SCRUTINY COMMISSION FOR HEALTH ISSUES	Agenda Item No. 7
12 MARCH 2013	Public Report

Report of the Executive Director of Public Health

Contact Officer(s) – Dr Andy Liggins
Contact Details - 207172

TRANSFER OF PUBLIC HEALTH FUNCTIONS FROM PETERBOROUGH PRIMARY CARE TRUST (PPCT) TO PETERBOROUGH CITY COUNCIL (PCC)

1. PURPOSE

1.1 The purpose of this report is to describe the responsibilities and implications of the transfer of certain Public Health functions from Peterborough Primary Care Trust (PPCT) to the Council under the Health & Social Care Act 2012 ("the Act"), with effect from 1st April 2013.

2. RECOMMENDATIONS

2.1 **1.** To note that the Council will become responsible for the delivery of certain public health functions with effect from 1st April 2013, and will acquire statutory responsibilities under the Health & Social Care Act 2012;

2. To determine when the Scrutiny Commission for Health would prefer to receive updates following the transfer of functions.

3. LINKS TO THE SUSTAINABLE COMMUNITY STRATEGY

3.1 The successful delivery of a robust public health function for Peterborough is directly linked to the Creating Opportunities – Tackling Inequalities priority, and indirectly linked to the other priorities.

Public Health will be measured through its ability to deliver the outcomes stated in the Public Health Outcomes Framework (see **Annex 1**), as opposed to the traditional National Indicators. Through the delivery of the various programmes by Public Health, **Annex 2** shows the outcomes that will be targeted.

4. BACKGROUND

4.1 The Health & Social Care Act 2012 (the "Act") set out substantial structural change to the organisation and delivery of health & social care services, including transferring the responsibility for certain public health functions to local authorities.

In support of these new responsibilities, the Council must appoint a Director of Public Health, jointly with the Secretary of State for Health, and in accordance with guidelines set out by the Department of Health, including guidance as to appointment and termination, terms and conditions, and management.

The enhanced role for local authorities includes:

i) leading joint strategic needs assessments to ensure coherent and coordinated commissioning strategies;
ii) ensuring local people's voices are heard, and the exercise of patient choice;
iii) promoting joined up commissioning of local NHS services, social care, and health improvement, and

iv) leading on health improvement and prevention activity.

5. KEY ISSUES

5.1 THE PUBLIC HEALTH RESPONSIBILITIES OF THE LOCAL AUTHORITY

Initially the Council's mechanisms for delivery of public health will be broadly the current responsibilities of the public health team (currently employed by PPCT). However it is widely recognised that the transfer is an opportunity to transform the delivery of public health, addressing the wider social determinants of health through the full range of Council functions and partnerships. An important aspect to improving health will be to pursue closer working and integration of health and social care, to respond to individual needs in a more holistic way.

Directly on commencement the Act transfers certain public health activities to the Council, relating to work within schools. It also transfers the school nursing service, that is, those working in a public health function with school–aged children and their families. This does not include responsibility for the under 5's, which will be the responsibility of the NHS Commissioning Board until 2015, when the Secretary of State has indicated that it will transfer to local authorities.

Department of Health policy documents make it clear that the provision of the additional public health services will become the responsibility of the local authority with effect from 1st April 2013, including:

- Providing appropriate access to sexual health services;
- Ensuring there are plans in place to protect the health of the population, including immunisation and screening;
- Ensuring NHS commissioners receive public health advice on matters such as health needs assessments for particular conditions or disease groups, evaluating evidence to support the clinical prioritisation for populations and individuals and new drugs and technologies in development – this advice has become known as the "core offer" from public health to Clinical Commissioning Groups; and
- The NHS Health Check programme for people between 40 and 74;
- The National Child Measurement Programme (NCMP).

The Act also places a duty on local authorities to take on the duties of the NHS for appointing medical examiners and related activities including funding and monitoring the work of medical examiners. These duties were created by the Coroners and Justice Act 2009, but are unlikely to be in force until at least April 2014. When these responsibilities come into force, they will be the responsibility of the local authority, and funded from the ring fenced public health grant.

The Director of Public Health and his team will be working closely with the CCG to agree a memorandum of understanding about the level of support and working arrangements.

The Council will receive a Public Health Grant (see Financial implications, section 9.1) from which it will be responsible for commissioning a range of services. Some services will be mandatory, and for those which are not, commissioning decisions will reflect the Joint Strategic Needs Assessment and Health & Wellbeing Strategy.

TRANSFER OF CONTRACTS TO THE COUNCIL

A range of contracts are currently held by PPCT and the NHS, which relate to the funding that will make up the Public Health Grant. Those contracts which will not expire by 31st March 2013 will need to transfer to the Council on 1st April 2013. A considerable amount of work has been undertaken with the PCT, the NHS, and within the Council, to identify the relevant contracts, and liaise with suppliers with a view to either novating transferring contracts to the Council, or entering into new contracts with effect from 1st April 2013. The majority of smaller contracts will be novated and in some cases, extended for a further period of time (not exceeding one year) to give the Council sufficient time to consider the value for money provided by the existing

provider, and consider whether it might be beneficial to re-commission the contracts.

A significant proportion of public health services are commissioned through three large provider contracts, as follows:

- Peterborough Primary Care Trust (PPCT) as Coordinating Commissioner and Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT) Agreement.
    - Under the terms of this contract GUM (genito-urinary medicine) services are commissioned from PSHFT. It was entered into by the Coordinating Commissioner PPCT on behalf of itself and its Associates, (Cambridgeshire PCT and Norfolk PCT). The contract is in practice renewed annually, and is due to expire on 31st March 2013, although historically it has been "rolled over" for many years. In practical terms, the amount of time available for the parties to extricate themselves from this arrangements, and make alternative provision, without there being a gap in service provision, make it attractive to both parties to extend the contract for a further year, and discussions are currently taking place with PPCT to agree terms.

- Peterborough Primary Care Trust (PPCT) as Coordinating Commissioner and Cambridgeshire Community Services NHS Trust (CCS)
    - The public health services provided under this contract which will pass to the Council include dietetics and obesity weight management and contraceptive and sexual health services,
    - The background to this contract is similar to that of the agreement set out above and for the same reasons it is prudent to extend this contract for a further year. Again, discussions are currently taking place with PPCT to agree terms.

- Cambridgeshire Primary Care Trust as Coordinating Commissioner (CPCT) and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Agreement
    - The public health services provided under the contract which will pass to the Council include school nursing services, alcohol services and the provision of a dedicated detoxification bed. The Coordinating Commissioner also acts on behalf of itself and its Associates, which includes Peterborough PCT. Discussions are currently ongoing regarding the recommissioning of these services for a further year for the same reasons as above.

STRUCTURE & TRANSFER OF STAFF

Under the Act, the Director of Public Health (who must be an appropriately qualified and accredited public health specialist) must be a statutory chief officer of the authority and the principal adviser on all health matters to elected members and officers. Direct accountability is expected to the Chief Executive, and the person appointed must have direct access to elected members. The Director of Public Health (currently employed by the NHS) is already a member of the Council's Corporate Management Team (CMT) and this will continue.

Under the national provisions for transfer of staff, the Director of Public Health currently employed by the NHS would transfer under TUPE conditions to the Council. However, the current Director of Public Health, Dr Andy Liggins, has decided to leave his role to pursue other personal and professional interests, and will leave before 1st April 2013. The Council is under a statutory responsibility to appoint an officer as Director of Public Health, and the Chief Executive will need to take steps to ensure a temporary appointment initially, with effect from 1st April 2013, followed by a permanent appointment as soon as practicable.

The Director of Public Health will have a team of staff to deliver the Council's responsibilities. There are national provisions in place relating to the transfer of staff as a result of the transfer of

public health responsibilities, and the majority of staff currently employed by PPCT in the public health team will therefore transfer across to the Council on their existing terms and conditions including the retention of an NHS pension scheme as directed under the guidelines issued. The staff will have the same service responsibilities on transfer, although working with the team, some changes may be made to maximise efficiencies and to take the opportunity to transform public health, although the primary focus immediately upon transfer will be to ensure continuity of service and outcomes.

The majority of the current public health team will transfer to the Council with effect from 1st April 2013, and have already relocated to Bayard Place (in October 2012) to work more closely with the Neighbourhood Teams. **Annex 3** shows the current Public Health organisation chart.

6. IMPLICATIONS

6.1 Financial

The Council will receive a public health grant which it is intended should enable it to fulfil its public health responsibilities. The grant is allocated by the Department for Health using a formula developed specifically for this purpose. For 2013/14 the sum will be £8,446,100 and this will increase to £9,290,700 for 2014/15. It is currently expected that this grant will be sufficient to meet the costs of the service. As some elements of the service are demand led, the service will need the same rigorous financial monitoring applied to it as for all other council services. Quarterly reporting to the Department of Health on the usage of the grant is mandated and the local authority Chief Executive will also need to return a statement confirming that the grant has been used in line with the specified conditions.

The Council will also consider how it can take best take advantage of the benefits of closer working with neighbourhoods and improved joint commissioning to see where efficiencies can be made. Although the grant is ring fenced, some of the Council's current activities fall within its new responsibilities and the broader approach to public health, and savings can be reinvested to help improve outcomes. The financial implications of the transition itself were covered by a Cabinet Member Decision Notice (Public Health Transition - DEC12/CMDN/159)

Legal

The Council has a statutory obligation to accept the transfer of responsibility for public health, and to accept the transfer of public health staff from PPCT. The legal obligations, including those relating to existing contracts, are set out in the body of the report. It should further be noted that s12 of the Health and Social Care Act 2012 amends s2 of the National Health Service Act 2006 and imposes a new duty under s2B as follows:

"Each local authority must take such steps as it considers appropriate for improving the health of the people in its area".

Human resources

The current public health staff employed by PPCT will transfer to the Council on 1st April 2013 under the Transfer of Undertakings (Protection of Employment) Regulations 2006, and under additional transfer guidance developed by the National Concordat Steering group (a group including the Local Government Organisation, Department of Health, NHS Employers and trade unions). The Council, as receiving organisation for the staff, is obliged to act in accordance with this national guidance.

Property

The Public Health team have already moved to the 4th floor of Bayard Place. Their previous location, on the 2nd floor of the Town Hall, has therefore been vacated and the plan is for that space to be used by additional members of Adult Social Care who are looking to consolidate the number of premises used by its staff.

Risk management
The transfer is being tightly project managed to minimise the risks of the transfer of public health responsibilities to the Council. Risks associated with the transfer will continue to be reviewed by CMT on a regular basis. The risks are shared with all upper tier Councils taking on public health responsibilities, and there is national support and guidance available to minimise risks, especially from the Local Government Association.

Equality
PPCT, in conjunction with the Council, have carried out a full Equality Impact Assessment on the transition of the Public Health service into the local authority, and no negative impacts were identified.

The transfer of public health functions will provide the Council greater opportunities to work with all residents to improve their quality of life and improve outcomes for all groups, particularly those who are in some way disadvantaged. There will be opportunities to consider how the Council's current core services are delivered, and whether they can be delivered differently to improve the impact on public health outcomes. Integration of services between health and the local authority is a driving theme of the Act, and equality should be addressed by the better integration of services meeting residents' needs in a more holistic way. It is intended that the transfer of public health functions to local authorities will enable them to reduce inequalities in health and wellbeing.

Crime & Disorder Act s17
This Act requires the Council to have regard to the prevention and reduction of crime and disorder in all its strategic planning and operational delivery. The duty will extend to the delivery of the public health function. The Council is also required under the Crime and Disorder Act to work specifically to reduce the harm to the community caused by drugs and alcohol, and this will be integrated with the work of the public health team in this area.

7. CONSULTATION

7.1 There has been close consultation with PPCT, and in particular with the Director of Public Health, and his team. Wider public consultation has not been necessary, because this is a national initiative, with which the Council has no choice but to comply, and in accordance with quite strict guidelines.

The affected staff are being consulted in accordance with the Council and PPCT's respective obligations in respect of the staff transfer, as have the appropriate Trades Unions.

8. NEXT STEPS

8.1 The next step is for the responsibility for public health, and the staff currently employed by PPCT in the public health team, to transfer to the Council with effect from 1st April 2013, and from that time the Council will work to integrate public health into its current core functions, and maximise the opportunity to improve the public health outcomes for the people of Peterborough

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985

9.1 Local Government association: Get in on the Act – Health & Social Care Act 2012

Department of Health Publications and Guidance, including Healthy Lives, healthy People: Update & Way Forward (July 2011),Transitional Working Arrangements (DH/LGA June 2012), Healthy Lives, Healthy People – Update on Public Health Funding (June 2012)

10. APPENDICES

10.1 Annex 1: Public Health Outcomes Framework
Annex 2: Local Authority Public Health Functions
Annex 3: Public Health Organisation Structure

Annex 1: Public Health Outcomes Framework

<table>
<tr><td colspan="2">Vision</td></tr>
<tr><td colspan="2">To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.

Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).</td></tr>
<tr><td>1 Improving the wider determinants of health</td><td>2 Health improvement</td></tr>
<tr><td>Objective
Improvements against wider factors that affect health and wellbeing and health inequalities</td><td>Objective
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities</td></tr>
<tr><td>Indicators
Children in poverty
School readiness
Pupil absence
First time entrants to the youth justice system
16-18 year olds not in education, employment or training
People with mental illness or disability in settled accommodation
People in prison who have a mental illness or significant mental illness
Employment for those with a long-term health condition including those with a learning difficulty/disability or mental illness
Sickness absence rate
Killed or seriously injured casualties on England's roads
Domestic abuse
Violent crime (including sexual violence)
Re-offending
The percentage of the population affected by noise
Statutory homelessness
Utilisation of green space for exercise/ health reasons
Fuel poverty
Social connectedness
Older people's perception of community safety</td><td>Indicators
Low birth weight of term babies
Breastfeeding
Smoking status at time of delivery
Under 18 conceptions
Child development at 2-2.5 years
Excess weight in 4-5 and 10-11 year olds
Hospital admissions caused by unintentional and deliberate injuries in under 18s
Emotional wellbeing of looked-after children
Smoking prevalence – 15 year olds
Hospital admissions as a result of self-harm
Diet
Excess weight in adults
Proportion of physically active and inactive adults
Smoking prevalence – adult (over 18s)
Successful completion of drug treatment
People entering prison with substance dependence issues who are previously not known to community treatment
Recorded diabetes
Alcohol-related admissions to hospital
Cancer diagnosed at stage 1 and 2
Cancer screening coverage
Access to non-cancer screening programmes
Take up of the NHS Health Check Programme – by those eligible
Self-reported wellbeing
Falls and injuries in the over 65s</td></tr>
<tr><td>3 Health protection</td><td>4 Healthcare Public Health and preventing premature mortality</td></tr>
<tr><td>Objective
The population's health is protected from major incidents and other threats, while reducing health inequalities</td><td>Objective
Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities</td></tr>
<tr><td>Indicators
Air pollution
Chlamydia diagnoses (15-24 year olds)
Population vaccination coverage
People presenting with HIV at a late stage of infection
Treatment completion for tuberculosis
Public sector organisations with board-approved sustainable development management plans
Comprehensive, agreed inter-agency plans for responding to Public Health incidents</td><td>Indicators
Infant mortality
Tooth decay in children aged five
Mortality from causes considered preventable
Mortality from all cardiovascular diseases (including heart disease and stroke)
Mortality from cancer
Mortality from liver disease
Mortality from respiratory diseases
Mortality from communicable diseases (Placeholder)
Excess under 75 mortality in adults with serious mental illness
Suicide
Emergency readmissions within 30 days of discharge from hospital
Preventable sight loss
Health-related quality of life for older people
Hip fractures in over 65s
Excess winter deaths
Dementia and its impacts</td></tr>
</table>

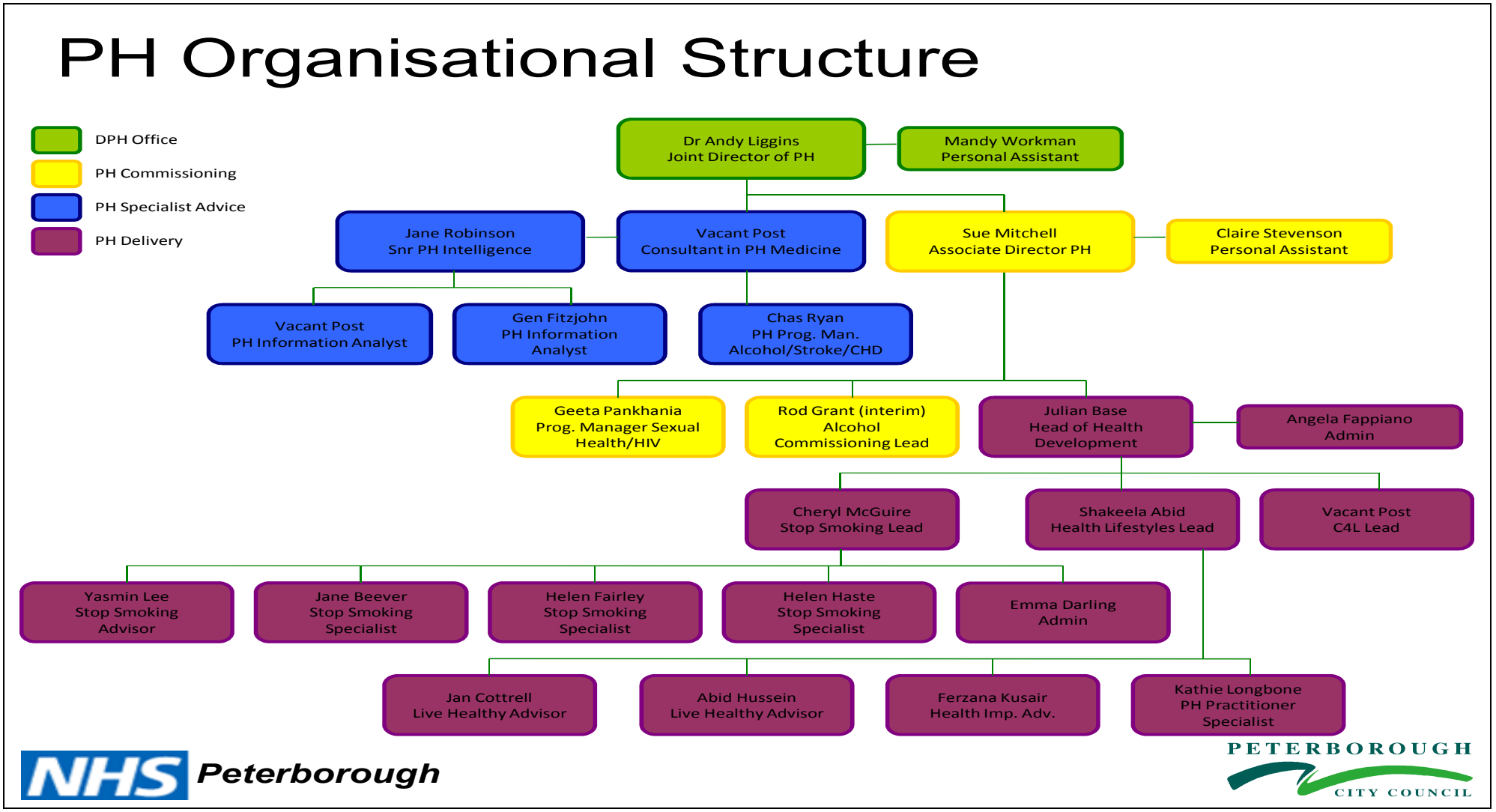
Annex 2: Local Authority Public Health Functions

Ref.	LA PH Functions	PH Outcomes	Programmes/Interventions Group	Delivery (Directorate)
PH001	Tobacco Control & Smoking Cessation	2.9 Smoking prevalence - 15 year olds 2.14 Smoking prevalence - Adults (over 18)	Stop Smoking Service	PH
			Pharmacy & GP LIS	OPS
			Illicit Sales Prevention	PH
PH002	Alcohol Misuse	2.18 Alcohol related admissions to hospital	Reducing Alcohol related admissions to hospital	OPS
PH002a	Drug Misuse	2.15 Successful completion of drug treatment	Young Peoples Drug & Alcohol	PH
			Adult Drug Treatment Service	PH
PH003	PH Services for CYP (5-19)	2.06i Excess weight in 4-5 year olds 2.06ii Excess weight in 10-11 year olds 4.2 Tooth decay in children aged 5	5-19 Healthy Child Programme	Childrens
PH004	NCMP	2.06i Excess weight in 4-5 year olds 2.06ii Excess weight in 10-11 year olds	National Childhood Measurement Programme	PH
				OPS
PH005	Tackling Obesity	2.06i Excess weight in 4-5 year olds 2.06ii Excess weight in 10-11 year olds	Reducing Childhood Obesity: Change 4 life Alliance leadership; Carnegie Weight Management Programme; Movers & Shakers follow-on programme; Early Years nutritional standards training and implementation	OPS
				PH
		2.11 Excess weight in adults 2.13 Proportion of physically active adults 1.16 Utilisation of Green Space for health & exercise	Reducing Adult Obesity & Increasing Physical Activity: inc. Lets Get Moving and Lets Keep Moving Activity Programmes and GP Exercise Referral Scheme; physical activity programmes for older people	OPS
				PH

PH006	Nutrition Initiatives	2.06i Excess weight in 4-5 year olds 2.06ii Excess weight in 10-11 year olds 4.2 Tooth decay in children aged 5	Eat Better, Start Better - training for EYFS Nutrition standards to Children Centres	OPS
PH007	Physical Activity	2.11 Excess weight in adults 2.13 Proportion of physically active adults 1.16 Utilisation of Green Space for health & exercise	Reducing Adult Obesity & Increasing Physical Activity	PH OPS
PH008	NHS Health Checks	2.22 Take up of NJS Health Check Programme 4.4 Mortality from cardiovascular disease under 75s (rate per 100000)	Delivering NHS Health Checks Programme	PH
PH009	PH Mental Health Services (inc. Promotion)	4.10 Suicide Rate (per 100k of pop.) 1.15i Statutory homelessness - acceptances 1.15ii Statutory homelessness - households in temp accommodation	Mental Health Suicide Prevention Suicide Prevention Homelessness Prevention	OPS OPS OPS
PH010	PH Dental Promotion	4.2 Tooth decay in children aged 5		
PH011	Accidental Injury Prevention	2.24 Injury due to falls in people (all indicators)	Care & Repair	OPS
PH012	Reduce & Prevent Birth Defects	2.1 Low birth weight of term babies 2.1i Breastfeeding initiation 2.2i Breastfeeding prevalence at 6-8 weeks 2.3 Smoking status at time of delivery 4.1 Infant mortality rate (per 1000)	Improving the health of pregnant women and infants, reducing infant mortality: Baby Cafes; peer supporters programme	PH Childrens
PH013	Lifestyle Campaigns/Interventions that include Cancer & Long Term Conditions	1.20 Social Connectedness 2.14 Smoking Prevelence 2.11 Diet 2.23 Self reporting wellbeing	Accredited PH/HPTraining Centre delivering to health and care professionals, other public sector and voluntary and community sector Improving Community Health Through Volunteering (Community Health Champions)	PH OPS PH OPS
PH014	Workplace Health	1.9 Sickness absence rates 4.5 Mortality from cancer under 75s (rate per 100000)	Workplace health programme: health improvement interventions delivered for local business	PH OPS
PH015	Screening & Immunisation and Infectious Disease	2.19 Cancer diagnosed at stage 1 and 2 2.20i Breast screening coverage (age 50-70) 2.20ii Cervical screening coverage (age 25-64) 3.3 Population vaccination coverage	Scrutiny and challenge role	PHE

				PH
			ISVAs	PH
		1.12 Rates of violent crime (inc. sexual violence)	Integrated Offender Management	OPS
		2.4 Under 18s conception (per 1000)	Reducing under 18 conception rate	PH
		3.2 Chlamydia diagnosis 15-24 year olds (rate per 1000)	Reducing chlamydia infection in 15-24 year olds	PH
			Improving sexual health (prevention, treatment and care)	PH
			Prescribing costs (primary care)	PH
PH016	Sexual Health Services/Commissioning	3.4 People presenting with HIV at a late stage of infection	HIV Prevention	PH
PH017	Reduction in Excess Deaths through Seasonal Mortality	4.03 Mortality from causes considered preventable	Seasonal Campaigns	OPS
PH018	Health Protection	3.6 Public sector orgs with board approved management plan 3.7 Comprehensive agreed interagency plans for responding to public health	Emergency preparedness & business continuity	PH
			DV Outreach Service	OPS
PH019	Promotion of Community Safety, Violence Prevention and Emergencies	1.11 Domestic Abuse	Reducing the impact of Domestic Abuse	OPS
				PH
		1.4 First time entrants in youth justice system by 18 years old 1.5 16-18 year olds NEET	Development & delivery of healthy lifestyle interventions for young people	OPS
			Neighbourhood Management	OPS
		1.20 Social Connectedness 2.14 Smoking Prevelence 2.11 Diet	Social Connectedness	OPS
PH020	Social Inclusion & Community Development	2.23 Self reporting wellbeing	NACRO	OPS
PH021	Environmental Risks	1.14i % of population affected by noise (no. of complaints)	Air Polution	OPS
PH022	PH Advice	-	PH Network	PH

Annex 3: Public Health Organisation Chart



This page is intentionally left blank