The Public Health White Paper, new public health responsibilities of Councils and Health and Wellbeing boards

Introduction

1. HM Government launched the White Paper on Public Health '*Healthy Lives Healthy People* ' on 30th November 2010. This sets out the vision of the Secretary of State for Health for addressing key public health issues for the future. It focuses on the main health problems that the government considers important, indicates the principles that underpin an approach to improving health and sets out the structures and systems through which it plans to address these.

2. The White Paper includes a series of consultation questions to which the government is inviting responses until 8th March 2011. The document is not published by the Department of Health, rather by the Government as a whole indicating the direction of travel away from health being just an issue for the NHS and being a cross governmental issue instead. It is supported by two further consultation documents. The first sets out a proposal for the Public Health Outcomes Framework through which local government, and other bodies will be monitored on. The second consultation paper sets out proposals for how funding will flow though the public health structures and where will be the accountabilities for commissioning different elements of the system.

Health Issues in the White Paper

3. The White Paper highlights specific health issues as important. These includes the inequalities in mortality rates that are experienced by different populations across the country. It notes the influence of wider factors on health and wellbeing referencing in particular the review on health inequalities by Prof Sir Michael Marmot earlier in 2010. There is an emphasis on maternal and early child health and about developing good health for young people including issues on obesity, substance misuse and mental wellbeing. It identifies those lifestyle issues that impact on adults long term health prospects emphasizing obesity, alcohol and smoking. Mental health is included in the health issues.

4. There is a strong focus on child health and the Secretary of State wishes to increase numbers of health visitors and double the numbers of families being supported through Family Nurse Partnership.

5. There is a strong emphasis on the role of work to improve health, both getting people back into work and on engaging employers in their role of improving the health of their staff. The importance of local environment where people work, live and play is recognised, as is the sustainability agenda.

Approaches to the new public health system

6. It assumes a partnership approach to improving health and focuses on innovation in improving health and on empowering local government and local communities to reduce inequalities and improve health at key stages of life.

7. The paper outlines a Public Health Responsibility deal on food, alcohol, physical activity, health at work and behaviour change working with industry, business, employers, voluntary sector, as well as the statutory sector.

8. The principles underpinning the approach are to reach out and reach across to individuals, families, communities, workplaces business, voluntary sector and NHS as well as local government. Central government will act where it considers it relevant.

9. The approach will be to

- Strengthen self-esteem, confidence and personal responsibility
- Positively promote 'healthier' behaviours and lifestyles
- Adapt the environment to make healthier choices easier

10. The values will be to ensure that interventions happen at the right place. There is a recognition that there is a spectrum of approaches to intervention between two extremes of leaving it to the individual/ 'hands-off' or intrusive intervention. Therefore the government will recognise this spectrum and balance the freedoms of the individuals with the need to avoid serious harm and will consider different approaches for different groups of the population. The approach they propose is a ladder of interventions with 8 rungs between 'Doing Nothing' (complete freedom for the individual to choose), through providing information and on to 'Eliminate Choice' (legislative banning by government).

Local Authorities and Public Health

11. There will be a new public health system with localism at its heart with the local authority taking responsibility for health improvement of local populations. Local authorities will have new local freedoms and there will be an expectation to create local solutions that meet local needs. Council will receive a ring fenced budget to support local activity on health improvement with an expectation that the majority of services will be commissioned.

12. This will mean the transfer of functions and accountabilities for many health improvement outcomes from PCT to Local Authority. For these purposes the council will receive a ring fenced allocation or grant to support it in the achievement of its outcomes.

Directors of Public Health

13. Local authorities will have a Director of Public Health. It is proposed that they will be employed by local authorities and jointly appointed between the local authority and Public Health England (a new nationally created body). The White Paper sets out an expectation that they will be public health professionals with appropriate training and skills. Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. It is proposed that they will be the principal adviser on all health matters to the local authority, its elected members and officers on the health of the local population, health inequalities, developing and implementing local strategies. There is an expectation that they will also provide a high quality public health input to the NHS services and work closely with GP consortia to identify, prevent and manage a range of conditions. They will be expected to play an important role in emergency preparedness and response to major public health threats. They will contribute to Local Resilience Forums.

Public Health England (PHE)

14. There will be a dedicated and professional public health service, Public Health England with a mission across the whole of public health which will be a part of the Dept of Health accountable to the Secretary of State and not a separate legal entity. It will include elements of public health activity from DH and bring in Public Health Observatories, Health Protection Agency and the National Treatment Agency.

15. The role will include: public health advice and evidence to the Secretary of State, effective health protection services, commissioning national health improvement services including campaigns, jointly appointing Directors of Public Health with councils, allocating ring-fenced public health grants and commissioning some services from the NHS Commissioning Board

London-wide Issues

16. As there are two tiers of local democracy in London there has been debate about where the health improvement function should be placed and what are the roles of borough councils vis-a-vis the GLA. The White Paper expresses that LAs are free to take joint approaches. The Mayor of London has made a case for a city-wide approach and the Secretary of State has invited the Mayor and local authorities in London to develop proposals on how they can work collectively together to improve health in London. Prior to Christmas an agreement was reached whereby London Councils will allocate 3% of their Public Health grant for city wide work on specific health issues with potential for a further 3% depending on the success of the programme

Transition to the new Public Health system

17. With regard to the Southwark situation there will be a number of steps through a transition period before the public health function of the

council will be established. It may be a straightforward process of transferring the DPH and staff from PCT to the council, or it may turn into a more complicated process, recognising that the responsibilities of council will not be exactly the same as those of PCTs. PCTs will retain responsibilities until April 2013, albeit through some different structures, yet to be decided.

18. Further information about the process for transition will emerge nationally and London wide. This is subject to the passage of the Health and Social Care Bill through Parliament. Furthermore the proposed or shadow budgets for grants to local authorities will not be available until the 2012/13 meaning that it is not possible to be specific yet about the shape and size of the public health departments in the local authority.

19. The process for planning this transition has now commenced with the establishment of a Public Health Transition Advisory Group for London. This group has been meeting since summer 2010 and includes representatives from London Councils, GLA, Chief Executives of Local authorities, representatives of the Directors of Adults Social Services and Children's services as well as DsPH, and representatives from DH, HPA and London Health Observatory and voluntary sector. Until now there has been a considerable focus on the interrelationship between councils and the Mayors Office/GLA focussing on the Mayors duties in relation to Health Inequalities. This work culminated in an agreement in late December between councils and the Mayors office that councils will provide 3% of budget to the Mayors office to support city-wide work on Health Inequalities and Health Improvement.

20. The next stage of planning for transition is being led as a transition project at the DH level, with the project being mirrored at the London level. It is expected that there will be a project plan released shortly at national level for the establishment of Public Health England and this will inform the plans for development of all other aspects of the new public health system.

21. While this is proceeding there are a number of Councils across London which are taking a more proactive approach to the changes and are currently arranging for public health departments to transfer to the local authority with funding still through the PCT but a legal arrangement through a Section 75 agreement (of the NHS Act 2006) allowing for council management of staff and budgets. Three councils are in advanced stages of these arrangements while other areas are taking a more cautious approach to this, as they await the parliamentary processes and clarity about budgets. In Southwark with the integrated structures this has not been such a pressing issue but with the changes to the NHS structures will in time need to be resolved.

Funding and Resources for Public Health

22. There is currently a consultation document from the Department of Health on the proposals for how funding and commissioning will work for the future for public health. It identifies the main areas that the funding will need to cover and which organisation will be responsible for commissioning which service.

23. PHE will allocate ring-fenced budgets weighted for inequalities to upper tier and unitary local authorities. There will be scope to pool budgets locally in order to support local public health work. The Dept of Health is currently consulting on their proposed approach to funding and commissioning of services. Within this they are setting out the levels at which different elements of the public health service will be commissioned e.g PHE, NHS Commissioning Board or local authorities. Currently it is proposed that local authorities will be responsible for commissioning the following:

24. Accident Prevention
Sexual Health and contraception services
Physical activity interventions
Obesity Programmes
Substance Misuse
Alcohol Misuse
Tobacco Control
NHS Health Checks
Health at Work
Childrens Public Health aged 5-19
Public Mental Health
Prevention and early presentation
Dental Public Health
Community Safety
Social Exclusion
Health Intelligence
Health Protections – with PHE

25. There will be a new health premium which will apply to part of the budgets for health improvement. Local Authorities will receive a health premium that depends on progress made in improving health of the local population based using the outcomes framework. It will be funded from within the overall public health budget. Disadvantaged areas will receive more if they make progress , recognising that they face the greatest challenges. Payments will reflect achievement and not ability to negotiate a less demanding target.

26. The Local Authority Chief Executive will be the accountable officer. There will be shadow allocations in 2012/13 providing for planning for 2013/14.

Health and Well Being Boards

27. There will be a statutory duty on councils to establish Health and Well Being Boards for upper tier local authority and unitary authorities. The minimum membership will be local councillors, Directors of Public Health, Directors of Adult Social Services, Directors of Childrens services, GP consortia and Health Watch. There will be a duty on GP consortia to participate.

28. There will be a joint and equal responsibility on the GP consortia and local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing needs of the local population. This will in turn inform development of a Joint Health and Wellbeing strategy which all H&WB Boards will have a duty to create. This will be a high level overarching strategy which will then have other more detailed plans sitting under it addressing specific issues.

29. The emphasis is on encouraging coherent commissioning strategies promoting joined up commissioning across the NHS, social care, public health and other local partners. There will be an expectation to go beyond the existing joint integration of services for groups such as those with disability to move to join up with housing or criminal justice system.

30. There is an existing Health and Wellbeing Board for Southwark, which is a subgroup of the LSP. Initial discussions have taken place with the existing core membership about the creation of the new Board that would replace the existing one. These are, by necessity, preliminary discussions as the formal new Board does not need to be in place until 2013.

31. The membership of the new Board will need to be established and agreed. The role, terms of reference and modes of operating have yet to be determined. The establishment of the new Board will need to take cognisance of the likely statutory roles and membership, defining its relationship and links with Southwark Alliance. The issue of how the Board will intersect with the Young Southwark Board will need to be considered, because matters relating to health and wellbeing of young people will also be the responsibility of the Health and Wellbeing Board.

32. Plans are underway to establish the process to engage all relevant stakeholders to develop how this Board will function and agree the membership that will best meet both statutory obligation as well as being responsive to local needs of the population.

33. The Health and Wellbeing board should be the main body that informs and drives the joint commissioning agenda for health and social care activity between council and GP Commissioners. With the disappearance of the PCT (and with current significant restructuring of the PCTs across London to be implemented in 2011), the roles of both the existing Health and Social Care Board and the existing Health and Wellbeing Board will need to changed. It is proposed that they subsumed into the responsibilities new Health and Wellbeing Board. It is suggested that this new Board should be established in shadow or interim form in 2011, until such time as the formal statutory body needs to be in place (April 2013).

34. Southwark GP Commissioners have been recognised as a Pathfinder groups of commissioners by NHS London. There is also an invitation for councils to put themselves forward as pathfinder Health and Wellbeing Board. This is an option that it would be possible for the council to consider in discussion with its partners.

35. Across London many councils are establishing Health and Wellbeing Boards already, although many did not have the structures similar to what Southwark has had.

Public Health Outcomes

36. There will be a Public Health Outcome Framework by which the local authority and the Director of Public Health will be held to account. The consultation on the contents and scope this Framework was published in late December. This sets out a framework with five main domains and a set of proposed outcomes within each of these domains. For some domains a large number of indicators have been proposed but it is assumed that the final number will be reduced.

Domain 1 Health protection and resilience, protecting people from - major health emergencies and serious harm to health	Nos of Indicators 6
Domain 2 Tackling the wider determinants of ill health: tackling factors that affect health and wellbeing	21
Domain 3 Health Improvement; helping people to live healthy lifestyles and to make healthy choices	10
Domain 4 Prevention of ill health: reducing the number of people living with preventable ill health	7
Domain 5 Healthy life expectancy and preventable mortality: preventing people from dying prematurely	9

37. Some of the indicators are shared indicators with the NHS Outcome Framework and a few are shared with the Social Care Outcomes Framework. While the final number of proposed Public Health Indicators is not yet known, it will be necessary for the Health and Wellbeing Board to consider which indicators across Public Health, Social Care and NHS that it will monitor. It does not preclude other local indicators from being considered.

Timetable for implementation

Early 2011

- DH will provide more information with a detailed roadmap for the system as a whole - NHS, PHE and the DH with key milestones
- Further detail on PH following responses to the White Paper on the NHS
- Human resources framework for people moving between different organisations
- Health and Social Care Bill introduced to Parliament

2011/12

- Detailed policy and operational design
- Overarching HR framework for NHS, PH and arms length bodies
- Develop and consult on a PH workforce strategy
- Accountability for delivery in 2011/12 will continue to reset with SHAs and PCTs
- Shadow Health and Wellbeing Boards begin to be developed
- SHA will be responsible for transition of the PH systems during 2011/12 with RsDPH as the lead
- Public Health England (PHE) set up in shadow form
- Start work with local authorities on local arrangements including the matching of DsPH to local authority areas.

2012/13

- PHE will come into being in April 2012
- Publication of shadow ring fenced budgets for public health in local councils
- Local authorities have Health and Well Being boards operating although not on a statutory basis

2013 Onwards

- Public Health system in place
- Ring fenced public health allocations to local authorities
- Full Health and Wellbeing Boards operating

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