Report for: ACTION/INFORMATION – *delete as appropriate*
Item Number: 4

Contains Confidential or Exempt Information	**NO – Part I**
Title	Update on transfer of Public Health responsibilities
Responsible Officer(s)	Christabel Shawcross, Strategic Director of Adult & Community Services / Interim Head of Paid Service
Contact officer, job title and phone number	Christabel Shawcross, Strategic Director of Adult & Community Services / Interim Head of Paid Service 01628 796258
Member reporting	Cllr David Coppinger
For Consideration By	Shadow Health & Wellbeing Board
Date to be Considered	07 December 2012
Implementation Date if Not Called In	April 2013
Affected Wards	ALL
Keywords/Index	Public Health, Berkshire Director of Public Health, Transfer of functions, Funding allocations

Report Summary

1. This report deals with the progress on the transfer of public health responsibilities from NHS Berkshire to RBWM from April 2013, managed through the Berkshire-wide project board, led by Bracknell Council.

2. It recommends the progress be noted.

3. These recommendations are being made because it is a statutory requirement to take on the new duties and to meet the Department of Health (DOH) timescales. This overarching project implementation has been co-ordinated through the Berkshire-wide group through Bracknell.

4. If adopted, the key financial implications are that the DOH will transfer public health budgets to each responsible council, based on a national allocation and

methodology. The issues relating to this, and risks, are under consideration as part of the Berkshire-wide group. There is a specific financial and contracts sub-group. The final allocation is expected from the DOH in December.

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 the progress on the transfer of public responsibility to RBWM be noted.

2. Reason for Recommendation(s) and Options Considered

2.1 Background and Context

The Health and Social Care Act 2012 confirms the relocation of Public Health functions, resources and commissioning responsibilities from the NHS into Local Government. Local authorities will be required to discharge their statutory public health responsibilities, detailed in the Public Health Outcomes Framework 2012 from 1st April 2013.

The framework identifies four specific domains that local authorities are required to focus on:

- Domain 1 – Improving the wider determinants of health;
- Domain 2 – Health improvement;
- Domain 3 – Health protection;
- Domain 4 – Healthcare public health and preventing premature mortality.

2.2 Approach across Berkshire Unitaries

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.

2.3 Director of Public Health

Early consideration was given to a model based upon a single Strategic Director of Public Health (SDPH) across Berkshire, or a continuation of two Directors.

2.4 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.

2.5 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 closed at the end of September 2012.

The guidance does not change significantly. 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.

2.6 RBWM Consultation

The RBWM subgroup has met three times and agreed the following:

- The format, layout and structure of the consultation document
- 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

2.7 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. The consultation commenced on Monday 19th November 2012 and closes on Sunday 13th January 2013. The analysis and priorities will be presented to the Health & Wellbeing Board in February 2013.

2.8 Sub work-stream leads and working groups have been established for the following areas:

- Information governance and security and its dependencies;
- Identification and recording of information/intelligence assets and liabilities;
- Information and intelligence allied to commissioning cycles;
- Supporting information/intelligence infrastructure and standards;
- Core offer to the NHS.

One of the challenges for local government with the transfer of Public Health services is that in some instances they are in possession of and working with patient identifiable data. The access to and use of which is governed by the NHS clinical information governance framework. This is recognised as a national problem and there is a Public Health task force in the NHS currently looking at this.

2.9 Finance and Contract Issues

The following sub groups have been established and are undertaking a more detailed analysis of the contracts and spend using the 2011/12 data (this is the programme spend and not staffing spend). These work groups are as follows:

- Acute Contracts
- Community Contracts
- GP provided services
- Other (such as drug, alcohol and smoking cessation etc.)

Each work stream is being led by one of the six UA's and has Finance, contracts/commissioning (from PCT and UA) and Public Health as part of the group membership.

2.10 Emergency Planning Working Group

This working group has now been implemented and the vast majority of the work plan has been completed and the necessary transfer arrangements are identified and either implemented or ready to be implemented.

2.11 Contracts

The transition board agreed in May 2012 that it is essential that we deliver a "safe landing" for PH in local authorities in Berkshire. It was agreed that the

best way to achieve this in relation to contracts with PH service providers would be to extend all existing contracts for a further 12 months beyond the 31st March 2013.

The majority of the contracts are currently split East and West, so this is not going to change during 2013/14 because of need to unpick value and activity per UA.

2.12 Forward Planning 2013/14 – Commissioning intentions

Local government will need to play an important role in defining commissioning intentions for health services in their localities. The majority of the responsibility for this will sit with CCG's but local authorities will have an important role to play in ensuring that CCG's commission services that will improve the outcomes for their populations.

This will be achieved in a number of ways, principally through the JSNA's and Health and Wellbeing Boards, but also through the mainstream public health functions.

The relationship(s) with the CCG's will play a critical role in ensuring that we get the right service in the right place for the right price. The seven Berkshire CCG's have already federated into East and West federations, which may continue to be the alignment going forward.

It is planned for a "safe landing" of PH un UA's on the 1st April and as such are establishing these working relationships and forums that will inform a set of commissioning plans for 2014/15 that will meet the needs of local populations.

2.13 Core Offer to CCG's

The core offer is a range of services and/or information that has been defined as a necessary and important input from the public health service that is currently provided to NHS commissioners and other service areas within the NHS. Therefore there is a requirement to continue to provide this service to the new commissioning structures post March 31st 2013.

A draft Memorandum of Understanding (MOU) has been produced to be agreed with CCG's, and in RBWM this relates to Windsor & Maidenhead CCG.

2.14 Joint Strategic Needs Assessment (JSNA)

The JSNA is a statutory requirement that public health are tasked with leading on and publishing, this document should identify and inform the commissioning intentions based on the locality priorities. This statutory duty will transfer to local authorities on the 31st March 2013.

This document often works on a 2-3 year cycle, but should be refreshed every year to ensure that it stays current and relevant. However it is a matter for each Unitary Authority to determine the exact timing of these cycles so as to ensure that they provide the necessary and accurate input to CCG annual commissioning plans.

Public Health England (PHE) will support local communities by providing services, expertise, information and advice in a way that is responsive to local needs. It will support local authorities, CCGs and Health & Wellbeing Boards by providing the most up to date information and evidence on what works to improve the public's health, including research and good practice. In addition, PHE will provide a public health service to the NHS Commissioning Board, and will support directors of public health and their teams in advising CCGs as required in the commissioning and delivery of health care services and programmes.

2.15 Risks and Issues

Overall a number of the risks have been identified and are being managed by the individual work stream leads although all risks have been escalated to programme level. Whilst some risks around contracts being novated in 2013, and taking into account the current stage we are at in the programme the trend is a reducing one. However the fact that an agreement to extend existing provider contracts by 12 months from March 2013 has embedded and inherent risk that UA's may have to implement post transition contract adjustments to ensure that services are delivered in an affordable way for UA's.

2.16 National PH Updates

Public Health England (PHE) has been set up with a CEO (Duncan Selbie) and the structures underneath are being formed. This will be the governing body for the public health activity across the country.

There are 23 regional offices of PHE and John Newton has been appointed as our regional lead for Public Health England, he has previously been the SHA lead for the region and has a lot of local knowledge and experience.

Health Education England will be the professional body for the training and continuous professional development of public health staff. They are in the process of establishing, with the Faculty of Public Health, the requirements that will be on public health specialists.

NHS Commissioning Board has released a document "Public Health Functions to be Exercised by the NHS Commissioning Board" detailing what they will be responsible for, summary below:

- National immunisation programmes
- Routine screening non-cancer
- Routine cancer screening
- Children's public health 0-5 years
- Child health information systems
- Public Health in prisons and other detention centres
- Sexual Assault Referral Centres (SARC)

The national financial allocation to councils for their ring fenced amount to meet the public health responsibilities has not been published and is expected by the end of 2012. The presumption is that this will be known on

the 19th December with the central announcement on council financial allocations

2.17 Public Health Outcome Framework (PHOF) indicators have been re-issued after undergoing a technical refresh from their original publication in January 2012. The PHOF sets out a vision for public health and the outcomes to be achieved. There are 66 PHOF indicators set in 4 domains and with 2 additional overarching outcomes of

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy in communities

Also released is the national baseline indicator for all of the councils with the data covering the domains of the PHOF. More information on the RBWM baseline can be found at www.phoutcomes.info

Option	**Comments**
1. Do nothing	This is not an option as RBWM has the statutory duty for Public Health from April 2013.
2. 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

What does success look like, how is it measured, what are the stretch targets

Defined Outcomes	Unmet	Met	Exceeded	Significantly Exceeded	Date they should be delivered by
N/A	N/A	N/A	N/A	N/A	N/A

4. Financial Details

a) Financial impact on the budget (mandatory)

There is no impact on the local authority budget for 2012/13. There will be an impact from 2013/14 if the total budget transfer does not reflect the contracted spend on services. Work is ongoing to correct the amount allocated, to validate the numbers of RBWM residents receiving services and to consider to take pre-emptive action such as precautionary notice to contractors.

Example	**Year1 (*state year*)**	**Year2 (*state year*)**	**Year3 (*state year*)**
	Capital £000	Capital £000	Capital £000
Addition	Not applicable		
Reduction			

Example	**Year1 (*state year*)**	**Year2 (*state year*)**	**Year3 (*state year*)**
	* Revenue £000	Revenue £000	Revenue £000
Addition	Confirmed by the DOH until November 2012		
Reduction			

*** Revenue figures need to be shown as incremental/year on year to the budget**

b) Financial Background

There is a shadow budget with the commissioning of the services being the responsibility of Berkshire NHS for the year April 2012 to March 2013. For East Berkshire this totals £10,529m and RBWM £3,240m. This is considered to be less than needed over East Berkshire. The detail of the Public Health spend for 2010/11 was reported to Cabinet in December 2011 and is attached as Appendix 2. The formula for DoH allocation is detailed in DoH spending estimates issued in February. It states that there is the opportunity for further validation with the PCT and SHA before final allocations are made in November 2012. There is a commitment to see the allocation as the baseline with the possibility of uplift as the Secretary of State is committed to increasing Public Health funding. The Berkshire Chief Executives have made representations to NHS Berkshire and the SHA about the allocations. Analysis work is ongoing £600k across East Berkshire, part of the gap is now explained as some sexual health functions will not now transfer to local authorities. The overall distribution nationally shows huge variation because of historical spend and some relation to population health inequalities. However in South Central, West Berkshire unitaries receive £25 per head, East Berkshire receives £21 per head and Portsmouth £68 per head. The estimated allocations for the six unitaries are at Appendix 3.

A key issue to note is that although the allocations are per unitary, this is simply done on a population basis and it does not reflect actual spend on each local authorities residents. Urgent work is being undertaken with the PCT to clarify this. Currently commissioned services are contracted across Berkshire East and it may be economies of scale are such that such arrangements continue or widen. The Public Health allocation includes an estimated 10% allocation of the contracting costs currently carried out by other NHS staff not part of the transfer.

<u>Financial Considerations for Public Health</u>

In addition to the ring-fenced budget, within the proposals there is a Health Premium, as a financial incentive discretionally awarded to councils who improve against a set of sub-indicators in the public health framework. How this will be awarded has not been finalised (as it is a part of the wider consultation). In the initial proposals the formula is retrospectively paid to authorities who achieve a level of progress against specific premium indicators. The Premium is weighted so that more deprived areas who achieve their outcomes measures receive more. Payments are for positive outcomes and those areas who do not achieve their outcomes will not be “punished”.

5. Legal Implications

It will be a statutory function for the local authority to take on public health functions from April 2013. Regarding the membership of SHWBs DoH has set out minimum

required membership and the RBWM shadow board has these representatives. It is open to the SHWB to consider, subject to Council agreement, additional members.

6. Value For Money – Work is being undertaken to look at commissioning and contracts to determine value for money issues.

7. Sustainability Impact Appraisal
Not applicable.

8. Risk Management

Risks	Uncontrolled Risk	Controls	Controlled Risk
If RBWM does not prepare for the NHS changes, there is a risk of not meeting the requirements of the Health and Social Care Bill when it becomes law, and of insufficient budget allocation.	Low	Retain links to the Early Implementer network and continue cross Berkshire collaboration and ensure that Cabinet are aware of implications of the Bill and any future risks that arise.	Having controls will ensure that local implementation is correctly managed and any risks are reduced.

9. Links to Strategic Objectives

Our Strategic Objectives are:

The work of the Shadow Health & Wellbeing Board (SHWB) meets all of the strategic objectives of putting residents first through achieving health & wellbeing outcomes and reducing health inequalities. The value for money strategic objective is met through the opportunities for joint commissioning and planning. Partnerships are a dominant feature of the work of the HWB, which involves delivering together the best outcomes for residents. The work of the HWB is about equipping and supporting the Council and partners to embrace the future of the NHS changes.

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

Consideration has been given to whether an EQIA is required, however as this report is for information only it is therefore not subject to an EQIA.

11. Staffing/Workforce and Accommodation implications:

11.1 Recruitment of the senior roles

A new post of the Strategic Director for Berkshire was created and "ring fenced" to the two existing Directors of Public Health for Berks East and Berks West.

The process itself was to a large extent governed by National Guidance from the Department of Health, The Faculty of Public Health and the Local Government Association.

As it was not possible to appoint from this process an interim appointment was made in November. Interviews for the new DPH post are being held on 7th December 2012.

11.2 Consultants in Public Health & Health Protection Consultant

The structural design that has been developed calls for a 'Lead Consultant' in Public Health that is employed by the individual Unitary Authority who will take the lead locally for delivering against the public health outcomes framework. They will also hold a brief for ensuring that economies of scale are realised by collaborative working across Berkshire when the conditions for collaboration are met. In RBWM this function is designated 'Head of Public Health' reporting to the Strategic Director of Adult & Community Services.

11.3 HR & Recruitment of the Tier 3 staff roles

The DH has set out a range of National Transitional Milestones for sender and receiver organisations to achieve. One of the critical milestones is around making sure that staff are informed of their future destination as early as possible.

A further detailed analysis of their roles and responsibilities and contracts attached to what they do will need to be undertaken to inform the future plans for deployment in the UA's on existing programmes or projects that will run beyond the 31st March 2013. The transfer selection for the team of staff reporting to the designated Head of Public Health is being completed.

11.4 Discussions are underway on the transfer of staff and any assets deemed to be liable to transfer as part of the Berkshire Implementation Group.

12. Property and Assets

See paragraph 11.

13. Any other implications:

None.

14. Consultation

The report is for the HWB to note and Scrutiny will see report with final update for February Cabinet.

15. Timetable for Implementation

From January 2013 there will be an agreed timetable for transfer of staff to RBWM. The designated Head of Public Health with RBWM and NHS HR will be leading on this, to be effective from April 1st 2013 as required by the DOH.

16. Appendices

Appendix 1 – Berkshire Model
Appendix 2 – Public Health Budget – East Berkshire PCT
Appendix 3 – Public Health Shadow Allocations 2012/13

17. Background Information

17.1 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.

17.2 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)
- Lead on the design, delivery and maintenance of systems to protect the population against existing and future threats to health

17.3 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 if the specialist and wider public health workforce

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

Stages in the life of the report (not all will apply)	**Date to complete**
1. Officer writes report (in consultation with Lead Member)	21 11 12
2. Report goes for review to head of service or DMT	-
3. To specialist departments: eg, legal, finance, HR (in parallel)	-
4. To lead member	29 11 12
5. To SMT or CMT	-
6. To the leader	29 11 12
7. To overview or scrutiny, if a cabinet report	February 2013
8. To cabinet	February 2013

APPENDIX 1

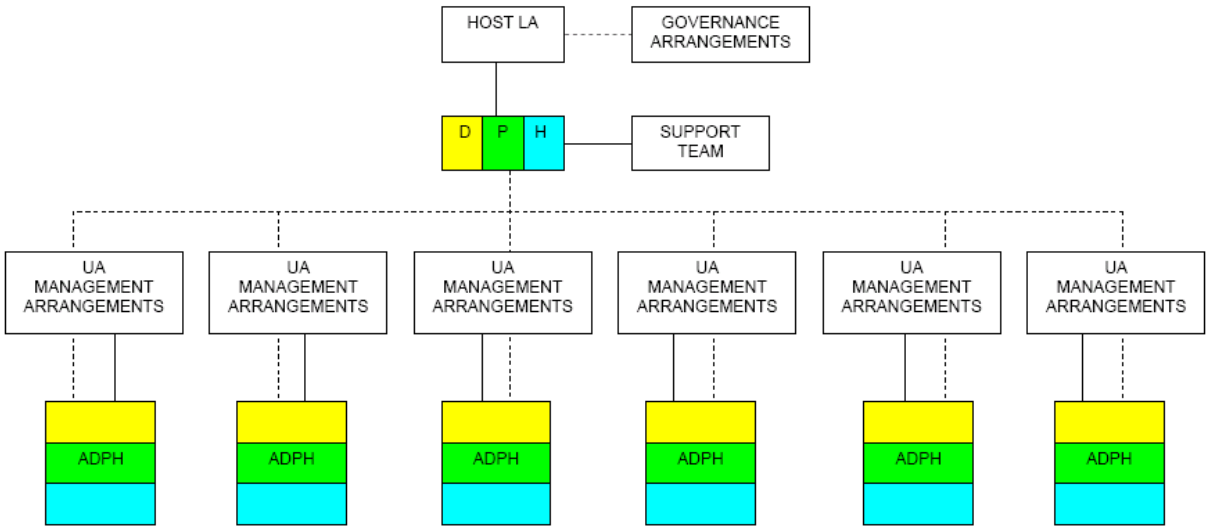
DRAFT BERKSHIRE HIGH LEVEL ORGANISATION STRUCTURE AND GOVERNANCE ARRANGEMENTS

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.

APPENDIX 2

Cabinet Report – Update on NHS Changes

Details of the budget for RBWM are not known as the PCT does not break down expenditure by local authority. The total spend reported to the Department of Health was £10,027,000 for public health actual spend across Berkshire East for the year 2010/11, with the headline of the figures relating to the transfer of responsibilities detailed below:

PUBLIC HEALTH OUTTURN 2010/2011	
Public health leadership	£1,003,000
Information & 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**

Nationally Local Authority Chief Executives were asked to comment on the quality of the information and all reported having significant reservations about this.

APPENDIX 3

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