AGENDA ITEM 6(ii)

HOSC/11/11

Committee Health Overview and Scrutiny

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An update on the transfer of responsibilities for public health to ECC and the future role of district /borough councils

Introduction

This paper provides a brief to HOSC members on key issues in this area. It recognises the fact that members have already discussed the issue and are aware of the national proposals and content including proposed public health outcomes.

While there will be local flexibility around how to do this, it is clear that at a time of resource constraint there will be a need to optimally use limited resources to deliver these outcomes.

Delivering the Outcomes – The Task

Public Health England and in turn local authorities and other organisations charged with commissioning public health services will be required to deliver on the public health outcomes agreed nationally. These are outlined as Appendix 1 but can broadly be summarised.

Outcome 1 – Health Protection and resilience:- This will largely be delivered by Public Health England discharged through a "health protection" function. Local authority emergency planning systems will have a minor role. It is yet unclear the role of local authority public health in out of hours support. There will be a need to commission an NHS response for example to enable vaccination to at risk groups during incidents.

Outcome 2 – Broader determinants of ill health:- The key broader determinants of ill health relate to material deprivation. Addressing the issues requires improved educational attainment and employment opportunities which will be interim proxy measures for a long term outcome. In the shorter term they would include access to benefits. There are a raft of measures underlying this outcome many of which are already within the gift of local

authorities. While a number reside at County level, some including housing, cycling, environmental health and issues around employment through regeneration are the responsibility of districts and boroughs.

Outcome 3 – Health Improvement:- This is largely around the lifestyle choices people make. This is an area where most work has historically been led and delivered by NHS commissioners and provider services around areas such as Smoking Cessation, Alcohol Prevention, Weight Management, Substance Misuse Services and Sexual Health. It also includes physical activity which has a key role for districts and boroughs in delivery.

Commissioning of these services is new ground in the main for County Councils with the skill base residing within health. It is likely services will be delivered through a variety of agencies including statutory and non-statutory health service and move health service agencies.

Outcome 4 – Prevention of Ill Health:- This is supported by a wide range of measures some of which are lifestyle related e.g. Chlamydia and some of which are driven through clinical services e.g. screening and health checks. It is proposed some will be the responsibilities of LAs e.g. health checks, Chlamydia and OTHERS the responsibility of NHS Independent Board e.g. Admissions for injuries under 5, screening uptake. This group will GENERALLY be delivered through NHS provider services including primary care.

Outcome 5 – Health Life Expectancy:- The National Support Team for health inequalities has clearly defined the interventions required to deliver optimally in this area in the timescales we need to consider many of. These are NHS provided and historically NHS commissioned interventions often driven by systematic evidence based approach in primary care. This is very new to LA commissioners. Work in this area is essential to optimise life expectancy in those already damaged through poor lifestyles and the adverse impact of broader determinants of health.

<u>Systems to support function</u>

While more work is planned across Essex to develop our vision of public health, the need to optimally deliver the national outcomes is a useful starting point. This will require:

- Strong support across all directorates within County Council to recognise and address their roles in delivery particularly around the broader determinants through variations to current contracts and new commissioning plans.
- Facility to take on and optimally discharge former NHS commissioning tasks around healthy lifestyles and health life expectancy.
- Strong partnership working with key agencies including district and boroughs especially around leisure and housing and with NHS (largely GP) commissioners around clinical interventions to deliver outcomes.

Director of Public Health role

The White Paper requires the appointment of a DPH jointly by the LA and Public Health England. The job description and person specification is likely to be centrally determined and be in line with Faculty of Public Health expectations. It is likely in a shift from a National to a locally driven service the centre will wish to be assured around the standard of appointed postholders. The Chief Operating Officer for Public Health England will be appointed in September/October and it is likely LA appointments will need to follow this. The direct ability of an LA based DPH to influence the local public health agenda will depend in part on the proportion of the ring fence with Public Health England that is devolved to LAs rather than to the NHS bodies. It is currently unclear what proportion this might be but it is important to consider models that enable the DPH to optimally influence NHS public health spend.

District & Borough roles in Public Health

Public Health in Essex has a very strong history of close working with district and boroughs with joint funded public health posts in a majority of districts. While the value of these posts is recognised by districts/boroughs, the increasing financial constraint on these organisations has meant funding has been curtailed. Nonetheless the PCT public health directorates have worked hard to retain these posts at their own cost recognising the added value of these roles.

There remains strong support for these roles amongst LA CEOs and any consideration of the future public health structure across Essex needs to consider the value of posts linked to district and boroughs.

Discussions need to take place with district/borough colleagues to look at the right model. Currently in some districts posts are more junior and operational and in others are senior and strategic.

District and Borough Councils have a crucial central role is influencing housing, regeneration, leisure and environmental health. It needs to be considered how we can ensure the local population may best benefit from a comprehensive range of public health initiatives. It is likely the best model includes senior staff with a Pan Essex role in for example Smoking or Physical Activity with an additional link to a district/borough council. There will also need to be alignment to GP Consortia.

Conclusion

Work is on going to define the vision and function of public health in Essex. To optimally deliver the public health function needs to have the broadest possible influence in a range of agencies and partners including all directorates within County Council, GP Consortia, district and borough councils and the NHS Independent Board locally.