Summary

To inform members of Cabinet of the findings of the review of KCC’s ground-breaking Department of Public Health pilot and to outline progress in implementing the reviews recommendations.

FOR INFORMATION

Introduction

1. Attached to this report at Appendix 1 is the full report of the review of the pilot Department of Public Health. The pilot – to establish a Department of Public Health within KCC - ran from November 2005 to the end of July 2006. The purpose of this innovative pilot was, in brief, to learn how better to develop the links between the NHS’s public health and local authorities’ well-being responsibilities in a more integrated fashion, so that each adds greater value to the efforts of the other.

2. The review was commissioned by the Chief Executive and undertaken by Jennifer Tankard, currently on secondment to KCC from IDeA, and Martyn Ayre, Senior Policy Manager in the Chief Executive’s Department, during June and July 2006. The Terms of Reference for the review are set out in Section 2 (p2), the Recommendations in Section 8 (p13-14) and Conclusions in Section 9 (p15).

Review findings

3. The review has found that KCC and NHS partners have made a good start in the learning about how to progress our shared aspirations, even if not all the deliberately ambitious specific targets set for the 9-month pilot have been fully achieved. The uncertainty emanating from organisational change – particularly that in the NHS – has been a significant contributory factor where achievement has fallen short.

4. It is evident from the interviews that there is a range of opinions about the strategic way forward for developing the public health/well-being agenda in and through KCC. Whilst the pilot has undoubtedly raised the public health profile within KCC, it has not yet been able to achieve a high level of awareness or a broader consensus. These might have been achieved had, for instance, the annual operating plan, which does clearly set out some suggested priorities, been
developed more inclusively, more consultatively with key stakeholders and Directorates.

5. A limited period of 9 months is probably insufficient to reach too-firm conclusions where significant cultural change is an issue, but the review has highlighted that strong and visible leadership will be essential to put a new and innovative development such as this firmly on the map. This goes hand-in-hand with the importance of internal and external communications to create awareness and understanding of the goals, priorities and impact of the Department of Public Health.

Future arrangements

6. With the current “Agenda for Change” reorganisation in the NHS well under way, it is very timely to incorporate the lessons into bringing together these converging elements of KCC and NHS strategy on a more permanent and substantive basis. The pilot concluded at the end of July and current efforts are now being focussed on working through a joint (with the 2 new PCTs which come into existence on 1 October) recruitment and selection process to appoint a KCC Director of Public Health (the exact job title is yet to be agreed). The person appointed will head up a small strategic KCC Department of Public Health (DPH) and have, it is proposed, management responsibilities for Associate Directors of Public Health in each of the two new PCTs. An Interim Strategy Board, comprising the key County Council and NHS stakeholders, has been set up to steer the transition. This will entail ensuring all partners are fully involved in decision-making regarding recruitment/selection processes; staffing and resourcing arrangements; operational arrangements within KCC and with other key NHS and district partners and colleagues and devising the framework for developing and consulting on a shared strategy for public health and well-being.

7. Chief Officers, in their initial discussions of the review, have made a provisional recommendation to locate the Department of Health as a specialist service within the Communities Directorate by the end of 2006. As will be noted from the recommendation at 8.5, the suggestion was for the appointment of a Lead Member if the DPH is located in a Directorate or a Cabinet Member if the DPH is established as a stand-alone Department. The decision has already been made, as part of the recent Cabinet reorganisation, to appoint Mr Graham Gibbens to the role of Cabinet Member for Public Health. Without prejudice to the provisional decision to locate the DPH in the Communities Directorate, it is proposed, in the light of this being such a new and innovative arrangement, to jointly review, with the Primary Care Trusts, the arrangements 12 months after the Director of Public Health takes up his or her appointment.

8. Discussions have already been started with the Chief Executive and Director of Public Health at the new South East Coast NHS Strategic Health Authority and with the newly-appointed Chief Executives of the 2 new Primary Care Trusts serving Kent from 1 October. Timing is critical as they are currently in the process of appointing to the executive directorship posts and it is essential to synchronise their and our recruitment processes. As this is something of a national first, discussions are also taking place with DH about whether we should offer Kent as a national test-bed to work with the Faculty of Public Health. Also because of the innovative nature of this approach, it needs to be emphasised that this is ‘work in progress’ where, although the pilot has given us a very solid foundation from which to start the next, 12-15 months will involve further innovation and learning.
Recommendations

9. It is recommended that Cabinet NOTE the contents of the report

Background Documents

None

Contact: Jennifer Tankard  -  01622 694102
    Martyn Ayre: Senior Policy Manager  -  01622 694355
Review of the Department of Public Health pilot at Kent County Council

Jennifer Tankard
Martyn Ayre

August 2006

1. Background

1.1. The Strategic Health Authority for Kent and Medway (K&M StHA) and Kent County Council’s (KCC) decision to enter into joint arrangements to tackle public health issues in Kent marked an innovative and bold approach to joining up public service delivery to improve the quality of life for local people.

1.2. The joint arrangements included the creation of a joint Department of Public Health and secondment of the Director of Health Improvement of K&M StHA into the joint post of Executive Director of Public Health based at KCC. These joint arrangements demonstrated a strong commitment to partnership working while reinforcing KCC’s long term commitment to tackling public health issues.

1.3. There have been a number of recent national Government pressures for local authorities to increase their co-operation in the public health arena. These include the ‘Choosing Health’ white paper, with its emphasis on promoting strategies for health improvement and tackling health inequalities and the ‘Our care, our health, our say’ white paper concerning the forging of closer links between the roles and responsibilities of PCT Directors of Public Health and Directors of Adult Social Services.

1.4. However the aim and focus of the joint arrangements put in place by KCC and K&M StHA was to build on work already underway in Kent in tackling public health. It also aimed to ensure this work had greater impact and focus and so better outcomes for local people.

1.5. The joint arrangements were established initially as a nine-month pilot from November 2005 to July 2006. The Chief Executive of KCC commissioned this review to help inform thinking and decisions about future options for a joint approach to tackling public health issues from August 2006 onwards.
2. Terms of reference of the review

The review was tasked to:

2.1. Assess the impact to date of the pilot on KCC’s corporate response to the public health and health improvement agenda
2.2. Examine the progress against the key deliverables set out in the agreement in September 2005 between KCC and K&M StHA
2.3. Examine progress in delivering key actions set out in the initial Annual Operating Plan drafted in January 2006, including specific reference to how those actions have contributed to progress in achieving relevant outcomes in the Kent Agreement
2.4. Assess the contribution made by the Department of Public Health to the health improvement agenda of KCC’s partners across the wider family of local government in Kent
2.5. Identify issues for further consideration by the Chief Executive

3. Format of the review

3.1. The review took place in June and July 2006. It involved an examination of relevant documents and interviews with 40 people including members and officers of KCC, officers at the SHA, external stakeholders including a representative of the Government Office for the South East, a Chief Executive of a District Council and a representative of the Voluntary Sector.

3.2. All interviews were conducted in confidence. The outcomes of the review and recommendations represent a careful balancing of all views made.

4. Review findings and recommendations

4.1. Context

4.2. The creation of the Kent Department of Public Health marked a significant step forward in demonstrating how public services can break down traditional barriers to join up and achieve improved outcomes for local people. Bringing together the largest council in England and corresponding health authority within a shared structure demonstrated the importance both organisations placed on public health. It also demonstrated at a national level that, yet again, public services in Kent were prepared to work differently and take bold initiatives to improve the quality of life for local people.

4.3. Local government is a natural leader for public health. It is responsible for providing community leadership and has a specific legal power to promote ‘well being’ under the Local Government Act 2001.
4.4. As Kent CC was the first local authority to set up a joint Department with the Strategic Health Authority (although others have set up joint arrangements with PCTs) there is no blueprint for how the arrangements could have worked or any benchmark against which impact could be measured.

4.5. Any initiative of this type, scale and level of ambition is bound to have teething problems. The rhetoric of joint working is always easier than the practicalities of overcoming different cultures, priorities and national frameworks for delivery. Whitehall itself is a good example in its repeated encouragement to local public services to join up effectively while admitting its own failure to make progress across Government Departments.

4.6. In the case of the Department of Public Health, the timing of set up was not advantageous. During the nine-month pilot period both organisations have undergone radical upheaval with changes to structures and senior personnel. This inevitably resulted in senior officers within K&M StHA and KCC increasing their focus on internal management issues, rather than strategic policy issues. It also resulted in significant additional demands on the joint Director of Public Health in particular, who was charged by the designate CEO of the new SHA to lead the public health transition work steam.

4.7. In public services where change is a constant feature it is impossible to choose or wait for good timing to launch any initiative, even one of this size, scale and potential impact. It is worth bearing in mind though that structural changes and consequent diversion of resources have hampered the success of the joint arrangements.

4.8. A review of the Department of Public Health after nine months is timely. Tackling the public health issues faced in Kent will require long-term, consistently applied policies and strategies. But the sooner Kent has the right framework, structures and skills in place to develop and deliver policies and strategies the sooner it will start to have an impact.

5. General impact

5.1. In the nine months since the creation of the Department of Public Health (DPH) it has made some progress:

5.2. The decision to set up the joint team and make a joint appointment in itself has had value. It has raised the profile of public health, indicated KCC’s intention to tackle public health issues in a strategic and joined up way and demonstrated the SHA’s commitment to working with local government on public health issues.
5.3. At a national level it has helped to confirm KCC’s continued willingness to innovate and lead the field in complex and challenging areas.

5.4. The profile and importance of public health has been raised across KCC.

5.5. K& M StHA has been able to influence and help develop key planks of the public health agenda, for example the Kent Agreement commitment on public health.

5.6. However this has been achieved against a backdrop of significant change with the NHS review and re-structure of SHAs and PCTs. This resulted in a diversion of resources and focus. It also resulted in the DPH Team losing momentum from an early energetic start. Having initiated a number of changes the Team was then faced with uncertainty about what future NHS public health arrangements would look like and how changes would impact on joint arrangements. This changed the Team’s focus from putting in place structures and frameworks to reflect existing arrangements and to focusing on creating the foundations and environments that others, for example the PCTs, could pick up and run with at a later date.

5.7. This report assesses the impact to date, against a backdrop of significant organisational change and recommends changes to strengthen joint public health arrangements so that they can build on the current base and have greater impact in the future.

6. Impact against the criteria set out in the terms of reference

The impact to date of the pilot on KCC’s corporate response to the public health and health improvement agenda

6.1. Overall this is an area where DPH has made the most progress and had the greatest impact.

6.2. The joint appointment of Director of Public Health, inclusion of the post holder within Chief Executive’s Operating Group (COG) and creation of the joint Department of Public Health in itself significantly raised awareness of public health issues across Kent and of KCC’s commitment to improving public health in Kent. It allowed public health issues to gain greater visibility at a senior management level at KCC and for public health issues to feed into COG discussions and decisions.

6.3. There is a now shared vision and Annual Operating Plan for the Department of Public Health.
6.4. The DPH has influenced a number of key strategies and frameworks to reflect public health priorities, for example Vision for Kent and Towards 2010.

6.5. The DPH held a public health seminar for Conservative members in February, which helped raise their awareness of health issues.

6.6. The DPH played a significant and positive role in supporting PCT officers and those in Children, Families and Education Directorate to gain support from Directors of Public Health in PCTs to bring commissioning of health services across to Children’s Trusts

6.7. However there is real disappointment that the DPH Team failed to develop a public health strategy. This would have provided a framework for KCC public health activity. Its development could have helped to build consensus across the SHA and KCC about the aims and objectives of public health work in general and the roles and responsibilities of the joint DPH in particular. It could also have played a key role in communicating the role and work of the DPH, raising visibility and awareness of the Department and public health issues across the Kent public service family.

6.8. There was also a significant failure to proactively build relationships and raise awareness of the new Department across KCC and beyond. This is particularly true in terms of elected members who generally have had little contact with the DPH and have very low levels of awareness of its role, responsibilities and impact over the last nine months.

6.9. The Annual Operating Plan could have provided an opportunity to communicate roles and priorities of the DPH. While the Plan was developed and agreed, this was not used as an opportunity to engage with officers and members or to build consensus about public health priorities. Some senior officers were shown the plan but this was perceived as a final draft for information not consultation draft for comment. In the one instance where comments were sent through these were not reflected in the final report. Many senior officers, who by the nature of their positions, could have expected to have seen or been involved in the operating plan had no awareness of it.
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<thead>
<tr>
<th>Areas of impact</th>
<th>Areas of limited progress</th>
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<tr>
<td>Overall people have responded very positively &amp; see the joint arrangements as</td>
<td>Little visibility or awareness of the DPH and its works across large sections of KCC. This is especially</td>
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<td>the right approach to tackling public health.</td>
<td>true for members whose main contact has been through the Overview and Scrutiny Committee and the seminar</td>
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<td>organised at the beginning of 2006. This has meant that Cabinet Members, for example, are not aware of</td>
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<td>DPH’s activities or impact.</td>
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<td>Appointment &amp; creation of Department</td>
<td>Concern that DPH has acted as an SHA presence within KCC rather than as a truly joint operation.</td>
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<td>gave clear signal of the importance of public health work. The joint secondment</td>
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<td>is seen as powerful in its’ symbolism.</td>
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<td>Raised public health as an issue, helped to present KCC as serious player in</td>
<td>Failure to create clarity about KCC’s public health role &amp; to communicate that to key audiences, such as</td>
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<tr>
<td>public health &amp; set the agenda for KCC to negotiate on public health issues.</td>
<td>members &amp; lack of awareness / clarity about the remit of the Department of Public Health and day to day</td>
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<td>responsibilities of the team.</td>
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<td>The DPH’s presence at meetings such as COG has resulted in more joint work</td>
<td>The DPH has helped KCC to remain in the loop about broader health developments.</td>
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<td>taking place. Public health issues increasingly picked up over last nine months.</td>
<td>DPH helped to bring commissioning services across from the PCTs to the Children’s Trust – critical outcome</td>
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<td>February seminar for Conservative members and briefing for Labour members helped</td>
<td>for KCC.</td>
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<td>to raise public health issues with members.</td>
<td>There are perceptions that the Team was encouraged to act as ambassadors / advocates for healthy schools</td>
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<tr>
<td>Formalised relationships between SHA &amp; KCC &amp; established more mature &amp;</td>
<td>project but failed to pick this up. However the DPH Team believe they spent a considerable amount of time</td>
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<td>productive dialogue.</td>
<td>advocating support of and investment in healthy schools, so it may be that these perceptions are due to a</td>
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<td>lack of communication rather then a lack of activity.</td>
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<td>The DPH has helped KCC to remain in the loop about broader health developments</td>
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<tr>
<td>DPH helped to bring commissioning services across from the PCTs to the Children’s</td>
<td>There is no evidence of reciprocal input to SHA strategies. For example, although the DPH had some input</td>
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<td>Trust – critical outcome for KCC.</td>
<td>to the Local Transport Plan the SHA took a series of decisions about location of bases that didn’t take</td>
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<td>accessibility &amp; transport issues.</td>
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<td>Influence on contents of key strategies, for example Vision for Kent, Towards</td>
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<td>2010 and the Local Transport Plan.</td>
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Progress against the key deliverables set out in the agreement in September 2005 between KCC and SHA

6.10. This review took place only nine months after the DPH was set up. As previously mentioned, this nine months has been a period of upheaval for both organisations. Given this it is perhaps ambitious to expect the DPH to have made much progress against the key deliverables. The Department’s ability to deliver must also be set within the context that its prime role was to influence and persuade and that the limited resources currently available to the DPH reflect this.

6.11. The creation of the DPH, appointment to the post (on secondment) of a Director of Public Health and alignment of resources to focus on public health work (three part-time and two full time) have provided the framework for joint public health activity.

6.12. Progress on leading and co-ordination of the LAA targets, which impact on public health, has been highlighted as a real area of success. The DPH has made a real difference to the LAA target 16, making it far more of a partnership activity and moving away from reliance on PCTs for delivery. As part of this the DPH negotiated for the LAA to release funds via the Public Health Network to invest in the Kent Lifestyle survey and so was able to influence the contents of the survey. This will establish a baseline for activity targets in the future.

6.13. As mentioned earlier the failure to bring forward the public health strategy is disappointing and a missed opportunity to clarify roles and responsibilities of the DPH and to communicate its vision and goals.

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<th>Areas of impact</th>
<th>Areas of limited progress</th>
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<tr>
<td>Establish and consolidate partnership arrangements in the form of formal</td>
<td>No progress on a public health strategy for Kent.</td>
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<td>structures, objectives and timetables for the delivery of joint policy – this</td>
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<td>has happened through the creation of the Department of Public Health and the</td>
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<td>Annual Operation Plan which sets out</td>
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objectives and a timeframe for delivery.

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<th>Action Plan</th>
<th>Progress and Challenges</th>
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<tr>
<td>Public health perspective has been applied to some KCC and partner organisations’ planning processes with input to Vision for Kent, Towards 2010, the Local Transport Plan and submissions made to SEEDA’s regional plan.</td>
<td>It is unclear whether this is being done in a systematic way rather then as opportunities arise. The aim of “assessing the impact of policy on the health population of Kent with solid progress to be demonstrated by August 2006” could be seen as a very ambitious target, although work around the lifestyle survey, for example, could be seen as contributing towards this.</td>
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<tr>
<td>Performance management of the PCTs public health work has been mainstreamed.</td>
<td>To offer strategic leadership to KCC and others to assist them in making their contribution to the Choosing Health objectives – no evidence that this has taken place.</td>
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<tr>
<td>Lead and co-ordinate the LAA targets which impact on public health – this is an area where the DPH has had significant impact. It is has picked up &amp; led on relevant targets (block 3 outcome 16). Results will not be measured until March 2008 but general view that this is working well as a consequence of DPH input.</td>
<td>Harmonisation of KCC &amp; NHS information systems - this is a long term objective.</td>
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<tr>
<td>Develop the public health workforce – the DPH has been able to work from inside KCC to deliver a robust no-smoking policy while also ensuring NHS establishments are smoke free zones.</td>
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**Progress in delivering key actions set out in the initial Annual Operating Plan drafted in January 2006, including specific reference to how those actions have contributed to progress in achieving relevant outcomes in the Kent Agreement**

6.14 Over the last nine months, the DPH has focused on creating the foundations that will underpin delivery of many of the key actions set out in the Annual Operating Plan. Identifying resources, for example allocating one person to work on the Health Impact Assessment, building support for the Healthier Communities Sub-Group of the PSB, which met for the first time on 20th July, and undertaking research for the model of social marketing will all support delivery of public health outcomes in the medium term.

6.15 Development of a no-smoking policy for KCC and the NHS in Kent is viewed as a positive step forward. Earlier mention has been made of input to key strategies such as Vision for Kent and Towards 2010.
However there are some areas, which KCC views as key priorities such as Supporting Independence where the DPH has had no input. Other areas, such as looking into a public health partnership board at Kent and publicising the work of the DPH which could have significantly helped to raise the DPH’s profile and gain support for the Department and its work have not seen any progression.

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<th>Areas of impact</th>
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<tr>
<td>DPH engaged with the Overview and Scrutiny Committee on obesity and participat...</td>
<td>However OSC felt only contribution was to attend and make contributions, which would have done in any case. There wasn’t any obvious added value although participation in the active learning exercise was appreciated.</td>
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<td>Contributed to the sustainable communities and regeneration agenda by feeding i...</td>
<td>Despite involvement in KCC’s LTP there is no evidence that DPH used this as an opportunity to raise transport and accessibility issues within the SHA. For example decisions to relocate SHA premises appear to be based on resource issues rather than transport accessibility issues.</td>
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<tr>
<td>DPH had an input to KCC’s Local Transport Plan in helping to provide a public h...</td>
<td>DPH input to SEEDA regional plan viewed by some as a naïve and patronising treatise on the importance of public health.</td>
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<tr>
<td>There is no evidence of involvement by the DPH in the SIP – a major priority for KCC. Although there were early discussions between DPH &amp; SIP lead officer, the DPH failed to pick up on this or make it a priority.</td>
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<tr>
<td>The creation of the Joint Department and joint appointment has, in itself, done m...</td>
<td>Little evidence of DPH successfully publicising work and low levels awareness suggest this needs more focus and attention.</td>
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<tr>
<td>Monitor and evaluate activity and resources devoted to public health – achieved th...</td>
<td>No progress on DPH partnership board.</td>
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Establish mechanisms to incorporate Health Impact Assessment & Community Health Profiles as mainstream elements in planning & evaluation of policy - appointment of Lawrence Oke to lead on this seen as key outcome.

Public Health strategy not started yet so no launch currently planned.

Establish clear linkages to complement the delivery of supporting people with long term conditions initiative - appointment of DPH as lead officer for long term conditions seen as key outcome.

Joint knowledge management strategy – longer term aim.

Model of social marketing – some research and ground work achieved on this & view that one of the first things the new DPH can get up & running.

KA CAMHS target – view at KCC that no one from DPH would take an interest & pick up. DPH though state that they received briefings & presentations, which demonstrates their involvement & interest.

Developed robust no-smoking policy for KCC & NHS but need to establish clarity about timeframe for roll-out and promotion campaign aimed at employees.

Support Interreg III project on health & social care inequalities – no evidence of impact given during interviews.

Have influenced relevant policy initiatives such as Vision for Kent & T2010.

Contribution made by the Department of Public Health to the health improvement agenda of KCC’s partners across the wider family of local government in Kent

6.17. It is perhaps not surprising that in nine months the DPH has made limited progress in this area. Influencing KCC’s health agenda as well as that of its partners is likely to take more time and proactive effort.

6.18. The DPH believes it has invested significant time and effort into building support across partners for the creation of the Healthier Communities Sub-Group of the PSB. This met for the first time on 20th July and will oversee delivery of the LAA targets that relate to public health as well as encouraging buy-in from across the public sector for joint public health work.

6.19. But this needs to be supported by better communication with partners about public health and the role and work of the DPH. Some high priority next steps should be considered to reinforce this work. For example, developing the Public Health Strategy and investigating the potential for a public health partnership board to secure support for joint public health work across Kent.
Areas of impact

DPH has invested significant time and effort into building support across partners for the creation of the Healthier Communities Sub Group of the PSB. This in itself will create the framework within which the DPH can contribute to the improvement agenda across the wider family of local government.

Areas of limited progress

The Healthier Communities Sub-Group has only recently met for the first time & there remains significant work to do to build awareness across the public sector of the role of the DPH in leading health improvement as well as having some impact on the health improvement agenda of KCC’s partners. The DPH may wish to consider how it can work alongside the Healthier Communities Sub-Group to ensure it beds down & has some tangible impact.

Engaged with the Overview and Scrutiny Committee on obesity, which will result in a report in the autumn recommending action for the whole public sector. It is expected that the DPH will take the lead in implementing the recommendations from the obesity review.

Areas of limited progress

As mentioned earlier representatives from DPH appeared as witnesses, which would have happened without the new arrangements in place.

Assessing the feasibility of a public health partnership board within KCC would have helped in this area. The DPH should consider this as a high priority next step.

Identify issues for further consideration by the Chief Executive

6.20. The review has identified a number of over-arching issues that the Chief Executive should consider. These are:

6.21. A significant lack of democratic engagement in public health work. There is limited buy-in and support amongst members for public health work and little awareness of the goals and impact made by the DPH. There are also divided views amongst members about the benefits and disbenefits of KCC further extending its work into the public health arena with real concern that KCC will be held to account for NHS failures as a consequence of leading on public health work. It is clear that the DPH team had limited experience of political exposure and these problems are partly attributable to that.

6.22. Evidence that the SHA has influenced public health activity at KCC to a greater extent than KCC has influenced activity and policies at the SHA. For example the SHA was able to influence policy documents such as Towards 2010 and the Vision for Kent through the DPH. But KCC’s views on the new PCT configuration for Kent were largely ignored.
6.23. A lack of strong, visible, strategic leadership and proactive relationship building and profile raising by the Director for Public Health. Although this needs to be set against the context of organisational upheaval, there is still less impact than could have been expected.

6.24. A failure to effectively communicate and promote the purpose and activity of the DPH resulting in low visibility across KCC and the local government family in Kent.

7. Future arrangements for public health

7.1. In the last nine months, the public health landscape has changed significantly. K&M StHA has been replaced by the South East Coast SHA with boundaries that extend across the counties of Surrey, Sussex and Kent and include the unitary authority of Medway. The eight primary care trusts in Kent have been reconfigured into two.

7.2. The new NHS structures suggest that future arrangements between county councils and the NHS are mainly conducted with the reconfigured PCTs with strategic conversations conducted with the SHA. This makes it likely that any future joint appointments on public health should be made between county councils and the PCTs or in Kent’s case jointly with the two new PCTs. Each PCT currently intends to appoint a head of public health, which could report to a joint Director of Public Health, appointed jointly by KCC and the two PCTs.

7.3. This new arrangement would need to take account of the district council role in delivering public health. Previously it is district councils who have held joint arrangements with PCTs. The SHA view is that this could be achieved by identifying individuals within the PCT public health team to liaise closely with one or more district councils either directly or through Local Strategic Partnerships (LSPs).

7.4. There is a view within the SHA that any joint Department of Public Health should be located within KCC but seen very much as a Kent wide organisation with KCC having a third of a stake and the other two thirds ‘owned’ by the PCTs. It is important to remember though that KCC is the organisation charged with providing community leadership, that has a specific power of well-being set out in the Local Government Act 2001 and that it has democratic legitimacy. Any future arrangements should support KCC’s ability to fulfill these roles.
8. Recommendations

Structures and resources

8.1. Given significant changes to the structure of the NHS in Kent, KCC should consider what joint arrangements and joint appointments it needs in place to manage public health issues. In doing so it should bear in mind its role as community leader for Kent and its power to promote ‘well-being’ under the Local Government Act 2001. Given the new health structures that came into operation on 1st July, KCC should consider making a new joint appointment between the two new PCTs and KCC to lead on public health issues.

8.2. There is currently an opportunity for KCC to put forward its own outline proposal for the configuration of public health arrangements in Kent. KCC should do this as soon as possible to influence a final decision and help ensure arrangements reflect the needs of Kent.

8.3. The lead officer post for joint public health work should be confirmed as a permanent position but with a transparent recruitment process to appoint to the post. This will help to raise the profile of the role and responsibilities inside and outside KCC as well as testing the market to assess the range of available skills to lead this work. The Department for Health (DoH) has recently issued guidance about how recruitment to Directors of Public Health should take place. KCC should consider this guidance while balancing it against the need to recruit someone with the right skills and experience to tackle public health issues across Kent.

8.4. KCC considers whether the new arrangements should exist within a stand alone Department of Public Health as at present. Alternatively, given the limited resources likely to be invested in it compared to other directorates and its prime role of influencing / brokering / negotiating, rather than service delivery, whether it should from a high-level and strategic unit within another directorate. This could be for a limited period of time, while the unit beds down and builds relationships while benefiting from strong political and managerial leadership and shared support services. A future review could then consider whether public health should stand alone as a Directorate once its’ role and activities have evolved.

Democratic engagement

8.5. Public health clearly needs stronger political leadership and ownership and higher awareness amongst all members about KCC’s role in public health and what is required to improve public health in Kent. If a stand alone Department of Public Health is agreed then it should have a
corresponding Cabinet Member. If it is placed within an existing service
directorate a lead member should be appointed reporting to the relevant
Cabinet Member.

8.6. Members should have more opportunities to influence key frameworks
and policies on public health, for example by feeding into the
development of a public health strategy.

8.7. The report mentioned earlier issues about the DPH Team’s limited
political experience and the impact this may have had on failure to build
effective relationships with senior members at KCC. KCC should
consider how it builds political awareness amongst those officers moving
into positions where these skills are critical to delivery.

**Impact and future activity**

8.8. Whatever mechanisms exist for the SHA or PCT to influence the health
work of KCC are reciprocated in KCC’s ability to influence public health
work at the SHA / PCTs.

8.9. That a briefing is done for all elected members at KCC, to be shared
with key stakeholders about public health, the goals and aspirations for
improvements in Kent and the impact joint public health work has had to
date. Building understanding and awareness of public health issues with
members and stakeholders will require continued work. But an initial
briefing will help create clarity about progress to date and future direction
of public health work.

8.10. KCC should start to develop a Kent public health strategy in partnership
with a wide range of stakeholders. This should then have a high profile
launch and wide spread dissemination.

8.11. The DPH Team moves quickly to assess the feasibility of establishing a
partnership board that would help to give public health work strategic
shape and direction as well as cross-organisational support and
ownership.

8.12. KCC, the new SHA and Kent PCTs should re-visit priorities set for joint
public health work to ensure they are ambitious but deliverable and have
clear outcomes and targets.
9. Conclusion

9.1. As mentioned at the beginning of this report the decision to set up joint arrangements between K&M StHA and KCC was a courageous step. It demonstrated a willingness by both organisations to push the boundaries of public service organisation to achieve improved public health provision for local people.

9.2. The key deliverables and key actions agreed for the DPH were ambitious and have resulted in impact in some areas. But overall progress has been limited, although this is partly due to significant organisational changes during the nine-month pilot period.

9.3. However the learning that both organisations have gained from the pilot will stand them in good stead to build new structures and arrangements to lead public health strategy and delivery in the future. This learning can also be shared with other public services nation-wide, which are now developing their joint approaches to public health work.

9.4. The new structures now in place at the SHA, PCTs and KCC create an opportunity to build on the work so far. In doing so, the focus should remain on shaping public health structures so that they reflect Kent’s needs and priorities and are effective at responding to these.

Jennifer Tankard
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