

## Summary of latest guidance on public health transition from the Department of Health

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**Author: Jim McManus, Director of Public Health, Birmingham City Council**

### 1. Background

On 20 December 2011 the Government issued a new tranche of “factsheets” on the new public health system. The documents are all accessible at <http://healthandcare.dh.gov.uk/public-health-system/>. They include:

- letter on reform of public health system
- the new public health system: summary
- public health in local government
- Public Health England’s operating model
- public health transfer of staff from PCTs to local authorities

### 2. Status of documents and statutory guidance

It is not clear what status these documents have and whether they constitute guidance with which local authorities must comply. The Department of Health (DH) call the documents “factsheets”. It is likely that they signal the Government’s intentions and pre-signal the statutory guidance government will issue later in 2012.

### 3. Summary of documents

#### Document 1: Letter on reform of public health system

**Accessible at:** <http://healthandcare.dh.gov.uk/public-health-system/>

A letter from the Chief Medical Officer alerting local government to the publication of the documents. It does not make clear the status of the documents but it essentially summarises the Government’s intentions.

#### Document 2 : The new public health system: summary

**Accessible at:** <http://healthandcare.dh.gov.uk/public-health-system/>

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# Briefing

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Local Government House, Smith Square, London SW1P 3HZ  
Email [info@local.gov.uk](mailto:info@local.gov.uk)  
Tel 020 7664 3000 Fax 020 7664 3030  
Information centre 020 7664 3131 [www.local.gov.uk](http://www.local.gov.uk)

Because of heavy and rising burden of disease, new arrangements for sustainable and affordable public services are needed. The new reforms for public health will do this. The Government has an ambitious programme for public health reform. The key elements are summarised below.

1. Overall goal of new public health outcomes framework will be to increase life expectancy and reduce health inequalities.
2. A new role for local government and transfer of services. Local political leadership will be central to making public health work – this is fleshed out in the series of local government factsheets (brought together into one document entitled *Public Health in Local Government*. See below for further details.
3. Public Health England (PHE) is a new executive Agency of the Department of Health (DH), and will have a number of national specialist roles and roles supporting local areas.
4. The NHS will continue to play a role in providing care; tackling inequalities and making sure clinical contacts are effective.
5. The Chief Medical Officer will continue to advise Government on population health.
6. Within Government, DH will set legal and policy framework for public health.
7. The focus will be on outcomes. A new Public Health Outcomes Framework will set out key indicators of public health from wider determinants to reducing early death. There are separate frameworks for children, public health, adult social care and the NHS. In addition there is also the “life course approach” to health improvement Marmot Framework, which identifies improved outcomes for each stage of people’s lives. The LGA has consistently argued for a single outcomes framework, or failing that an assurance that the frameworks are aligned and allow for maximum local flexibility in determining locally appropriate outcome measures. Several areas are adopting the “life course approach” as an overarching framework.

### **Document 3: Public Health in Local Government**

**Accessible at:** <http://healthandcare.dh.gov.uk/public-health-system/>

This document comprises a series of factsheets with an introductory section on the importance of embedding good health into all council policies and systems. The main issues arising from this are:

- Councils will be responsible for commissioning children and young people’s public health services from 0 – 18 from 2015 onwards.
- Role of Directors of Public Health (DsPH) is defined. They must be specially trained and qualified.
- Councils will not commission abortion services.
- DH will not mandate the child health programme in 2013.

- Further statutory guidance will be published on the role of DsPH, mandated services, health protection planning and health protection incidents.
- Statutory health protection role for DsPH.
- Some greater clarity on health protection but clarity on accountability for managing communicable disease threats is still needed.
- Government will mandate councils to provide population healthcare advice to the NHS.

This is a significant list of services which will have significant resource implications for local authorities. These specific responsibilities will also require: data analysis and information on population health need; population needs analysis; data on outcomes and effectiveness; service review and reconfiguration; applying health economics, programme budgeting, appraising evidence, disinvestment and horizon scanning. It will also include public health advice on medicines management, effectiveness and cost-effectiveness of interventions. This will require suitable skilled and qualified staff.

Professional standards will continue to be important through public health staff having regular appraisals, undertaking revalidation for registration etc.

### **Role of local government as commissioner**

The next factsheet on the new public health functions identifies that local government will take on important roles to commission public health services. The document emphasises the importance of commissioning in line with the *Open Public Services White Paper* and to commission with due regard to most disadvantaged communities. Councils are encouraged to develop diverse provider models and work closely with clinical commissioning groups.

The Secretary of State will have the power to prescribe that councils take certain steps, and have already identified access to sexual health services, health protection plans, the NHS Health Check and the National Child Measurement Programme.

The Government will mandate elements of the age 5-19 healthy Child Programme to councils, but more work is needed by DH to model this and so the Government does not intend to mandate any elements for 2013. This doesn't mean local government shouldn't do so.

### **The role of the Director of Public Health**

Each council must, 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<sup>1</sup>. Guidance on the process of appointing DsPH will be produced in early 2012. This will build on existing Faculty of Public Health Standards. DPH will need to have specialist skills and qualifications under this framework.

The Government intends to amend the Health and Social Care Bill to add DsPH to the list of statutory chief officers in the Local Government and Housing Act 1989.

The Director of Public Health will be responsible for all the new public

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<sup>1</sup> This could be shared with other authorities where that makes sense e.g. the local government management team itself is shared with another.

health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will make it a statutory requirement for the Director of Public Health to produce an annual report, and for the local authority to publish it.

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...He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director.

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.

### **Commissioning Responsibilities**

Only some 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. This means DsPH will need to give expert guidance on priorities locally.

Councils 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
- reducing obesity (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.

On abortion, the document says:

*“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.”*

A consultation on this revised recommendation will begin in due course.

On sexual assault services, the document says:

*“...responsibility for sexual assault services, including Sexual Assault Referral Centres, at least in the short to medium term, should rest with the NHS Commissioning Board.”*

The list of commissioning responsibilities above is not exclusive. Councils may choose to commission a wide variety of services under their health improvement duty.

DsPH will also work with new Police and Crime Commissioners on community safety aspects of public health.

### **Children and local government**

In *Healthy Lives, Healthy People: Update and way forward*, the Government said 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. But the Government’s medium-term aim is now 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.
- Transfer 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.
- Ensure Public Health England retains a close interest in the specification of Child Health Information Systems, to make sure that public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.”

In essence, the Government is signalling the movement over the medium term of all public health commissioning for children into councils.

### **Sexual Health (except Abortion)**

Councils will become responsible for commissioning all confidential contraception and sexually transmitted infections (STIs) testing and treatment services.

These services will be mandated for two reasons:

1. STI testing and treatment services are a central part of protecting health, and high-quality services must be available in all areas.
2. The Secretary of State for Health has a duty, 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**

*(This should be read in conjunction with the Public Health England Operating Model paper).*

Health protection is 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.

The Health and Social Care Bill states that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population. However, the Government wants 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.
- Take a pivotal place in protecting the health of its population.

Councils will therefore be required to take steps to ensure that plans are in place to protect the local population from threats and to prevent, as far as possible, those threats arising in the first place. The scope of this duty will include immunisation and screening, as well as the plans NHS and others have for prevention and control of infection.

The paper summarises how it expects the health protection system to work locally :

- At the Local Resilience Forum (LRF) level, a lead Director of Public Health from a local authority within the LRF area will coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.
- PHE will 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 are a formalisation of existing health subgroups found in the majority of LRF areas.
  - The lead director appointed by the NHS Commissioning Board and the lead DPH will act as co-chairs at the LHRP during emergency planning.
  - There will be further operational guidance for the system-wide emergency preparedness, resilience and response model.
  - DsPH 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.
  - DsPH will play a role in ensuring that immunisation care pathways for programmes are robust. The Board will remain accountable for responding appropriately to that challenge from local public health teams, and for driving improvement.
  - Clinical commissioning groups will have a duty of cooperation with local authorities.

#### **Document 4: Public Health England Operating Model**

**Accessible at:** <http://healthandcare.dh.gov.uk/public-health-system/>

The paper gives some clarification about working models and methods but mostly focuses detail on the internal roles of PHE. There is still a need for a greater clarity on how PHE will work locally. The Government intends to consult on this during 2012 and establish an advisory forum.

PHE will be established as an Executive Agency of the Department of Health with various tasks:

- PHE's overall mission will be to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes.
- PHE will do this in concert with the wider health and social care and public health system, and with key delivery partners including local government, the NHS, and Police and Crime Commissioners, providing expert advice and services and showing national leadership for the public health system.

PHE will work with its partners to provide national level expert evidence and intelligence, and the cost-benefit analysis that will enable local government, the NHS, and the voluntary, community and social enterprise sector to:

- invest effectively in prevention and health promotion so that people can live healthier lives and there is reduced demand on health and social care services, as well as on the criminal justice system
- protect the public by providing a comprehensive range of health protection services
- commission and deliver safe and effective healthcare services and public health programmes across the whole life course and across care pathways
- ensure interventions and services meet the needs of different

groups in society, and reduce inequalities.

PHE will ensure the effective supply and deployment of a qualified and expert workforce and to provide professional support for those working in public health specialisms.

### **Working with local government**

Public Health England will not duplicate the work of councils, but will provide specialist skills, information and services to support councils at a level that would not be practicable to replicate in each local authority. Public Health England will be responsive to local needs.

### **Working with the NHS Commissioning Board**

Public Health England will provide a public health service to the NHS Commissioning Board to support the commissioning and delivery of health and wellbeing services and programmes, providing public health and population healthcare advice. It will work with the NHS Commissioning Board to ensure that the prevention of ill health and promotion of good physical and mental health and wellbeing are addressed systematically across services and care pathways.

This will be subject to further work because there is potential overlap between local government and CCG's roles.

### **Organisational design**

There will be a national office with four sub-national hubs (contiguous with the four NHS Commissioning Board Sectors and DCLG Resilience Hubs) and then local units based on current HPA local unit geographies. There will also be a range of national/diffused networks.

National centres of expertise will be distributed across the sub-national hubs but will be part of the national office framework.

In early 2012 there will be a consultation on how PHE can best prove its responsiveness and expert contribution to localities.

The Secretary of State will remain ultimately accountable for the work of PHE. The Government expects to appoint a PHE Chief Executive in 2012.

Staff from a range of specialist organisations will be brought together to form PHE:

- Health Protection Agency staff to identify and respond to health hazards and emergencies caused by infectious disease, hazardous chemicals, poisons or radiation
- National Treatment Agency for Substance Misuse staff
- Department of Health staff, including public health practitioners
- Public health staff working in strategic health authorities
- The regional and specialist public health observatories
- The cancer registries and the National Cancer Intelligence Network.
- The National End of Life Care Intelligence Network
- NHS Screening Programmes
- The UK National Screening Committee
- The quality assurance reference centres
- Public health staff working in primary care trusts whose functions



- are expected to transfer to Public Health England
- Public health staff working in specialised commissioning groups

This will have important implications for how we ensure effective local co-ordination.

## **Document 5: Transfer of public health staff from PCTs to local authorities**

**Accessible at:** <http://healthandcare.dh.gov.uk/public-health-system/>

This document provides no new information on staff transfer. Guidance is being developed at a national level, which outlines the human resources (HR) processes and expectations on PCTs, councils, NHS and local government trade unions in managing change.

Guidance includes:

- PCT Transition Planning Guidance published in December 2011.
- Local Government Transition Guidance being developed by the LGA supported by NHS Employers published in January 2012.
- PHE people transition policy due early 2012
- DH guidance for DH people going to PHE due in early 2012

Public Health Workforce Strategy is due early 2012. The Public Health concordat was published in late 2011. The principles of the concordat are:

- consult and engage early with employees and their representatives, making sure they are kept fully informed and supported during the change process
- actively promote equality and diversity standards through all transfer, selection and appointment processes
- ensure professional behaviour towards all employees moving between organisations so they are treated with dignity and respect
- work with pace to minimise disruption and uncertainty for employees affected by change
- ensure the consistent treatment of employees at all levels
- ensure that all reasonable steps are taken to avoid redundancies to ensure that valuable skills and experience are retained
- highlight necessary compliance with relevant employment legislation.

The Concordat states that it is the responsibility of all employers involved to ensure that the HR transition principles are applied and adhered to. It also states that transfers of functions will be guided by the legal requirements of the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and/or Cabinet Office Statement of Practice on Staff Transfers in the Public Sector (COSOP) guidance, as appropriate

#### **4. Conclusion**

The factsheets summarised in this briefing note provide a useful summary of current state of play in relation to the new public health system. However, there are several notable areas that will need urgent clarification to ensure that the transition is completed successfully over the coming months, including public health funding.

The LGA has consistently argued that the reforms to public health are potentially a great opportunity for local government to deliver better services for local people in an integrated way. But there are some concerns that this will not be achieved in some areas. On children and young people's health, for example, the separation of public health services for children aged 0 – 5 from those aged 5 - 18 could undermine moves towards greater integration for individuals and families. We welcome the Government's intention to transfer responsibility for children's public health from 0 – 5 to local government after 2015 but seriously question the rationale for the fragmentation in the short-term.

In addition, more work is needed to provide a greater national clarity on some areas, such as health protection. It is likely that good local relationships and plans will help shape this when guidance is issued, but this issue remains one where most stakeholders would acknowledge more work remains to be done.

The LGA is working closely with the Department of Health to provide clarity and support to local authorities and their partners to ensure a smooth transition. We will continue to push for urgent clarity on the funding of public health for local government among other issues, and will seek to ensure that resources are sufficient to meet the new public health responsibilities.