Report for
Item Number: 4

Contains Confidential or Exempt Information	Part I
Title	**Update on NHS Changes and Transfer of Public Health**
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Member reporting	Cllr Simon Dudley
For Consideration By	Health & Wellbeing Board
Date to be Considered	28 September 2012
Implementation Date if Not Called In	April 2013
Affected Wards	All
Keywords/Index	Health and Social Care, Transfer of Public Health, Healthy Lives Healthy People, Health & Wellbeing Strategy

Report Summary

1. This report deals with the impact of public health becoming a function of councils from April 2013, and the preparations for the transfer from NHS Berkshire in preparation for April 2013 when the SHWB will have full statutory owners as a board and the transfer of public health responsibilities to councils will come into effect.
2. The report confirms the arrangements to participate in the Berkshire-wide model for one Public Health Director.
3. The key financial implications are that the local authority will have responsibility for the public health budget, subject to a DoH formula and final allocations, in November 2012. Berkshire unitaries have made representation to the DoH over concern about the allocation and potential gap in funding. The DoH published in June its updated formula for Public Health allocations. This could provide RBWM with a higher allocation, details in paragraph 4. Final allocations are expected by December 2012.
4. An additional point to note is that the local public health decisions are going to have a wider impact on local residents, improving health outcomes and will give local people more say in setting priorities through the health and well being strategy. The timetable for this is set out in the report.

If recommendations are adopted, how will residents benefit?	
Benefits to residents and reasons why they will benefit	Dates by which residents can expect to notice a difference

1. Residents will influence priorities for improving health and wellbeing	April 2013
2. Improved health outcomes for Residents	April 2014

1. Details of Recommendations

RECOMMENDATION: That approval is given to RBWM participating in the Berkshire model for Public Health, subject to annual review.

2. Reason for Recommendation(s) and Options Considered

2.1 The DoH has set a timeline for the transition which details that the agreement on the formal transfer of HR and finance processes will take place through the "shadow" year of 2012 / 2013. There is a requirement that each area will have a transition plan for the shadow year that covers the formal management of the transfer of public health functions.

2.2 Locally there is a Public Health Transition Plan, developed through the Berkshire CEO Programme Board, which is looking at all aspects of the transfer of public health into local authorities. The Transition Plan has been discussed on a Berkshire wide basis and each unitary plan reflects the complexity of the current financial arrangements with the previous Berkshire East and West PCTs. The first was returned to the DoH in January and the second in March 2012.

2.3 Local Transfer of Public Health

The RBWM NHS Changes Programme Management Board, chaired by the Director of Adult & Community Services, links with the Berkshire sub-groups to ensure involvement and engagement to influence key areas. These are HR, IT and systems, emergency planning and protection, finance and contracts and communications. The DoH, with the LGA, issued a series of resource sheets to assist local authorities with the issues in April.

2.4 Promoting Health and Well Being

In RBWM the Shadow Health and Wellbeing Board is taking forward the formation of a local Health and Well Being Strategy for April 2013. However, the SHA expects a shadow strategy to be agreed with partners by September to inform GP Commissioning intentions. Although, as guidance will not be issued until the summer, the draft will be ratified through the Shadow Health & Wellbeing Board by February 2013. Consultation and engagement commenced last October on the framework using the Marmot social determinants of health and focus on the life course approach from birth to old age detailed in the JSNA as reported in the December cabinet update. These are on the Council website.

2.5 Public Health Structures

The arrangements have to be approved by the SHA and comply with DoH guidance. Specifically the DPH role, qualifications and experience is prescribed as a statutory function and the job description and interview process has to be agreed with the institute of Public Health. Work on this and consultation within NHS Berkshire has commenced. Formal consultations with affected NHS staff have to commence by October to ensure statutory consultation and TUPE arrangements are completed for transfer by April 2013.

2.6 Berkshire Model to approve

The Berkshire Transition Plan to the SHA proposed the option of one DPH across Berkshire unitaries with a designated assistant director post for each unitary with public health staff. As with other services, the Berkshire unitaries are committed to working collaboratively to ensure efficiencies and economies of scale are maximised. This model ensures a clear focus on public health responsibilities and budget control for each unitary. See Appendix 1.

RBWM confirmed, an agreement to this at May Cabinet. It is proposed this is also subject to annual review to ensure the model delivers best outcomes for local residents. There was a Berkshire Leaders meeting on May 15th to consider unitary views on options. Broad agreement was given to the model in principle.

2.7 Progress on the draft Joint Health & Wellbeing Strategy (JHWS)

A subgroup of the Health & Wellbeing Board has been formed to support the development of the JHWS. The guidance from the Dept of Health about the JHWS has been issued as a second consultation, which closes at the end of September 2012.

The guidance is not expected to change significantly at the close of the consultation, significant points to note are:

- The Health and Wellbeing Board is overall responsible for the production of the Joint Strategic Needs Assessment and the JHWS< with the CCG and the Local Authority having a joint and equal duty to prepare both publications
- Two or more health and wellbeing boards can work together on one strategy
- The NHS Commissioning Board must participate with the development of the strategy (once they are fully formed)
- There will be no national timescales for the production or refresh of the documents; it is up to local determination to set the time frames other than that the JHWS must be developed by April 2013.
- The JHWS must encourage integrated working
- The JHWS will not be centrally monitored or performance measured. No targets or penalties will be applied.

The subgroup has met twice and has agreed the following:

- The format, layout and structure
- The timescales for public engagement and consultation in the process
- The priorities that form the public consultation. *Note*: these priorities are based on the evidence of the JSNA, the health profile, health and social care performance indicators, national guidance (such as the Outcomes Frameworks) and local views from stakeholder and public events that have been hosted or attended.
- Principles for delivery

More detailed information about the development of the JHWS will be reported to the HWB at the meeting of the 28 September 2012 in a separate report.

Option	**Comments**

Do nothing.	This is not an option as RBWM has the statutory duty for Public Health from April 2013.
The RBWM implements the agreement to the Berkshire model for public health. **RECOMMENDED**	This will ensure the Council can take on the full statutory powers for public health and the HWB come into effect. This will include setting the strategic direction for public health in the future subject to Cabinet agreement.

3. Key Implications

Defined Outcomes	Unmet	Met	Exceeded	Significantly Exceeded	Date they should be delivered by
RBWM's responsibilities for public health will be delivered by way of a Berkshire-wide model	The DoH timescales for confirming transfer arrangements with NHS Berkshire are not met.	The DoH timescale for transfer of all responsibilities are met and RBWM is prepared to take over the public health budget in November 2012	Implementation by January 2013	Earlier implementation by September 2012	November 2012
Residents are kept fully informed of the health and well being strategy and priorities, and have the opportunity to comment on those priorities.	Less than 500 residents comment on strategies and priorities.	Residents are informed of the health and wellbeing strategy and priorities via the website and Around the Royal Borough articles. Three public consultation events are run. 500 residents comment on strategies and priorities.	Residents are informed of the health and wellbeing strategy and priorities via the website and Around the Royal Borough articles. Five public consultation events are run. 600 residents comment on strategies and priorities.	Residents are informed of the health and wellbeing strategy and priorities via the website and Around the Royal Borough articles. Seven public consultation events are run. 700 residents comment on strategies and priorities.	April 2013

The Health & Wellbeing Board has a Communication Strategy to try to engage with as many residents as possible interested in commenting on health and wellbeing priorities. The response to this is likely to be low and will build up over the next three years as more information and communication reaches more people on the benefits of influencing health priorities. The target of 5% of residents is extremely challenging and will be a mixture of adults and young people able to comment.

4. Financial Details

a) Financial impact on the budget (mandatory)

The public health transfer of responsibilities does come with a ring-fenced budget that has been announced, as set out in 4.1.

Example	**Year1 (*state year*)**	**Year2 (*state year*)**	**Year3 (*state year*)**
	Capital £000	Capital £000	Capital £000
Addition			
Reduction	N/A		

Example	**Year1 (*state year*)**	**Year2 (*state year*)**	**Year3 (*state year*)**
	* Revenue £000	Revenue £000	Revenue £000
Addition	N/A		
Reduction			

b) Financial Background

4.1 The financial aspects of the public health transfer were released in January based on local financial information that was submitted to the Department of Health for East Berkshire and reported to Cabinet in December 2011. The allocation for RBWM is estimated to be £3.24m based on £21 per head and based on the Berkshire East declared spend for 2010/11 of £10.027m for 3 unitaries. They did not have spending amounts per unitary. The total estimated allocation across East Berkshire is £8.74m, leaving a gap of £1.785m. Details in Appendix 2. A finance sub-group is looking to understand how each unitary budget will be built up and commissioning and contracting commitments. One issue being explored is to confirm activity levels per unitary, as traditionally services have been provided for patients across East and West Berkshire, so individual take up by unitary residents is not always known. In addition, the focus is on 2011/12 budget as the DoH return for baseline was 2010/11 and NHS Berkshire are spending more on public health 2011/12.

4.2 The gap has been subject to continual interrogation with NHS Berkshire and the SHA. About £600,000 is accounted for by functions that will not transfer. This still leaves a gap of £1.185m. The Department of Health are allowing representations to be made, but final allocations will not be announced until November 2013. The financial allocations were created through a national formulae and it has just been announced that the national formulae used to calculate the amounts will be disclosed due to the number of concerns that have been expressed nationally.

4.3 The Department of Health (DH) report “Healthy Lives, Healthy People: Update on Public Health Funding” published on 14 June sets out the interim recommendations of the Advisory Committee on Resource Allocation (ACRA)

which have been accepted by the DH. The report states that further work is required before their 2013/14 recommendations can be finalised. These interim recommendations deal with the relative distribution of Public Health resources between local authorities. The interim recommendations of ACRA imply that the share of the national public health funding to be allocated to RBWM should be 0.23%, this is significantly higher than the 0.15% implied by the DH February 2012 indicative allocations. Assuming the national total sum to be transferred remains as stated in February then RBWM would receive £5,114m per year, the February figure was £3,240m. It is likely, where there are significant changes between current spend levels and the allocation from the proposed national formula, that these will be phased in over a period of years.

4.4 The Berkshire model for one DPH provides best use of the budget because of the efficiencies in sharing the costs for one DPH and other functions, such as information analysis.

5. Legal Implications

It will be a statutory requirement for the local authority to take on public health functions from April 2013.

6. Value For Money

Work is being undertaken to look at commissioning and contracts to determine value for money issues.

7. Sustainability Impact Appraisal

N / A

8. Risk Management

Risks	Uncontrolled Risk	Controls	Controlled Risk
Delay in implementing proposed Berkshire arrangements.	Medium If the council does not meet timescales of the public health transfer then RBWM may not comply with statutory functions.	Low There is a Berkshire coordinated collaboration that is supporting the transfer of the responsibilities; this is combining resources and specialisms in order to ensure effective and efficient use of budgets with clear focus on RBWM needs.	Having controls will ensure that local implementation is correctly managed and any risks are reduced or shared with Berkshire unitaries.

9. Links to Strategic Objectives

Public health as a discipline meets the strategic objectives through sustainably improving the health of all of the population for long term health improvement. The strategic coordination of the transfer allows for the best use of resources and value

for money. The implementation of a new statutory Health and Wellbeing strategy is dependant on a flourishing local Public Health function.

Our Strategic Objectives are:

Residents First

- Support Children and Young People
- Encourage Healthy People and Lifestyles
- Improve the Environment, Economy and Transport
- Work for safer and stronger communities

Value for Money

- Deliver Economic Services
- Improve the use of technology
- Increase non-Council Tax Revenue
- Invest in the future

Delivering Together

- Enhanced Customer Services
- Deliver Effective Services
- Strengthen Partnerships

Equipping Ourselves for the Future

- Equipping Our Workforce
- Developing Our systems and Structures
- Changing Our Culture

10. Equalities, Human Rights and Community Cohesion

This report does not require an Equalities Assessment as this concerns national and local process for developing the Health & Wellbeing Strategy which will be subject to an EQIA.

11. Staffing/Workforce and Accommodation implications:

There are complex issues to consider due to the public health transfer of responsibilities as there will be possible TUPE implications of staff transfer. However, these need considering alongside the totality of public health responsibilities of the services to be offered, costs and contracts, as well as cross Berkshire options. These will be agreed on a unitary basis through the Berkshire model. A nationally issued HR Framework for staff affected by this change is due to be published by Central Government shortly. Discussions were held to determine options on Public Health across Berkshire and the shape of the Public Health function per unitary led by the Berkshire Chief Executives Group reporting to the Berkshire Leaders Group. This led to the proposal of one DPH to cover six unitaries, with a host unitary for the DPH and possible analytic functions. Each unitary to have its own public health function based on a minimum allocation of 5.5 posts. A new job description will be agreed with the Institute for Public Health for the new roles and functions of DPH.

There are many factors still to be determined on how the whole transfer will take place, including staff and TUPE issues, service provider contracts, and commissioning, within the overall budget as set out in the finance section of this report.

12. Property and Assets

This will depend on where the Public Health staff are based and it is not yet known.

13. Any other implications:

N / A

14. Consultation

The option to consider seeking Public Health Director input from outside Berkshire was not seen as viable and could lead to fragmentation. The CCGs across Berkshire are acting in a federated way on key common issues and Public Health advice would be part of this. Support was also given to this by the local LINKS representative.

15. Timetable for Implementation

- 30 May 2012 - Berkshire participating authorities agree to model
- June - agreed job description and recruitment process
- September - appoint DPH
- October - NHS staff consultation
- March 2013 - transfer of staff

April 2013

- Public health will be the responsibility of Councils
- The national body of Public Health England will be fully established
- Health and Wellbeing Boards will have full powers
- Healthwatch functions will commence (this has been changed from October 2012)

16. Appendices

Appendix 1 – Draft Berkshire High Level Organisation Structure and Governance Arrangements
Appendix 2 - Total estimated budget allocation across East Berkshire
Appendix 3 - Berkshire programme board work-streams looking at the specific areas regarding the different elements of the public health transfer

17. Background Information

<u>National Information on Public Health Responsibilities</u>

17.1 Factsheets have been issued by the DoH that cover the local government new public health function, including the role to monitor or commissioning responsibilities for:

- Tobacco control
- Drug and Alcohol misuse services
- Public health services for children aged 5-19 (including Healthy Child Programme)
- The National Childhood Measurement Programme
- Obesity – to include lifestyle and weight management solutions
- Nutrition initiatives
- Physical activity
- NHS health check assessments
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle changes to prevent cancer
- Local initiatives on workplace health

- Support, review and challenge delivery of key public health functions such as immunisation and screening programmes
- Sexual health services
- Reduce excess details due to seasonal mortality
- A role in health protection incidents, outbreaks and emergencies
- Public health aspect of promotion of community safety, violence prevention and responses
- Public health aspects of social exclusion
- Reduction of environmental risks to health

17.2 In addition to the above there is a requirement for local authorities to be able to act as the public health advisors to NHS commissioners.

17.3 The staffing aspects of the transfer are being addressed through central government guidance including a *Public Health Human Resources Concordat* (issued November 2011) and *Public Health Workforce Issues, Local Government Guidance* (issued January 2012) and guidance on the appointments of the DPH role.

17.4. There have been several guidance documents from the Department of Health regarding the roles and responsibilities of Public Health England (PHE) and public health in local government.

17.5 PHE will be established from April 2013 and will be the authoritative national voice and expert service provider for public health. The core purpose of PHE is described as:

- to deliver, support and enable improvements in health and wellbeing in the areas set out in the PHOF (Public Health Outcomes Framework); and
- lead on the design, delivery and maintenance of systems to protect the population against existing and future threats to health.

17.6 PHE three main functions will be:

1. Delivering services to national and local government, the NHS and the public.
2. Leading for public health.
3. Support the development of the specialist and wider public health workforce.

17.7 Nationally the Public Health Outcomes Framework (PHOF) has now been finalised. The way that the PHOF will work with the NHS and the Adult Social Care Outcome Frameworks has been reported to the Health & Wellbeing Board for the Feb 2012 meeting. The key areas for which local authorities will be paid a new health premium for progress include indicators on:

- fewer children under 5 will have tooth decay
- people will weigh less
- more women will breastfeed their babies
- fewer over 65s will suffer falls
- fewer people will smoke
- fewer people will die from heart disease and stroke

And new measures will look at tackling causes of ill health, such as school attendance, domestic abuse, homelessness and pollution.

The Berkshire CEO's have formed a Programme Board to look at the most effective ways of managing / commissioning the public health functions now and key information is issued in regard to finances available and the priorities

of each locality stemming from the JSNA reporting to the Berkshire Leaders Group. Options to be considered are the potential of sharing posts, functions and some commissioning across Berkshire unitaries and determining key functions for each unitary. These will be discussed at the Berkshire Leaders Group prior to options for each unitary agreement and Cabinet approval. A key function to consider is the requirement for the DPH to arrange clinical advice for the Clinical Commissioning Group which the DH has issued draft guidance on, showing this can be 25 – 44% of DPH time.

There is a co-ordinated approach across Berkshire to managing the implications of the transfer of public health, under which there are work-streams looking at the specific areas regarding the different elements of the transfer details in Appendix 3.

17.8 DoH Healthy Lives, Healthy People: update on Public Health Funding June 2012.

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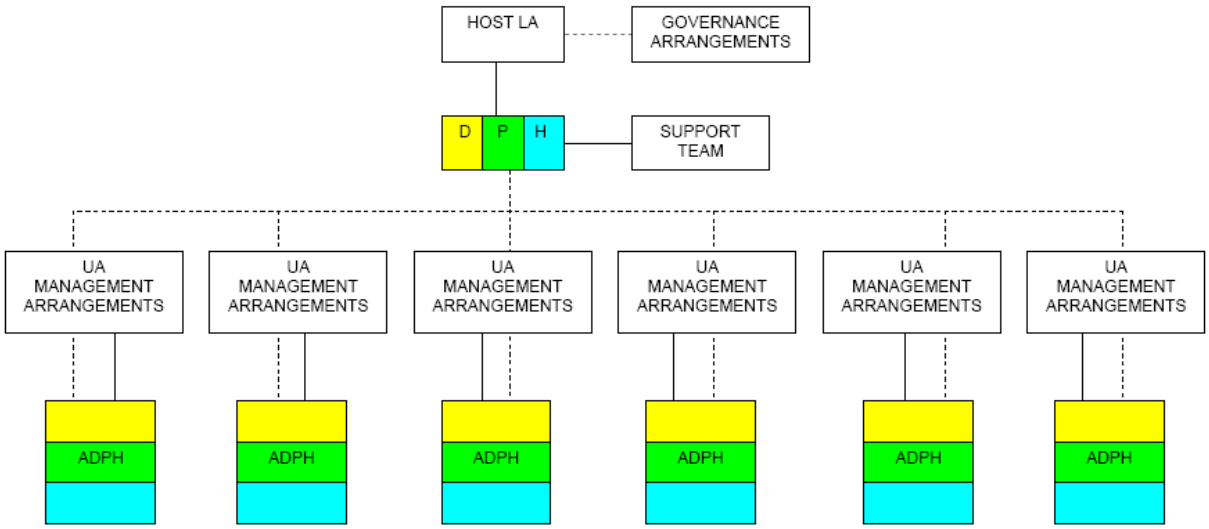
DRAFT BERKSHIRE HIGH LEVEL ORGANISATION STRUCTURE AND GOVERNANCE ARRANGEMENTS

1. INTRODUCTION

1.1 This paper has been amended following discussion at the Public Health Transition Board on 17 April 2012. The practical applications of developing the model for Public Health in Berkshire were accepted in principle. There needs to be agreement as to the hosting of the Director of Public Health (DPH), together with accountability and managerial arrangements in terms of making it work. This paper now includes at Section 3, the potential governance arrangements.

1.2 The working proposal is that there is one DPH for Berkshire, with senior level (I have used Assistant Director – AD as shorthand) leadership in each Unitary Authority (UA). That AD would fit into the organisational structure of the UA. Consequently, it is recognised that the location of the local Public Health function will be in different places, responding to the local situation.

1.3 The diagram below attempts to summarise the arrangements:-



1.4 The colours are intended to indicate three functions (but not the proportion allocated to each function):-

- Strategic leadership across Berkshire
- Local leadership within the UA
- Public Health support to the NHS

2. DISCHARGING PUBLIC HEALTH LEADERSHIP

2.1 There is no doubt that the Public Health challenge in Berkshire is unique and that the arrangements will need to be adaptive and flexible to respond to the specific challenges in each UA.

2.2 The Public Health leadership team will comprise of the DPH with an appropriate support team (the content of which is being worked on elsewhere) and the strategic leadership component of the AD Public Health (ADPH) at the UA level.

2.3 There is an expectation that the ADPH will have strategic leadership across Berkshire (or sub Berkshire geography) in work being undertaken. As examples: Health Protection, Children's Public Health.

NHS BERKSHIRE

PUBLIC HEALTH OUTTURN 2010/2011	
Public health leadership	1,003,000
Information and intelligence functions	226,000
Nutrition, obesity and physical activity	670,000
Drug misuse	3,134,000
Alcohol misuse	355,000
Tobacco	876,000
Dental public health	0,000
Fluoridation	0,000
Children 5 – 19	846,000
NHS Health Check Programme	0,000
Misc health improvement and wellbeing	310,000
Sexual health (STI testing and treatment, contraception, abortion, prevention)	2,607,000
TOTAL – East Berkshire	**£10,027,000**

Public Health Shadow Allocations 2012/13

The shadow allocations (http://www.dh.gov.uk/health/2012/02/baseline-allocations/) for Berkshire Unitary Authorities are:

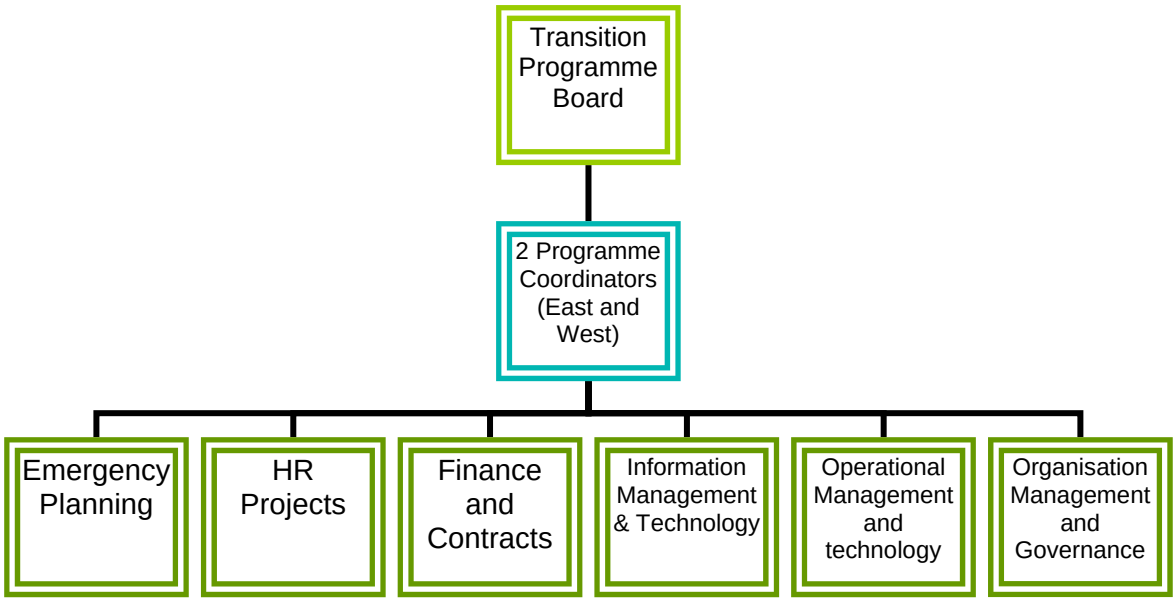
	12/13
Bracknell Forest	2,579
West Berkshire	4,132
Reading	4,150
Slough	2,925
Windsor & Maidenhead	3,240
Wokingham	4,357
	21,383
Berkshire East	8,744
Berkshire West	12,639

This compares to original submissions from the PCTs of their 10/11 Public Health spend of:

Berkshire East PCT	10,529
Berkshire West PCT	13,350
	23,879
Minus	21,383
Gap of	2,496
Estimated gap for East PCT	1,785
Costs not transferring	600
	1,185

APPENDIX 3

BERKSHIRE TRANSITION GOVERNANCE ARRANGEMENTS



There is an additional element that has a focus throughout the 6 work-steams which is around communication.