Nottinghamshire County Council

Report to the Policy Committee

14th November 2012

Agenda Item:8

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

A JOINT PUBLIC HEALTH FUNCTION FOR NOTTINGHAMSHIRE COUNTY AND NOTTINGHAM CITY - PROPOSAL FOR IMPLEMENTATION

Purpose of the Report

1. To describe a proposal for implementing a joint public health function across Nottinghamshire County and Nottingham City.

Information and Advice

2. Following the decision by Nottingham City Council not to appoint a Director of Public Health on 3rd October 2012, it has been suggested by both Nottinghamshire County Council and Nottingham City Council that it would be desirable to develop a joint PH function across both organisations in order to make most efficient use of the local PH resource and expertise. This paper is intended to be a proposal as to how this new system could operate in practice.

3. This would enable 3 crucial objectives to be met which are the most important aspects of the PH functions in the County and City over the next year or so:

   - Develop the PH staff into a cohesive force to help drive forward the PH agenda within both local authorities for the benefit of both Nottinghamshire and Nottingham residents. This includes a clear focus on health improvement, health protection and access to high quality health services through the commissioning roles of both the local authorities and Clinical Commissioning Groups. Targeting populations most in need and a focus on reducing health inequalities is fundamental to this approach.

   - Ensure there are robust plans to effectively spend the £30m (county) and £21m (City) PH budgets which will be allocated to the councils from April 2013. (These figures are estimates. Definitive allocations to be announced in December 2012.)

   - Ensure there are strong Health and Wellbeing Boards and Strategies which are based on an assessment of population health need, evidence of effectiveness of interventions and supported by stakeholders and elected members.

4. There are a number of potential **advantages** to a joint PH function:

- Efficient use of PH capacity, doing things just once when this makes sense eg commissioning sexual health services
- Coherent capable PH teams with the ability to have expertise in all relevant areas

- Ability to manage the PH function as a discrete entity but ensure all staff are fully integrated into LA systems

- Breakdown cross border problems as they relate to major PH programmes eg drug misuse

- Public sector cooperation will be seen positively by both politicians and the electorate

- Better contractual levers with providers when commissioning services from them eg alcohol services

- In the vanguard of how to provide a modern 21st Century PH function.

5. However, there are some potential **disadvantages**:

- *Lack of agreement on the model;* there will be no right answer as to how to manage such a new system; the DPH will need to be accountable to both LA Chief Executives to ensure both organisations are happy with the process of implementation as it progresses

- *Too much time taken up by one organisation at the expense of the other;* the DPH will strive to ensure this does not happen

- *Difficult to maintain focus on locality needs where these are different across 2 organisations;* part of the fundamental principle is to target areas of high need whether in the county or city; both organisations have a good track record for this way of working, so there is no reason in principle why this cannot continue

- *Possible impact on the DPH.* Ongoing support required from all colleagues in both councils to ensure the job is doable.

Risks

- Impact of political change in either LA; currently this proposal is not a political issue and the political leaders of both organisations are supportive in principle; the impact of political processes over the coming year (eg election for Police and Crime Commissioner Nov 2012 and county council elections May 2013) remain unknown

- Impact of new substantive CE in the city; likely to be small as there is already clear organisational commitment to the proposal

- CCGs views; currently there is support in principle and the DPH will work hard to ensure the MOU between the LAs and the CCGs is implemented as fully as possible

- Support from Public Health England / Regional DPH; OK in principle but keen to ensure full buy in from both councils.

Options

6. The options are as follows:

    1. Appoint county DPH to the City DPH post and he runs the City PH function as a separate entity, simultaneously running the county PH system. This is not likely to generate any of the benefits outlined above, and is probably not do-able as a job.

    2. Appoint county DPH to the City DPH post, and he fully merges the 2 PH directorates into one managerial entity, jointly accountable to the two local authorities. This would generate many of the benefits outlined above but is likely not to be sufficiently sensitive to the needs of each individual organisation.

    3. Appoint county DPH to the City DPH post but maintain 2 PH directorates. However, the senior PH staff of each organisation would be directly managed by the DPH and would meet together as a virtual team to ensure the most effective deployment of PH resource. Although the staff would be managed centrally, they would functionally integrate into the council systems as necessary to ensure the council benefits from the transfer of PH staff. This is likely to generate many of the benefits outlined above and would sustain sufficient focus on the needs of each organisation.

Proposal for implementation

7. Option 3 would seem a practical way forward. There are no HR implications as each member of staff remains as an employee of whichever organisation employs them as at 1 April 2013. No need for any staff to move from their current base. It is acknowledged that currently the Nottinghamshire County / Nottingham City PCT Cluster is still technically the responsible employing authority and this will continue to be so until the end of March 2013. However these proposals are made in the light of the transfer of PH responsibilities to the local authorities from April 2013.

8. However, there are a few important implications:

    a. Nottinghamshire County needs to understand the needs of Nottingham City and be sensitive to those needs and complexities. The City has significant health needs, and in particular its ethnic and cultural diversity is very different to the county. Also its decision making processes are different eg there is only one local authority and one PCT/CCG; part of one Local Area Team (LAT) of the new NHS Commissioning Board (ie Nottinghamshire and Derbyshire); there are providers on the H+WB Board.

    b. At the same time Nottingham City needs to understand the needs of Nottinghamshire County. The PH function has developed at a different pace over the last year and any combined function with the City needs to ensure this development continues. Also the decision making processes are very different eg one county council, seven district councils, two PCTs, six CCGs,

part of two LATs of the NHS Commissioning Board (Bassetlaw is part of the South Yorkshire and Bassetlaw LAT).

c. The system will only work if the DPH is given full managerial responsibility for the PH staff under his wing (current PH staff within the county, plus PH consultants and their teams within the City), and fully supported by both LA Chief Executives.

Details of Implementation

9. This is considered under the following headings:

1. PH departments
2. Role of DPH
3. PH staff
4. Finance

PH Departments

10. These would remain separate managerial entities as they are at the moment, accountable to the relevant local authority. No merger of the departments is planned as part of this process, although the DPH will be managerially accountable for both. Each department would continue to provide a full PH function to all relevant stakeholders. This includes a focus on health improvement, health protection and commissioning health services. This latter function will continue to be a combination of directly commissioned services by the LA (from April 2013) using the PH ring fenced grant (eg sexual health services, drug and alcohol services, school nursing, health checks, smoking cessation services etc) and also a support function for the Clinical Commissioning Groups. These groups will continue to commission the majority of local health services and be supported by PH staff via a Memorandum of Understanding, which is currently in place but is in the process of being strengthened to be more CCG specific from April 2013. It is anticipated that around 40-50% of PH staff time will be spent on CCG support.

Role of DPH

11. Under this proposal the Nottinghamshire County DPH will be formally appointed as the Nottingham City DPH, and given all the relevant authority which comes with this post. He will be formally accountable to the Nottinghamshire County / Nottingham City PCT Cluster Chief Executive until March 2013, then to the Chief Executives of Nottinghamshire County Council and Nottingham City Council from 1 April 2013. However in practice the 2 LA Chief Executives will oversee this new system with immediate effect, in keeping with other aspects of the PH transition process. The DPH will be a member of the corporate leadership teams of both councils, accountable directly to each chief executive, and will be a member of both Health and Wellbeing Boards. He will also be a member of the Clinical Executive Forum (county) and Professional Executive Committee (City) to ensure the PH support function for CCGs is implemented as planned. He will also be an Executive Director on the PCT Cluster Board until March 2013. Details of how the new role will interface with other health policy or management groups (NHS or

LA) will be determined after discussions with the senior PH staff of both organisations.

Public Health Staff

12. The DPH will directly manage all the senior PH staff, including PH Consultants, Associate Directors of PH and any other staff at Band 8d or above. He will put in place a management structure to ensure all other staff are in a position to be effectively managed to allow maximum empowerment with maximum accountability. There are no plans to mix the managerial arrangements between city and county staff, but in exceptional circumstances it may be appropriate for a County Consultant to manage a City member of staff (or vice versa), although the DPH will only do this after consultation with the LA Chief Executives. The DPH will ensure that each senior PH member of staff has an appropriate balance of health policy responsibilities, and responsibilities to support one of the 7 CCGs. He will also ensure a functional integration with LA structures, so that all senior PH staff work closely with relevant LA staff, particularly in the areas of adult or children's social care, schools, community safety/substance misuse, health protection, emergency planning and environmental health. This balance between being managed separately but functionally integrated is likely to be the best way of ensuring the LA gains most benefit from the knowledge skills and experience of PH staff. This is also likely to be the best way of avoiding duplication between PH and LA staff.

13. In addition the DPH will ensure the senior PH staff meet regularly as a virtual team. This process will coordinate the allocation of work among senior staff to ensure the most efficient and effective deployment of expertise. Currently there is some duplication between senior PH staff between the city and county, and this mechanism will ensure that duplication is minimised.

Finance

14. Each local authority will retain responsibility for the ring-fenced grant funding allocated to it by the Department of Health. The 2 authorities will need to agree the funding proportions for each authority for shared costs and a mechanism for reviewing these arrangements to reflect future changes in any jointly shared activity.

Next Steps

15. Develop appropriate governance arrangements and funding arrangements for shared activity.

16. Develop joint business plan to include greater emphasis on influencing the wider determinants of health

17. Communication plan for all staff

18. Clarify deputy DPH arrangements

19. Issue press release

20. Ensure review of new system at 3 6 and 9 months.

Reason/s for Recommendation/s

21. This paper summarises some of the advantages and disadvantages of a combined PH function across Nottingham City and Nottinghamshire County, and makes a proposal about how this may happen in practice.

Statutory and Policy Implications

22. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) The policy committee is asked to approve the development of a joint public health function across Nottinghamshire County and Nottingham City.

DR CHRIS KENNY
Director for Public Health

For any enquiries about this report please contact:
Dr C Kenny

Constitutional Comments (LMc 05/11/2012)

23. The Policy Committee has responsibility for the discharge of all functions and exercise of all powers of the County Council not expressly reserved to the Full Council or to any other part of the County Council by statute or by the Constitution. The Policy Committee may therefore approve the recommendations in this report.

Financial Comments (RWK 05/11/2012)

24. The financial implications are set out in paragraph 14 of the report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Electoral Division(s) and Member(s) Affected

All.

PC10