Deeper into the DNA: an update on the transformation of public health, September 2012

Key messages

• Councillors and senior teams in local authorities have developed a good understanding of how public health can add value; this is now being cascaded throughout councils and their partners.

• Safe transition is the key priority but public health is also involved in major initiatives in Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) to integrate and transform services.

• Clinical commissioning groups (CCGs) are providing significant opportunities for public health and councils to work more closely with GPs at a neighbourhood level.

• Recommendations from the Marmot review¹ are being adopted by health and wellbeing boards to shape JHWSs meaning that public health is fundamental to system-wide planning and delivery.

Introduction

In February 2012, six resource sheets were produced reflecting the main themes, challenges and solutions emerging from the early stages of public health transition, but with a focus on the potential for transformation. Nine case studies were also produced, chosen to represent different types of local authorities from across England which had already started to implement elements of the new local public health system.

These case studies have been updated to identify what progress has been made in subsequent months. Six new resource sheets have also been produced on key topics for transformation across the lifecourse.

This resource sheet, ‘Deeper into the DNA’, updates the original resource sheets under two overarching themes:

- embedding public health in local authorities
- public health in partnerships for commissioning and delivery.

‘Deeper into the DNA’ is based on information from case study areas and the steering and reference groups which supported the production of the resource. Examples of practice were also sought from regional and local public health teams across England. The themes and messages expressed in the resource sheets were developed from this information.

The resource sheets provide a snapshot suggesting the general direction of travel in public health transformation; they do not provide a comprehensive summary of developments across England.

Embedding public health in local authorities

With the agreement of the primary care trust (PCT) and shadow CCG, Doncaster’s Cabinet has agreed that public health will start to operate in shadow form within the council from October. While formal accountability remains with the PCT until April 2013, to all intents and purposes it will operate as a council department. This will enable a seamless start in April 2013 and will enable the council to develop experience of public health governance. Doncaster Public Health and Wellbeing Directorate has used the Local Government Association’s ‘Councillor’s Guide 2012/13’ to promote better understanding of working in the local authority. It has also developed staff objectives focused on public health functions in local government.

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Lincolnshire Public Health Directorate includes a range of functions including supporting people and supported employment. To develop understanding of the value of joint working throughout the directorate, an independent audit was undertaken which found three issues on which people wanted greater understanding:

- health protection (some public health staff also requested this)
- health information and intelligence
- community engagement.

Awareness-raising events are taking place and could be extended beyond the directorate in future.

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Case study areas generally indicated that in the months since the first case study it felt as if public health had been welcomed into the ‘local authority family’. There were some common themes in the examples they gave for how public health was becoming embedded.

- Public health objectives, outcomes and targets are being included with council objectives and forward plans, and as part of the corporate performance management framework. Responsibility for delivering objectives is often shared with, or owned by, other council directorates.

In Blackburn with Darwen, local authority directors have jointly led the various workstreams of public health transition (eg HR, finance, IT) with Care Trust Plus directors and public health consultants and are therefore closely involved in embedding public health. This has enabled a much wider understanding and ownership of the issues and challenges involved in moving public health services to local government.

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- Elected members and senior officers are generally seen as having a good understanding of the potential for public health in councils; work is now taking place at all levels of councils to extend this understanding, this includes welcome packs for PCT staff and joint development sessions.

- Public health specialists and staff are now working much more closely on joint issues within councils, such as the troubled families programme, spatial planning, leisure and housing. Over time, this is seen as having a positive impact on the wider determinants of health.

- External stakeholders, such as the local voluntary and community sector, are being involved so they understand transition issues and have an opportunity to learn about and contribute to the transformation of public health.

Devon County Council and NHS Devon have established a fixed-term dedicated post of communication and engagement lead to keep both staff and external stakeholders engaged in transition. Activity includes regular public health articles, eg a day in the life of a public health specialist, a dedicated webpage, and events with staff.

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Earlier in the year there was a concern that district councils could be in danger of being left out of health and wellbeing developments. However, the case studies and examples submitted from across England suggest that councils have given this considerable attention and are starting to co-design comprehensive arrangements for involvement (Resource Sheet 12 Public health in two-tier areas).

Some areas were being proactive regarding arrangements for health protection and emergency response.
In Doncaster, work is now taking place to map local health protection arrangements with a view to developing a comprehensive health protection assurance framework and the possibility of establishing a local Health Protection Committee reporting to the Health and Wellbeing Board.

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The Yorkshire regional health protection group have drafted a service specification for all of health protection, excluding screening. It describes the tasks, and who is responsible for what, in the post-April 2013 world for both NHS and the local authority, and for both commissioning and provision. It has been shared nationally and used by many areas to plan how health protection can work locally.

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In Resource Sheet 1 ‘Transition so far’, three types of models were identified (January 2012):

- a distinct public health directorate, often including additional local authority functions
- a section of another directorate
- a distributed or integrated model with a virtual team or hub.

Another model can be added to this list – a merged model in which public health and another local authority directorate are combined. For example, Worcestershire County Council has agreed to merge the directorates of public health and adult social care into a ‘directorates of adult social services and health’. The new directorate will lead and support the whole council as well as local partners and communities to improve health and wellbeing.

In Wirral the director of public health has assumed responsibility for ensuring a consistent approach to performance and commissioning across the council, and under a proposed restructure will also take responsibility for policy. The new post will be renamed the ‘director of policy, performance and public health’. This arrangement is intended to make good use of the public health skills coming into the council and will enhance the overall approach to responding to national policy and shaping local policy. It will build on existing partnerships to support local communities and the changing public sector to focus clearly on performance, and will reinforce Wirral’s role as a health improving council.

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In September, the case study areas had continued with the model they had adopted earlier in the year, and arrangements were becoming established. However, not all were completely finalised. In some areas there was still the possibility of combinations with other local authority functions up to and beyond April 2013.

**Partnerships for commissioning and delivery**

Respondents to the snapshot indicated that the top priority at the current time is for public health to land safely in local authorities so that mandatory services transfer effectively and discretionary services run seamlessly from April 2013. This is within the context of considerable organisational change – not just the practical aspects of transfer, but the authorisation of CCGs, the establishment of Public Health England (PHE) and NHS Commissioning Board local area teams, as well as new political administrations, restructuring, and efficiency and spending reduction plans in some local authorities.
At the same time, people also reported energy and enthusiasm for major system-wide reforms, and there was a feeling that this time of change needed to be capitalised on. Opportunities and ideas were naturally emerging from JSNAs and JHWSs and people were coming together with ambitious plans for improving commissioning and delivery. The focus was starting to shift from internal restructuring outwards to partnership planning and service redesign.

Role of public health in strategic development

In the case study areas, public health was heavily involved in reshaping arrangements for integrated commissioning and delivery across health, public health and social care. Some areas indicated that the transfer of public health and the development of JSNAs, JHWSs and health and wellbeing boards had resulted in public health having a greater role in system-wide strategic development.

The role of the director of public health (DPH) may have been particularly significant in some areas because it was seen as a trusted broker by both local authorities and CCGs.

Oxfordshire is looking to develop a ‘new public health’ working through ‘the organised efforts of society’. This is commencing with a coherent work plan involving the voluntary and faith sectors, local entrepreneurs, philanthropists and universities to harness energy and creativity. The DPH is leading work across the council on liaison with the voluntary and community sectors.

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Working with GP practices

Some areas were developing neighbourhood, district or locality activity in health and wellbeing by, for instance, extending current provision or linking it with mainstream delivery. A key driver for neighbourhood work was the greater focus on joint work with GP practices or groups of practices through CCG arrangements.

Most districts councils in Lincolnshire have a health and wellbeing group which links to the health and wellbeing board and district councils. CCGs are now coming together for joint work, such as a joint project in East Lindsey with the British Heart Foundation, looking at reducing the incidence of coronary heart disease.

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Blackburn with Darwen is reshaping wellbeing services from separate programmes into an integrated self-care and wellbeing service based in GP practices. This includes support to tackle wider determinants of health such as employment, and is aligned with a range of neighbourhood providers. (See Resource Sheet 8).

An example for the model took place in a GP practice in which a community asset map found 200 health-related activities provided by 52 different groups within walking distance of the practice. Bentham Road Health Centre is supporting people in the community to provide activities that will benefit health, from family support to health clubs. A web resource providing information on what is available locally has been set up and the GPs are offering ‘volunteering on prescription’ through an arrangement with local voluntary organisations including the children’s centre.

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Reshaping public health roles
Some areas were looking at the role and skills of public health professionals, and the balance between specialist and general responsibilities, to ensure they can offer a flexible response in relation to local priorities identified within JHWSs.

In Coventry, a small number of public health posts will be based on specialist knowledge, but the majority will be based around a set of generic skills and competencies. There will be a matrix management approach in which team members have clear and consistent line management, but day-to-day management may alter depending on which project or programme they are working on.

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A priority for public health in Salford has been to refocus the portfolios of team members from highly specialist topics (eg focusing solely on stop smoking or obesity) to a model built on public health competencies covering skills such as needs assessment, equity audit and evidence building.

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New commissioning models and a wide range of providers
Most areas were clear that they felt it was important to work in different ways, to develop new models for commissioning health and wellbeing services and to encourage a wider range of potential providers from across the voluntary, community, social enterprise and private sectors. While this was a longer-term aim for many areas, some were already working on this either because existing contracts were up for renewal or a priority for action had emerged from JSNAs and JHWSs.

Examples of new or developing commissioning activity include:

- council use of NHS tariff
- investigating social impact bonds
- building capacity in the voluntary and community sectors.

Making public health everyone’s business
The Making Every Contact Count (MECC) initiative trains frontline staff from a range of organisations such as councils, the NHS and the voluntary sector to make brief healthy living interventions or referrals to appropriate health advice. Some areas that did not have MECC fully in place were developing or extending this across the council and other partners.

Salford Council has made a major investment in training for frontline staff to Make Every Contact Count. All staff will complete an online self-assessment tool which will point them to the right training for them and ensure that all frontline staff meet an agreed set of competencies. In the first six months several hundred staff have completed the assessment and gone on to complete the relevant training course.

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In Lincolnshire, the CCGs have agreed to put ‘Making Every Contact Count’ (MECC) into provider contracts – the first time this has been comprehensively introduced in the NHS in Lincolnshire. A project manager has been identified in each trust to take this forward. The local authority is also looking to adopt MECC, for example with library staff.

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Collaboration across local authority boundaries

Collaborative arrangements across local authority boundaries and with groups of CCGs have continued to develop since January. There are many examples of collaboration. Some involve a small number of areas working together on specific issues. Some are large, long-standing networks that are now responding with new working arrangements. Some involve groups of local authorities collaborating with lead arrangements for specific areas of responsibility such as screening.

Developments – up to April 2013 and beyond

In prioritising work for the coming months, there were local differences in choice of service development activity, but also many topics in common.

Safely managing transition was the overarching priority for all in the snapshot. Another shared priority was the need to establish ways of working with the emerging local arms of the NHS Commissioning Board and Public Health England, and with commissioning support units.

Some areas were considering relationship leads to liaise with these new partners. Many areas were also working on shared outcomes for health and wellbeing boards using the national outcome frameworks and aligning this work with local authority performance management systems.

Maintaining communication across public health, the local authority and wider partners was another priority. A number of areas were planning activity such as shared-learning sessions or welcome events to mark the move into the local authority.

Areas were clear that April 2013 was an important milestone, but the process of integration and development would need to continue throughout the coming year and beyond.

Greater Manchester Public Health Network is made up of 10 areas which have worked together for many years on service redesign and public health policy advocacy. It is now reshaping its business model to complement the new arrangements.

The collaborative will work alongside the Greater Manchester Family – a group of organisations leading economic growth for the sub-region eg the Association of Greater Manchester Authorities (AGMA) and fire and police services. It will also work closely with CCGs which are already starting to network within the Greater Manchester footprint. Discussions with stakeholders have indicated that the following functions will be key in the future:

- support for sector led improvement
- establishing a Greater Manchester level public health intelligence and customer insight function
- promoting innovation in the design of public health services
- ensuring the public health leads policy development and influences strategic design making throughout Greater Manchester
- support to public health leadership on local or national issues
- developing shared services between local public health teams and with the Public Health England Centre in Greater Manchester.

Early discussions are also taking place with the emerging Public Health England on a range of areas where partnership working will deliver better outcomes for local people.

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Nine local authorities in Cheshire and Merseyside have agreed to fund a new public health collaborative service for a two year period from April 2013. Building on the existing ChaMPs public health network, the aim is to offer cost and quality benefits to each local authority and the populations they serve through the aggregation of specified public health functions where it makes sense to do so. The service will have four components:

- reviewing and improving local authority public health commissioning, ensuring quality and best value
- coordinating public health advice to the NHS including clinical commissioning groups and to health and wellbeing boards
- facilitating the sharing of health protection support for local authorities
- enabling and support functions, including facilitating strategic partnerships, communications, behaviour change campaigns and learning and development programmes.

The concept and key functions for the new service were developed following consultation with stakeholders from local authorities and public health teams.

The service will consist of a core team hosted by one of the nine local authorities and a network of public health consultants across Cheshire and Merseyside. The return on investment is estimated at a potential saving of around £8.6 million over a three to five year period.

The service will enable directors of public health to make the most of limited resources over the next two years and will provide the infrastructure, skills and expertise for effective public health leadership to improve and protect the health of local communities. It should also be helpful for engaging with the NHS Commissioning Board and Public Health England at a sub-regional level.

The councils involved are: Cheshire East, Cheshire West & Chester, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington and Wirral.

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### For Information

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**Description**
This resource focuses on transformation and provides information on how Local Authorities and Public Health teams are developing visions for transformation and designing new models for implementation via case studies. It is intended to complement other resources which are focussed on transactional issues such as HR or finance

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