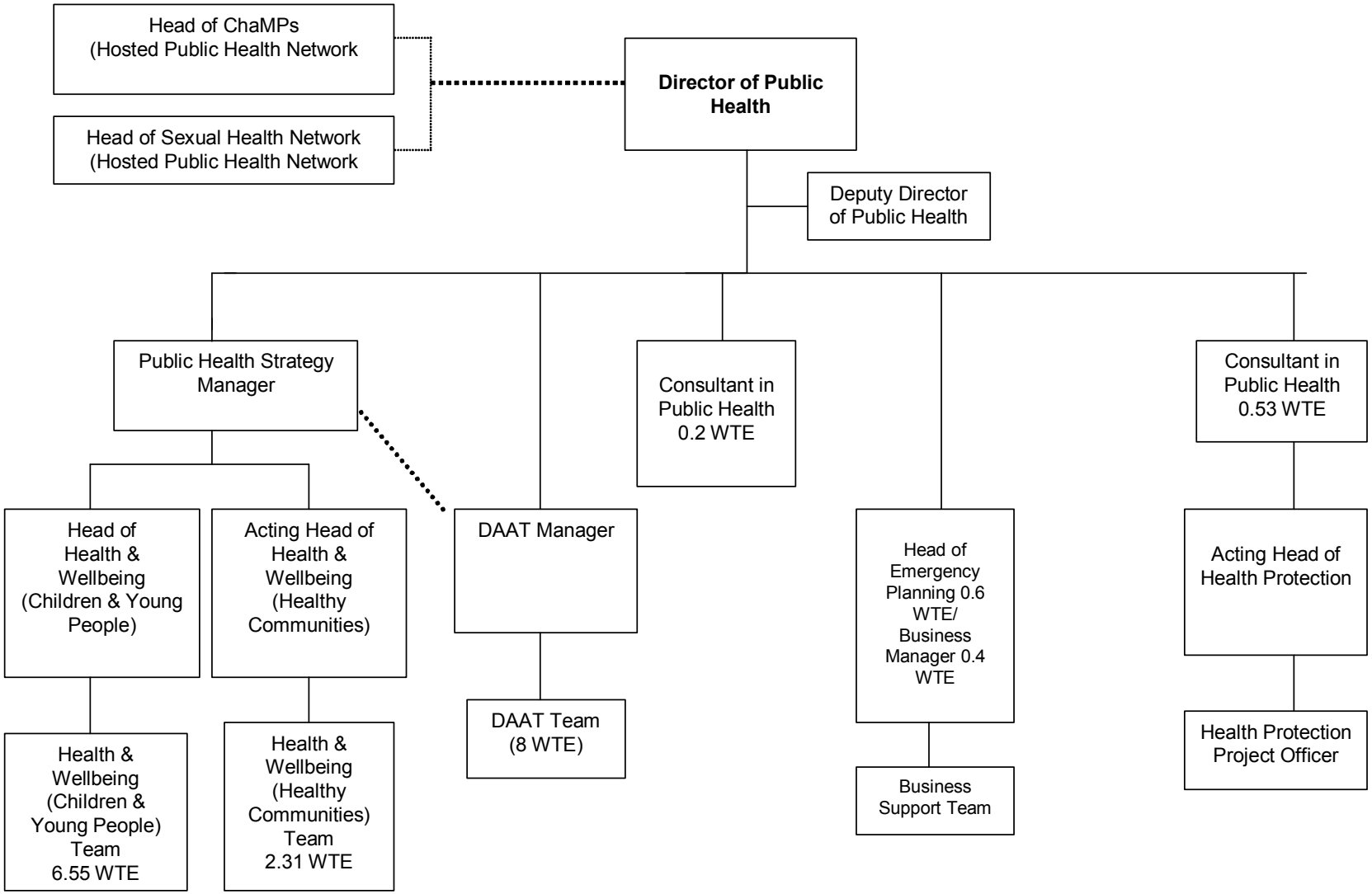
Appendix 3.1

Proposed Public Health Structure



Appendix 3.2

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

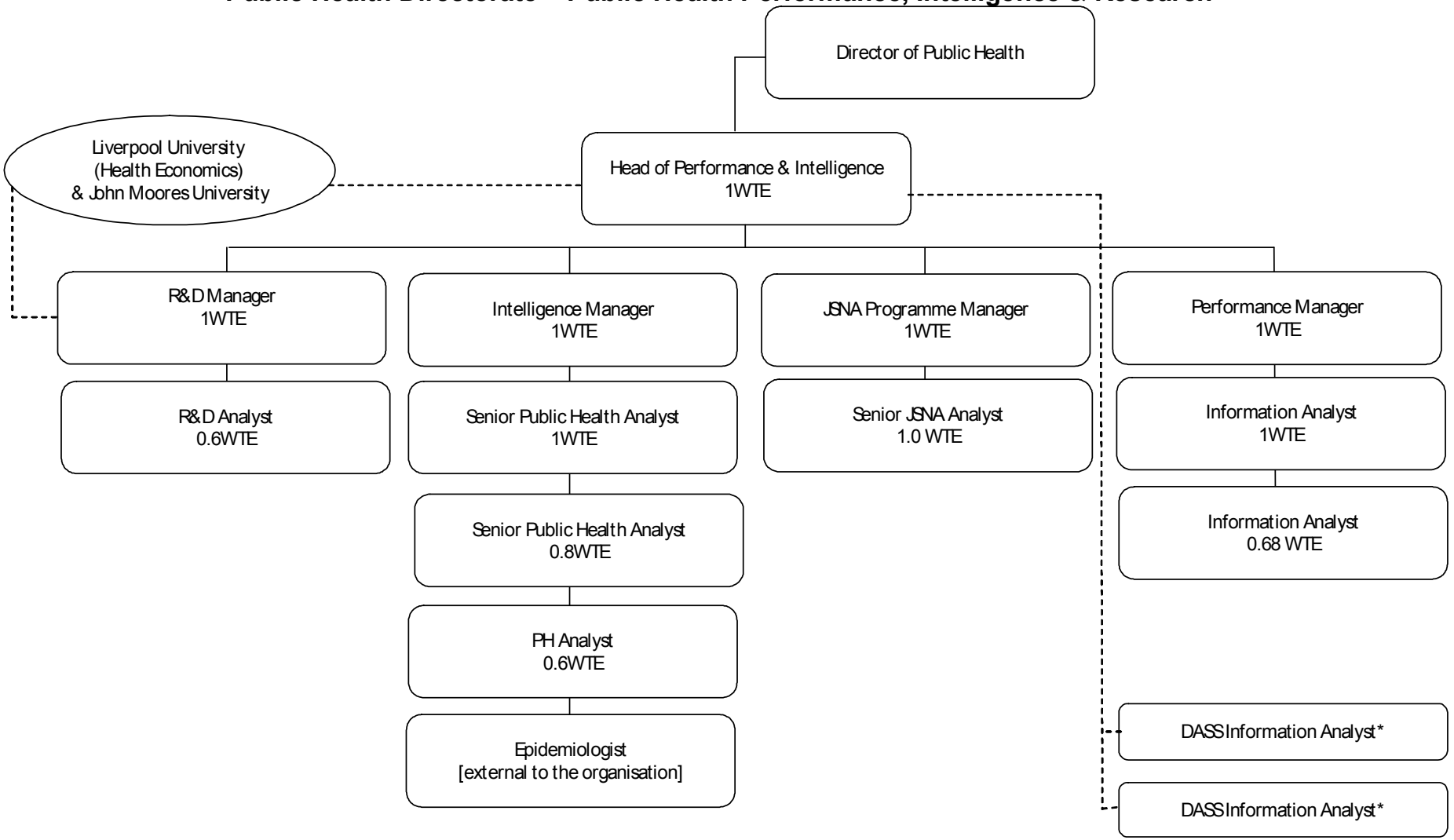


Public Health Directorate – Health Improvement, Health Protection and Healthcare-related Public Health Work Activities and functions

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.