HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Report subject	**Future of Public Health in BCP Council**
Meeting date	20 May 2024
Status	Public Report
Executive summary	The Committee have been offered a briefing on the Council's public health responsibilities to inform their findings. The Committee's discussion will inform design work.
Recommendations	**It is RECOMMENDED that:** Committee members consider the report and provide their findings. Committee members agree that a further report will be provided ahead of the meeting in July.
Reason for recommendations	This falls under Procedure at Overview and Scrutiny meetings 18.2.4 consideration of any matter referred to the Committee by Full Council or by the Cabinet.

Portfolio Holder(s):	Cllr David Brown, Portfolio Holder for Health and Well-Being.
Corporate Director	Jillian Kay, Corporate Director for Well-Being.
Contributors	Jillian Kay, Corporate Director for Well-Being Sam Crowe, Director of Public Health
Wards	All
Classification	For recommendation

Background

1. The Health and Social Care Act 2012 enacted the transfer of public health responsibilities into local government. In Dorset, those responsibilities have been discharged as a shared service since then. The current arrangement is that Public Health Dorset operates under a shared service agreement between BCP Council and Dorset Council.

2. BCP Council's corporate strategy sets out a new vision for the Bournemouth, Christchurch and Poole area: 'Where people, nature, coast and towns come together in sustainable, safe and healthy communities'. It was adopted in January 2024 and puts greater emphasis on the principles of developing healthy communities, putting public health more strongly at the heart of the Council's strategy and aspirations.

3. On 10 April 2024, in this context, BCP Council Cabinet agreed to give notice to terminate the shared service agreement and to establish a programme to shape the future public health function. The Chief Executive wrote to Dorset Council's Chief Executive on 19 April, providing the requisite notice. A joint programme board has been established across the two Councils, and planning has begun to oversee the transition and deliver the separation by April 2025.

4. As part of the process, Cabinet invited the Committee to:

   'Assess options for configuring public health functions within the council's corporate structures to maximise community benefit, and to report findings to the Corporate Director for Wellbeing by the end of May to inform this work ahead of any job design or appointments process'.

Shaping the future of public health in BCP Council

5. The ambition is to achieve greater community benefit through an embedded public health function. To achieve this, we need to establish a future model for public health which is:

   - **Influential** - across the whole of BCP Council's agenda for people and place
   - **Expert** – we need to maintain a strong professional function, which is data led
   - **Ambitious** – to drive the Health and Wellbeing Board's ambitions for 'strategy into action'
   - **Collaborative** – connected with communities and working with partners across Dorset and beyond
   - **Safe** – for example, in our health protection responsibilities

6. The Committee may find it helpful to consider the 'models of practice' at Annex A. This is drawn from a 2008 paper, when joint Director of Public Health appointments between

the NHS and local authorities were first mooted. It continues to be a relevant reference document for the design of public health functions.

7. Public health will be a central part of the Wellbeing Directorate, with the Director of Public Health a member of the Health and Wellbeing Board. The public health team will need to influence horizontally across the whole council – within the Directorate, this includes adult social care, commissioning, housing, communities and regulatory services. Beyond the Directorate, this means working with children's services, planning, transport and environment.

8. Many councils have gone further and created Director of Public Health roles with direct responsibilities for some of these related services – for example, communities, libraries and regulatory services. In any configuration of functions, it is essential that the DPH role has sufficient capacity to carry out the core public health responsibilities, and that ideally there is an opportunity to achieve greater community benefit through alignment between services and funding streams.

Does the Committee agree with the criteria in para 6? Are there any others to add?

Does the Committee have any views on the 'models of practice' best suited to BCP Council's ambitions?

Can the Committee see any particular opportunities for public health influence across the council?

In terms of functions reporting into the DPH, are there any configurations that could work well? And any that should be ruled out e.g. because of conflicts of interest?

Summary of financial implications

9. None

Summary of legal implications

10. None

Summary of human resources implications

11. None

Summary of environmental impact

12. None

Summary of equality implications

13. None

Summary of risk assessment

14. None

Background papers

BCP Council Cabinet paper – 10 April – Future of Public Health in BCP Council

Appendices

Appendix A – Models of Practice (taken from Perspectives.pdf (adph.org.uk))

Appendix A: Models of practice[1]

The expert

Characteristics This appointment is the in-house information expert. The DPH will be a skilled statistician who is aware of levels of health and sickness, and is able to correlate these with measures of affluence and social disadvantage across the area, mapping them using scientific and objective methodologies. The emphasis is on facts. This DPH may have less regard for attitudes and opinions and little understanding of the views and motivations of local politicians or those of local people.

Commentary This role is a legitimate one. It sets a baseline for action, but the responsibility for action lies elsewhere. The purity of the model comes from the scientific objectivity of the post holder, and the concentration on producing a balanced picture of need for the locality.

Local authority best fit The local authority must have capacity to understand the material presented and develop policies to create change. It will have a track record of drawing on an evidence base for effective health interventions. Health improvement and tackling health inequalities will already be strong priority for the leaders in management and councillor roles. There will be strong management systems in place and resources to develop action plans that lead to real impacts on the health and well-being of the area.

The critical friend

Characteristics In this role the DPH will have an understanding of the facts about the health of the community, together with an understanding of the health impact of different policies and service delivery models. This information is used constructively to challenge the status quo and suggest ways in which the council can improve its health improvement performance.

Commentary This role is well established across the country. DsPH have often attended scrutiny committees, and presented their annual reports on the state of health in the area to the council's political and managerial executives. The DPH will be used to review council plans and policies and will make suggestions for change that maximise health benefits. Crucially, there is little or no personal accountability for delivering change. The DPH is firmly independent of the executive leadership of the authority and can speak with professional freedom.

Local authority best fit There needs to be a leadership at both managerial and elected member level that is aware of health issues and motivated to listen. The authority will have a strong and effective scrutiny function which examines health improvement issues. Their deliberations will influence future priorities. Information and decision making processes will be open and inclusive. This model can enable elected members who are close to their communities to become well informed health champions, using messages provided by the DPH. The model will work less well in a confrontational political culture.

The adviser

Characteristics This jointly appointed DPH is part of the executive support to the political and managerial leadership of the authority. The main difference between this role and that of the critical friend is one of accountability. He or she will go beyond advising on what should

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[1] Perspectives on joint Director of Public Health appointments, Edited by David J Hunter, Durham University, commissioned by IDeA, December 2008.

be done to helping to reach conclusions about what can be done within available resources. This may make the DPH less able to speak out as the independent expert. The scrutiny committee may on occasions hold the DPH to account for progress in areas of his or her responsibility.

Commentary This role offers more direct influence than the expert or critical friend as there is significant involvement in the decision making process. There is opportunity to argue for approaches that maximise health improvement. This influence comes at a price of having to take some form of collective responsibility and publicly support decisions once made. The DPH will rarely be able to circumvent this by claiming professional privilege and independence.

Local authority best fit This model will work best where there is an understanding of the health improvement agenda and a willingness to support it in policy development and operating practice. Ideally this should be both at political and managerial leadership levels, although it can work where only the management team is committed. The management and political culture needs to be a reasonably open one, with appropriate forums for debate. The model will probably work most effectively in councils without a very confrontational political tradition that seeks to exploit and polarise differences in opinion.

The provider

Characteristics The significant feature of this model is that the DPH has taken on significant operational management and budgetary responsibilities within the council. Usually, although not always, it is restricted to staff involved with work that has a clear impact on health promotion.

Commentary The model can offer an opportunity for the DPH to demonstrate operational best practice. Mainstream services such as social welfare housing and environmental health have historic links to health in local authorities. Social and economic regeneration areas also have obvious links. These can be drawn together with NHS services such as health visiting and school health to create an integrated provider service.

Local authority best fit This role will be familiar to those local authorities where senior managers hold service responsibilities alongside a contribution to corporate strategic planning and development and may be helpful in strengthening the perceptions of the importance of the DPH role. It may also be helpful in authorities that struggle with capacity at senior level. Sharing the burden of managing service delivery can create space for new initiatives in areas like health improvement.

The catalyst

Characteristics The focus of this model is on maximising the benefits of partnership work. The DPH will use the role to develop trust and a shared understanding across two very different organisational cultures. The technical expertise will still be there but the balance of time will be weighted towards networking activities.

Commentary A DPH well versed in both cultures is well placed to facilitate shared understanding and effective partnership working. The role can also be influential in bringing in other partners in work to improve health and narrow health inequalities. The strength of the role may come from being slightly independent of the two employing agencies, especially in bringing in other public, private, voluntary and community group partners. Where the catalyst role is successful the partners will develop a commitment to working together towards a shared purpose.

Local authority best fit To give scope for this model partnership will not be working particularly well but there will be a recognition that it is worth cultivating. Key leaders must be prepared to work with the DPH to improve relationships and will accept health improvement and addressing health inequalities as part of their agencies' areas of responsibly.

The community advocate and leader

Characteristics The professional expertise and independence of the DPH is at the heart of this model. He or she speaks for the disadvantaged and advises the wider population on health issues. In doing this, the DPH may develop a substantial public profile, sometimes becoming better known than the council leader or chief executive. With the high public profile comes the potential for controversy and opposition from individuals and groups who do not share the DPH's analysis.

Commentary Historically, there are a number of examples of DsPH who have acted as the conscience of their communities in this way. The annual report of the DPH which usually receives publicity in the local media, can be seen as part of this role. There are no real parallels for this role within local government management. Elected members, who are increasingly encouraged to see themselves as local community leaders and advocates, would be the nearest equivalent. There are dangers and difficulties in this model, most obviously where the action being advocated is counter to the council's policies or priorities. It will not work well where there are significant political differences between groups on the council as the DPH's opinions will be used to fuel these debates.