Dudley
Metropolitan Borough Council

Agenda Item No. 4

Special Meeting of the Health and Adult Social Care Scrutiny Committee

5th April 2012

Report of the Lead Officer to the Committee

Call-in of Decisions of the Cabinet Regarding the Health and Social Care Bill and its Implications for Dudley MBC

Purpose of Report

1. To consider and respond to the call-in of the decisions of the Cabinet on proposed changes to the National Health Service (NHS) and Public Health systems set out in the 'Equity and Excellence' White Paper and the implications for Dudley MBC. A copy of the report submitted to Cabinet is attached as Appendix 1.

Background

2. At its meeting held on 14th March, 2012 Cabinet approved the recommendations as set out in Appendix 1 of this report.

3. The decision has subsequently been called-in for scrutiny by the Chairman of the Health and Adult Social Care Scrutiny Committee in accordance with Paragraph 15 of the Scrutiny Committee Procedure Rules.

4. A list of questions submitted under paragraph 15 of the Scrutiny Committee Procedure Rules are attached as Appendix 2 to this report. Responses to those questions are attached as Appendix 3 to this report.

5. The Leader, Cabinet Member for Adult, Community Services, Chief Executive and the Director of Adult, Community and Housing Services have been invited to attend the meeting to address the meeting and to respond to questions from the Committee.

Finance

6. The financial implications are as contained in the report of the Chief Executive attached as Appendix 1 to this report.

Law

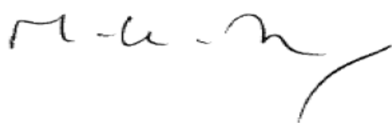
7. The legal implications relating to the provisions under the proposed Health and Social Care Bill are as set out in the report of the Chief Executive, attached as Appendix 1 to this report. The provisions regarding the call-in of decisions are contained in the Council's Constitution under the Scrutiny Committee Procedure Rules. The Constitution was adopted by the Council under Part II of the Local Government Act, 2000.

Equality Impact

8. The equality impact is as contained in the report of the Chief Executive, attached as Appendix 1 to this report.

Recommendation

9. That the Committee consider the decisions of the Cabinet as set out in the report attached as Appendix 1 on proposed changes to the National Health Service (NHS) and Public Health systems set out in the 'Equity and Excellence' White Paper and the implications for Dudley MBC and determine the course of action it proposes to take, if any.



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Mohammed Farooq
Assistant Director of Corporate Resources (Law and Governance)

LEAD OFFICER TO THE HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

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Background documents used in the preparation of this report:-

1. Report to Cabinet – The Health and Social Care Bill and its Implications for Dudley MBC – 14th March 2012

2. The Council's Constitution

APPENDIX 1

Dudley
Metropolitan Borough Council

Meeting of the Cabinet – 14th March 2012

Report of Chief Executive

The Health and Social Care Bill and its Implications for Dudley MBC

Purpose of Report

1. To update the Cabinet on proposed changes to the NHS and Public Health systems set out in the 'Equity and Excellence' White Paper and the implications of these for Dudley MBC.

Background

2. *Equity and Excellence: Liberating the NHS*, the Coalition Government's White Paper, was published on 12 July 2010. It states three key principles:

   - patients at the centre of the NHS
   - changing the emphasis to clinical outcomes
   - empowering health professionals, in particular GPs.

3. The proposals in the paper are being taken through to primary legislation via the Health and Social Care Bill (the Bill), currently before Parliament.

4. Currently, apart from specialised services, the majority of healthcare services, including primary care services, are commissioned by the local Primary Care Trust. Primary Care Trusts also lead on local public health and health improvement services.

5. By April 2013 it is proposed establishing an Independent NHS Commissioning Board, Clinical Commissioning Groups (CCGs) and new Local Authority Health and Wellbeing Boards, as well as developing Monitor as an economic regulator. The new commissioning system is expected to be in place by April 2013 by which time Strategic Health Authorities and Primary Care Trusts along with the Health Protection Agency, General Social Care Council and National Treatment Agency for Substance Misuse will be abolished. Their responsibilities will be transferred to other bodies, including:

   - Clinical Commissioning Groups
   - NHS Commissioning Board

- National Public Health England (with a local Director of Public Health (DPH) jointly appointed with the Local Authority with a ring-fenced 'Public Health budget')
- Local Authorities with new responsibilities for population health and health improvement
- HealthWatch England and local HealthWatch

6. Abolishing 10 Strategic Health Authorities and 150 Primary Care Trusts by 2013 is expected by the Government to achieve a targeted reduction of 45% in management costs from NHS services. These will be replaced by about 500 GP consortia who will control about £70bn currently used by PCTs to commission local health services.

7. Specialised services and others that benefit from national commissioning will be within the remit of the NHS Commissioning Board.

8. All NHS Trusts will become Foundation Trusts (FT).

9. Any willing provider that can meet safety and quality standards will be able to provide NHS services.

10. It has been proposed that Monitor will become an economic regulator across the health sector, not just Foundation Trusts, responsible for registering organisations and holding expanded powers similar to other regulatory bodies such as OFWAT. The Care Quality Commission will continue as the quality regulator as well as hosting National HealthWatch.

11. Under the new system, while the Department of Health (DH) will remain responsible for the health and care legislative framework, and Ministers will continue to be ultimately accountable, most day-to-day operational management in the NHS will take place at arm's length from the Department. With the exception of the remaining Special Health Authorities, all organisations in the NHS will have their own statutory functions conferred by legislation, rather than delegated to them by the Secretary of State.

12. While adult social care, the NHS and public health are funded and structured differently, and have different mechanisms for accountability, in future, they will all be covered by a consistent set of outcomes frameworks. Collectively these will be used to hold the DH to account for the results the DH is achieving with its resources, working with and through the health services and social care delivery system.

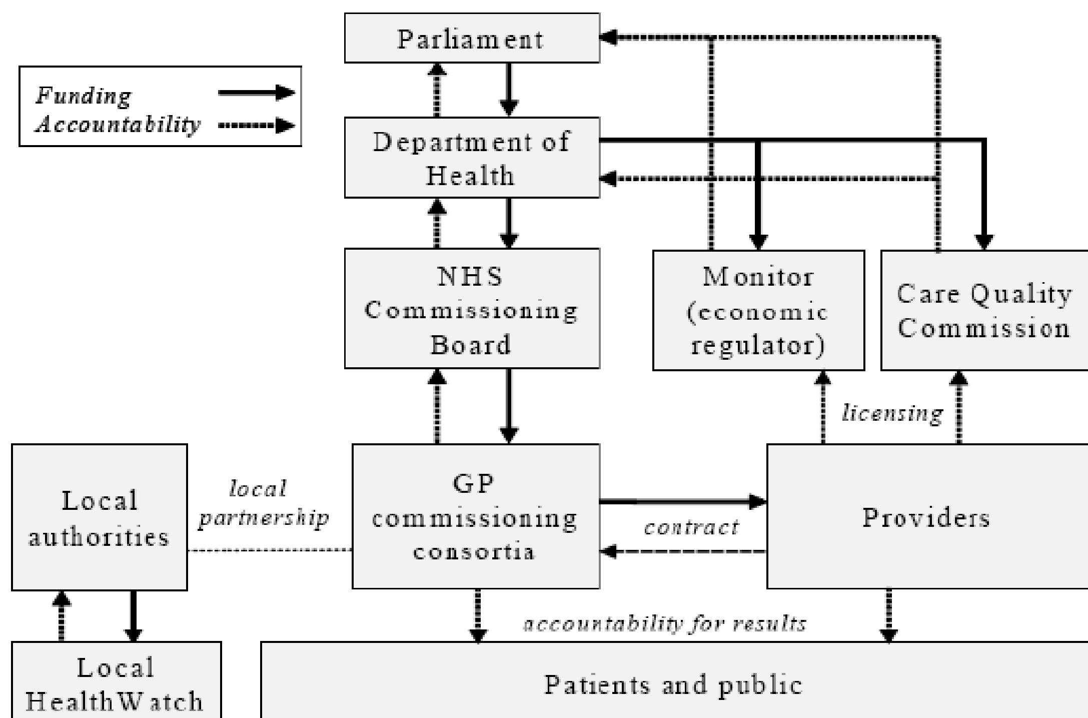
13. The proposals and the Bill include a significant role for Local Government. PCTs' public health function will pass to Councils. Local Directors of Public Health will be Chief Adviser on health matters to the Local Authority. A ring-fenced public health budget is being created and will be allocated (ultimately on a formula). Directors of Public Health will have statutory responsibilities in respect of the Public Health

Service. A number of services currently provided by the PCT are to be transferred to Public Health England.

14. Local Authorities will take the lead for improving health; coordinating efforts to protect the public's health and wellbeing; and ensuring that health services effectively promote population health.

15. The Bill makes clear that the Director of Public Health is responsible for exercising the Local Authority's new public health functions (statutory guidance will be issued). Recent DH guidance has indicated *the 'legal responsibilities should translate into the Director of Public Health acting as the lead officer for health and championing health across the whole of the Authority's business'*. Councils will take on the function of promoting partnership and joint working of local NHS services, social care provision and health improvement. This includes leading on the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy; promoting collaboration on local commissioning plans; and supporting joint commissioning arrangements where appropriate. This will build on previous Local Strategic Partnership's work via a statutory "Health and Wellbeing Board". The Board will include elected members, NHS commissioners, public health, adult social services, children's services, urban environment and the local HealthWatch.

16. The new Governance Structure for the NHS is:



17. The changes set out in the NHS and Social Care Bill are very wide ranging and their extensive nature means that this represents what is probably the biggest reorganisation of NHS functions in half a century.

Implications for the Council

Public Health Transition

18. Work on the transition of the Public Health service in Dudley has commenced. A wider Public Health Transition Group with representation from the Council and relevant stakeholders is arranged. As previously stated Public Health England is being established which will also provide Public Health activity including the provision of national data on health issues and co-ordination at a national level of some activities. Through these local and national arrangements we are working to transform services to help improve the health of the public in Dudley so that we can work effetively with partners to improve health and address any inequalities.

19. Ensuring appropriate fit for purpose Public Health services in the context of the Council's structure and plans, makes it important that the services support the direct commissioning and delivery of our frontline services. My recommendation to Cabinet is that Public Health should be situated within the Directorate of Adult, Community and Housing Services but with strong linkages to other Council services to ensure that we have a clear corporate focus on Public Health issues. For example, this would include co-location of appropriate staff where joint working is essential.

20. As Cabinet is aware, the four Black Country authorities have developed an agenda for shared services and collaboration. In this context we are having discussions with Sandwell about the viability of having a joint appointment for the role of Director of Public Health. Clearly time is of the essence in reaching a conclusion on this proposition and, in view of the fact that we do not have another scheduled meeting of the Cabinet for three months, I am recommending that Cabinet authorise me, in consultation with the Leader, Councillor David Vickers and Councillor David Sparks, to determine whether we should have a joint or single appointment and then make the necessary arrangements through the Appointments Committee.

Dudley Clinical Commissioning Group

21. The Dudley Clinical Commissioning Group was formed at a very early stage in this process and has made very encouraging progress which has been recognised with a national award. The CCG is chaired by Dr David Heggarty and a number of appointments have been made including Ms Kimara Sharp as the Interim Senior Officer.

22. The CCG engages with the Council through its membership of the Shadow Health and Wellbeing Board and other relevant work groups and relationships are well developed. In addition I have been a member of the CCG Board for the last 9 months.

Black Country Primary Care Trust Cluster

23. As part of the ongoing transition of NHS Services to new arrangements, the powers and duties of the local NHS Dudley have been taken on through the Black Country PCT Cluster with Dr Steve Cartwright working as Managing Director for Dudley.

National plans for the development of a local office for the National Commissioning Board (which will commission the primary care services provided through GPs) are in hand.

Shadow Health and Wellbeing Board

24. The Council has appointed a Shadow Health and Wellbeing Board for the current municipal year. The purpose of the Board is to improve the integration of care and health services through the commissioning and delivery of services in order to improve the health of Dudley people. The Board has met three times in public session and also undertaken Board development sessions. The Board has made good progress in setting the scene for its final year in shadow form and will continue to develop its agenda in readiness for implementation of the Health and Social Care Bill.

Healthwatch

25. Healthwatch will be a new organisation locally but it will carry forward many of the functions currently undertaken by the Dudley Local Involvement Network. Healthwatch will have three main functions:-

- Influence local health and social care
- Inform and signpost local people on local services
- Advice and advocacy

26. The Council has the lead on procuring the organisation but is working with partners through a reference group to oversee its implementation under the auspices of the Shadow Health and Wellbeing Board. Healthwatch will, however, be independent of the Council and NHS agencies. A Healthwatch representative will be a member of the formal Health and Wellbeing Board after April 2013 to help strengthen the voice of people using care and health services.

Summary

27. The Health agenda is clearly complex and dynamic. The Health and Social Care Bill will continue to be amended during its passage through Parliament and at this stage it is difficult to predict with any certainty what the legislation will ultimately contain.

28. However, given these uncertainties, we must continue with our preparations at a local level, particularly with regard to Public Health, but during the course of 2012/13 there will be further update reports to Cabinet in addition to the work that will be undertaken by the Shadow Health and Wellbeing Board and the Health and Adult Social Care Scrutiny Committee.

Finance

29. From 2013/14 onwards, Dudley MBC will receive a ring-fenced grant from Public Health England to support the public health function transferring from the NHS.

Law

30. This report refers to the provisions under the proposed Health and Social Care Bill currently before Parliament. The Bill continues to be subject to a large number of amendments, some of which are proposed but not yet agreed/finalised. Many of the items referred to in this report will be the subject of further Regulations.

Equality Impact

31. The Department of Health has completed an Equality Impact Assessment in relation to these changes. This is available at the DH website:

    http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

    The Health and Social Care Bill places new duties to reduce health inequalities on the Council, the Secretary of State for Health and Clinical Commissioning Groups.

Recommendation

32. It is recommended that Cabinet:-

    (1) Note this report
    (2) Agree that Public Health should be located within the Directorate of Adult Community and Housing Services and note the arrangements for ensuring that Public Health Services are delivered on a Corporate basis.
    (3) Authorise the Chief Executive, in consultation with the Leader, Cabinet Member of Adult and Community Services and the Leader of the Opposition Group, to determine whether there should be a joint or single appointment of the Director of Public Health and then make appropriate arrangements for the appointment through the Appointments Committee.

John Polychronakis

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JOHN POLYCHRONAKIS
CHIEF EXECUTIVE

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List of Background Papers

DH (July 2010) Equity and Excellence. Liberating the NHS. White Paper.
DH (January 2012) Accounting Officer System Statement.
DH (January 2012) JSNAs and Joint Health and Wellbeing Strategies- Draft Guidance
DH (January 2012) NHS CB Operating Framework
DH (January 2012) Public Health in Local Government Fact Sheets

APPENDIX 2

QUESTIONS FOR HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE REGARDING CALL-IN OF DECISION OF CABINET

Comment of the Chairman of the Health and Adult Social Care Scrutiny Committee:-

I am fully aware that reforming our health services is ongoing and appears to be subject to daily change, however, I believe that the Scrutiny Committee have a duty to look at these decisions for change and to understand the implications and risks that are involved so that the citizens of our Borough are assured of the best service possible.

Questions relating to the placing of public health within the Directorate of Adult, Community and Housing Services.

Question 1 – What are the advantages of this when Public Health has such wide-ranging implications for all aspects of the Authority's work?

Question 2 – Should not the Public Health have a degree of independence to Directorates to make improvements for the benefit of the health of our communities?

Question 3 – What views were taken into account in deciding this was the best model for Dudley?

Question 4 – I understand that the present staffing numbers, some 80 employees, what will the numbers be under the new arrangements?

Questions relating to the Appointment of the Director of Public Health

Question 5 – What are the implications of a joint or single appointment?

Question 6 – Are there any risks associated with a dual or single appointment?

Question 7 – What benefits would either appointment bring?

Other Questions

Question 8 – What are the views of the Health and Wellbeing Board?

Question 9 – Have the following partners had input in this decision: Chair of Black Country Cluster, Chair of the GP Commissioning Board and the Regional Director of Public Health.

Question 10 – What are the financial implications for the decisions as there is a considerable budget that will accompany the movement of Public Health.

APPENDIX 3

DUDLEY METROPOLITAN BOROUGH COUNCIL

SCRUTINY COMMITTEE FOR HEALTH AND ADULT SOCIAL CARE

"CALL-IN" RE Report of the Chief Executive to the Meeting of the Cabinet – 14th March 2012 on The Health and Social Care Bill and its Implications for Dudley MBC

5th April 2012

BACKGROUND AND INTRODUCTION

1. At the meeting of the Cabinet on the 14th March 2012 I made it clear that, as Chief Executive, I welcomed the repatriation of Public Health to local government because Public Health lay at the heart of modern local government from the 19th century until 1974. Our aim is to provide the best Public Health Services possible.

2. The Government's NHS reforms were initiated in July 2010 through the Department of Health's overall NHS White Paper, *Equity and Excellence – Liberating the NHS.* A further White Paper was published in November 2010 with more detail on the direction for Public Health services under the heading of *Healthy lives, healthy people: our health and wellbeing.*

3. These documents proposed changes to the provision of public health services and the development of new Health and Well-Being Boards in Councils with a remit to provide strategic leadership for the local health and care community. The Local Director of Public Health will be the Chief Adviser on health matters with statutory responsibilities to the Local Authority. A ring-fenced public health budget is to be created and allocated to Councils using a formula. A new national organisation, Public Health England, is also to be set-up with a remit for analysis, setting outcomes to measure whether people's health actually improves and combining experts from public health bodies such as the Health Protection Agency and the National Treatment Agency.

4. There has been much debate about the NHS reforms nationally and it is ongoing. The Health and Social Care Bill has now completed its passage through Parliament.

5. This debate means that many changes may still need to be determined, both locally and nationally. It is recognised that there are important implications and risks for the Council. To respond to this, during 2011 the following interim arrangements were put in place to support consideration of all issues relating to the NHS reforms including those affecting public health:

    - the establishment of a Shadow Health and Well Being Board bringing together Elected Members, Directors, General Practitioners and officers from partner and Council agencies, meeting in public on four occasions during the municipal year where issues about the purpose and function of the Board arising from the NHS reforms could be discussed. In addition, four Shadow

- monthly meetings were arranged between the Chief Executive and Dr David Hegarty, Chair of the Clinical Commissioning Group together with relevant Directors and other officers of the Council and the Clinical Commissioning Group.

- the Chief Executive was invited to represent the Council as a Member of the Clinical Commissioning Group Board

- regular meetings of the Chief Executive, Directors and Assistant Directors together with the Director and Deputy Director of Public Health to reflect on linkages between Council services and Public Health services. Following national developments with the announcement of the funding for public health, this Group is now becoming a Public Health Transition Group with representation invited from the Clinical Commissioning Group, the Black Country PCT Cluster and Elected Member representation to be confirmed after the local election.

6. Regionally, a Public Health Transition Board led by the NHS Strategic Health Authority was put in place with Council representation. The SHA also met with Council officers and colleagues from the Clinical Commissioning Group and the Black Country Primary Care Cluster as part of a "re-assurance" process with regard to the transition of public health.

7. In addition, in 2011 the Association of Black Country Authorities Chief Executives and Leaders were mindful of work which they had already begun with regard to sharing services or activities at a Black Country level, such as Library Management and they commissioned a co-operative analysis by Council Officers working with Directors of Public Health on issues connected to the sharing of public health services across the Black Country. The Black Country Leaders considered the outcome of this process in reflecting on a paper which analysed perceptions about the advantages and disadvantages of sharing public health services including a variety of models for delivery of public health. Black Country Councils have adopted a variety of positions to date and these are outlined in the responses to the question given the background referred to in this Introduction.

CALL-IN QUESTIONS FROM THE COMMITTEE

8. ***The placing of public health within D.A.C.H.S.***
    - ***What are the advantages of this when public health has such wide ranging implications for all aspects of the authority's work?***
    - ***Should not the Public Health have a degree of independence to directorates to make improvements for the benefit of the Health of our communities?***

9. In my report to Cabinet of 14th March 2012, a recommendation was made that Public Health should be situated within the Directorate of Adult, Community and Housing Services ***but with strong linkages to other Council services to ensure that we have a clear corporate focus on Public Health issues. For example, this would include co-location of appropriate staff where joint working is essential***. In addition, this would be supported by the creation of a corporate group, chaired by the Chief Executive together with the Directors of Public Health; Adult, Community and Housing Services; Children's Services; and Urban Environment to ensure the corporate focus. In this way, it is not envisaged that public health would be different to many Council services which have a wide ranging remit in serving people across all ages even though they are located within one Directorate e.g. carbon emissions; corporate parenting; safeguarding of adults and children; anti-social behaviour, etc.

10. A case could be made for placing Public Health in any directorate, including that of the Chief Executive, but, in my view, the best fit is with DACHS because of the synergies between adult social care and health. I do not consider that a Public Health team of 80 FTEs (with an indicative budget of £16.3m for 2012/13) justifies its own separate directorate when compared to the structure of the rest of the Council.

11. Similarly, with regard to the issue of independence, Director roles can require independence as advocates for safeguarding, adults with social care need or children in terms of corporate parenting. It is believed that everyone in the Council will contribute towards health improvement in the same way that we are all responsible for safeguarding or other such themes. Our communications will ensure that all staff are reminded of this. The Director of Public Health will continue to advocate on behalf of health improvement through Council and NHS services and will not only be a member of Corporate Board but also have direct access to me as Chief Executive.

12. In terms of benchmarking, we are aware that there are a variety of models being adopted with best fit for local circumstances in mind. Wolverhampton City Council, for instance, is locating the public health service within its Directorate of Community Services.

13. ***What views were taken into account in deciding this was the best model for Dudley*?**
I *understand that the present staffing numbers some 80 employees what will the numbers be under the new arrangements?*

14. In reaching my recommendation to Cabinet I have had discussions with Council Directors, the Director of Public Health, other Black Country Chief Executives, a Director of Public Health from another West Midlands area, the Regional Director of Public Health, the Chief Executive of the Black Country PCT Cluster and individual members of the Cabinet. I also briefed the Leader of the Opposition Group before finalising my report to Cabinet.

15. The Background and Introduction section explained the changes which have occurred through the implementation of the NHS Reforms since 2010 and the way in which so far, Dudley Council and the Association of Black Country Authorities have sought to address the issues it has raised on behalf of their Councils.

16. Discussion with the Scrutiny Committee on Health and Adult Social Care had been assumed for the new municipal year (see para 28 of the Chief Executive's Report to Cabinet of 14th March) on this and other issues relating to the relationship between the Select Committee and the Shadow Health and Well Being Board.

17. The Shadow Health and Well-Being Board is considering a paper at its April meeting concerning engagement with the public and stakeholders on the development of the local Healthwatch and the development of a Joint Health and Well-Being Strategy. This is at an early stage of planning but it is recognised that the event also offers an opportunity to up-date attendees about local implementation of the NHS Reforms including those relating to public health.

18. With regard to the numbers of staff expected to transfer to the Local Authority, our present calculation is that there are in the region of 80 Full Time Equivalents. The West Midlands Councils are seeking to take a collective approach to transfer of staff and Dudley Council is represented in this. Final numbers will be determined in due course.

19. ***Appointment of Director of Public Health.***
What are the implications of a joint or single appointment?
Are there any risks associated with a dual or single appointment?
What benefits would either appointment bring?

20. Implications of a joint or single appointment have been considered by the Leaders of the Association of Black Country Authorities in 2011 in terms of relative advantages and disadvantages of sharing public health services overall and the Director role in particular. It is acknowledged that whatever the scenario, there are risks to the Council and arrangements to develop a formal Risk Register are in hand.

21. In terms of advantages of taking a shared approach to public health, Directors of Public Health themselves have considered sharing at various levels over time. These efforts recognised different strengths in different areas and sought to identify work on which collaboration might bring better outcomes for local people. The proposal for deeper sharing between Sandwell and Dudley builds on that work and links to the reality of wider Black Country-wide NHS developments. A number of significant arrangements are now being made at Black Country level in relation to health and health-related services, and sharing would enable a stronger voice for Dudley and Sandwell as the Director of Public Health would represent a population of nearly 600,000 in working with the current Black Country Primary Care Trust Cluster, the Black Country Senate (which brings all Black Country GP / Clinical Consortia together) or the *NHS Commissioning Board* when it is finalised. In addition, it is understood that some public health activities such as health surveillance are more effective at a level higher than just one Local Authority and

this model is the best one for issues of managing activity associated with pandemics or contingency and disaster management.

22. The current proposal for sharing with Sandwell would generate some efficiencies which could be ploughed back into direct services so that things such as research are not duplicated.

23. In terms of budget, in comparison to Council budgets and workforce numbers, current Primary Care Trust public health budgets may be seen by Councils as similar in kind to "low incidence" or low budget service where Councils have decided to work together in the Black Country to concentrate effort on greater economy of scale and effectiveness e.g. Looked After Children Independent Visitors scheme and the Black Country Children's Rights work. These examples add force to the attraction of shared approaches for public health as the current estimate provided by the NHS for the local public health budget for Dudley is £16 million. As a relatively small budget in relation to those in Council Directorates, the intention is to make even better use of our collective approach by close linking of this expenditure to that of Directorates.

24. With regard to the specific role of the Director of Public Health, there does not appear to be a "right" level of population for the appointment of a Director of Public Health. The defining factor for the appointment of a Director of Public Health generally speaking appears to have been Local Authority boundary. Therefore, the size of population for which the Director of Public Health has had responsibility varies. The 2009 Office for National Statistics Mid-Year Population Estimate[1] for Dudley and Sandwell populations were Dudley - 306,600 and Sandwell 291,000. Birmingham City Council will be appointing one Director of Public Health for a population of about 1,028,700. In other words, if Birmingham is considering having one Director of Public Health, it is possible to argue from population size that a Director of Public Health for larger population sizes such as between Sandwell and Dudley can work. A further attraction of a role serving this population, therefore, would be allowing the two Authorities as part of the Black Country to "punch our weight" in the West Midlands region. The right candidate would have to be someone committed to the opportunity presented to forge an innovative path with the aim of improving the health of the people across Dudley and Sandwell. The role could also be seen as extending the influence of the shared Director with our Black Country colleagues

25. Sharing these public health functions would create synergies between the Councils working on broadly similar agendas relating to the main issues in the health of people in Dudley and Sandwell e.g child poverty or obesity. Although not seeking to be part of the current proposed arrangements between Dudley and Sandwell, it is our understanding that Walsall and Wolverhampton remain open to sharing in other ways that may yet be determined and everyone agrees that it would be beneficial to do so.

[1] Cf. http://www.statistics.gov.uk/statbase/product.asp?vlnk=15106

26. We are aware that other Authorities have also considered sharing public health functions including the role of the Director. For instance, we are in touch with our colleagues in Dorset, Bournemouth and Poole where such an option is being pursued and we believe that the London Boroughs of Hammersmith & Fulham, Kensington & Chelsea and the City of Westminster are also adopting this approach.

27. It is recognised that there are challenges and risks in this approach and evidence suggests that agreeing to any shared service requires energy and commitment to make it work. For instance, one area of risk is that any sharing brings with it practical problems of ensuring that partners feel comfortable about the resources allocated to their area. Therefore, mitigation of the risk would be addressed through a Partnership Agreement which clearly states the "design rules" for sharing. A further risk may be that it will be challenging for a shared Director to serve two Health and WellBeing Boards in practical terms by attendance and given different approaches within the two Boroughs. A mitigation to this will be the identification of the "right" candidate who can see the opportunity and work out acceptable ways in which the two Boards can access the public health resource it needs through the Director as the chief health adviser to the Council. It may also be thought that there is a risk that the Director of Public Health would be less 'visible' in a shared arrangement. However, the Director would continue to be a member of Corporate Board with direct access to the Chief Executive, which it is deemed will address this. Finally, more detailed work with our colleagues in Sandwell is needed to develop the business case more strongly and it may yet be that the proposal for sharing cannot be made. Dudley's planning is being made with both options in mind, therefore it is for this reason that my recommendation to Cabinet included both political groups in the delegated authority to make a final decision on a shared or single appointment.

28. ***What are the views of the Health and Wellbeing Board?***
Have the following partners had input in this decision: chair of Black Country Cluster, Chair of the G.P Commissioning Board, Regional Director of Public Health?
What are the financial implications for the Decisions as there is a considerable budget that will accompany the movement of Public Health?

29. The Shadow Health and WellBeing Board have considered the wider issues relating to its purpose both in the public and developmental meetings during the year. Key elements of this have been debates about the Joint Strategic Needs Assessment, a way forward on a Joint Health and WellBeing Strategy and working with the Clinical Commissioning Group on their commissioning intentions. Public Health in-put has been given at every stage of these considerations. A specific query concerning public health transition was raised and discussed at the Shadow Board's January 2012 Development Day and further involvement of Elected Members in the Dudley Public Health Transition Group will deepen influence. Whilst the Shadow Health and Well-Being Board is an important new Committee for the Council, the Cabinet is the overall decision-making body for the Council on this issue and as such it is right that the Cabinet came to a view about the possible directions that might be taken.

30 As indicated earlier the Chief Executive of the Black Country PCT Cluster has been aware of the debate about sharing public health functions in the Black Country and the latest stage of developments between Dudley and Sandwell. He has stated his view that he believes it is better for all Local Authorities to have their own Director of Public Health. He also attended the Shadow Health and WellBeing Board in January 2012 and issues of mutual interest were discussed. The Black Country PCT Cluster have also been invited to join the Dudley Public Health Transition Group and will be able to exercise influence in the meetings during 2012.

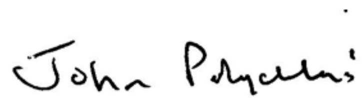
31. Through the contacts outlined in the Introduction, the Chair of the Clinical Commissioning Group, Dr David Hegarty, is aware of the debate about sharing public health functions in the Black Country and the latest stage of developments between Dudley and Sandwell. The Clinical Commissioning Group have been invited to be members of our Dudley Public Health Transition Group and will have further opportunity to comment and influence decisions through the process.

32. The Regional Director of Public Health, Dr Rashmi Shukla, was consulted as part of the wider work on possible Black Country sharing in 2011. As part of that process, it was understood that she believes that a Director of Public Health for each Local Authority is probably the best solution from every point of view. One consideration which she gave was the issue of attracting potential candidates who tend to prefer to represent a given area in their role as Director. The Regional Director has also led a West Midlands-wide re-assurance process and met with senior colleagues from Dudley Council, the Clinical Commissioning Group and the Black Country Cluster in January 2012 to discuss progress. NHS Dudley through the Black Country Cluster have responded to the Strategic Health Authority as required on two occasions in 2012 already with reports on progress.

33. With regard to budgets, there has been a national work to which the Black Country PCT Cluster have had to input as possible budgets have been considered. Most recent versions have required sign-off by the Chief Executive. In a document entitled *"Baseline spending estimates for the new NHS and Public Health Commissioning Architecture*" published on 7th February 2012, the Department indicated an allocation to Dudley of £16,288 million for the forthcoming year 2012/13. There have been concerns regionally and nationally about the allocations and the formula used to calculate the allocation. It is understood that details of the formula used will be shared but at the time of writing, we are not aware of those details. Our overall concern is to be sure that we can continue to deliver the public health work that we currently have on-going in the locality. We also need to make necessary linkages to the budgets held across the Council so that we can secure value for money as we integrate our new public health responsibilities over time across the Directorates where, for instance, both children's and adult, community and housing services manage budgets over and just below £200 million per year. A draft Action Plan for the Council is in place and work on understanding the details of the budgets in this context is commencing.

CONCLUSION

34. Public Health is an extremely important service for the people of this borough and I am determined that it will be fully integrated into the work of the Council. I believe that the arrangements summarised in this paper provide an excellent framework for this integration and ensuring that we have a Public Health service that delivers improved health outcomes for the residents of this borough.



John Polychronakis
Chief Executive