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

Contains Confidential or Exempt Information	**NO – Part I**
Title	Transfer of Public Health to RBWM & Update on NHS Changes
Responsible Officer(s)	Christabel Shawcross, Deputy Managing Director / Strategic Director of Adult & Community Services
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Member reporting	Cllr David Coppinger
For Consideration By	Shadow Health & Wellbeing Board
Date to be Considered	08 February 2013
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 transition board, led by Bracknell Council.

2. It recommends the progress be noted and that the risk sharing agreement within Berkshire Unitary Authorities be endorsed.

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 is transferring public health budgets to each responsible council, as a specific grant based on a national allocation and methodology. The issues relating to this, and risks, are under consideration as part of the Berkshire-wide group and are identified in this report. It is considered that the allocation of £3,191,600 should be sufficient to cover current costs and risk sharing will enable mitigation of risks of over commitments.

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 2014
2. Improved health outcomes for residents.	April 2014

1. Details of Recommendations

RECOMMENDATION: that Shadow Health & Wellbeing Board

- **notes the progress on the transfer of public health responsibility to RBWM; and**
- **endorses the Berkshire Public Health Transition Board's proposal to share financial risk in 2013/14 for contracts that cover more than one Unitary Authority (UA). And notes that this report and recommendations is going for approval to the RBWM Cabinet on 21st February 2013.**

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; and
- Domain 4 – Healthcare public health and preventing premature mortality.

2.2 Approach across Berkshire Unitaries

The proposals for the Berkshire-wide approach to ensure a safe transfer have been agreed through the Berkshire Leaders and Chief Executives Group supported by the Berkshire Transfer Board. The Strategic Director of Adult & Community Services is the representative and lead in RBWM for 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.

2.3 **Director of Public Health (DPH)**

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. There was agreement for one DPH across Berkshire providing individual public health functions for each unitary.

2.4 **Berkshire Model approved**

The Berkshire Transition Plan to the Strategic Health Authority (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. Progression on the transfer of staff is outlined in paragraphs 11.3 and 11.4.

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

There is a statutory duty for the local authority to have a health and wellbeing strategy agreed with the Clinical Commissioning Group (CCG) in place from April 2013. However there is a degree of flexibility with it as the guidance from the DH on what a JHWS should look like was due out at the end of November 2012, but has been delayed until the end of March 2013.

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

The guidance has not changed significantly. Important points to note were:

- 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, which 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 with the Health & Wellbeing Board:

- 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 20th 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; and
- 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 **National public health 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 PHE, 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 was published on 10 January this year, the delay enabled the DOH to provide allocations for both 2013/14 and for 2014/15. RBWM has been allocated £3,191,600 in 2013/14 and £3,510,700 for 2014/15. Appendix 2 to this report sets out the allocation to all the Berkshire Authorities for the two years. More details are in paragraph 4.

2.10 **Emergency Planning Working Group**

The Emergency planning group seeks to provide a way forward for the delivery of the emergency planning function across Thames Valley. The Group focuses on the coordination and leadership of the new Public Health role in coordinating emergency planning, training and exercising at Thames Valley level only. It does not impinge on the sovereignty of individual Local Authorities to make their own arrangements and structure this as they see fit locally. 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 public health in local authorities in Berkshire. It was agreed that the best way to achieve this in relation to contracts with public health 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 Berkshire East and West NHS boundaries, so this is not going to change during 2013/14 because of need to determine value and activity per UA.

2.12 **National Funding Allocation 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 and 2012/13 (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 UAs and has Finance, contracts/commissioning (from PCT and UA) and public health as part of the group membership. Detail on this is provided in paragraph 4.

2.13 **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 CCGs but local authorities will have an important role to play in ensuring that CCGs commission services that will improve the outcomes for their populations.

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

The relationship(s) with the CCGs will play a critical role in ensuring that we get the right service in the right place for the right price. The seven Berkshire CCGs 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 public health in UAs 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.

2.14 The DOH requirements on public health functions that local authorities must and ought to carry out were issued in January 2013. These are set out in Appendix 3. During 2013/14 consideration will be given based on the joint needs assessment and Health and Wellbeing Strategy what the priorities need to be from April 2014 and what funding is available for any improvements for residents. The circular sets out grant conditions categories of spend which will need to be reported to DOH and a statement that will need to confirm the grant has been used in accordance with conditions. The circular states it is vital these funds are used to:

- Improve significantly the health and well being of local populations
- Carry out health protection functions delegated from the Secretary of State.
- Reduce health inequalities across the life course including within hard to reach groups.
- Ensure provision of population health care advice.

In commissioning services using sums from this grant, local authorities should also ensure appropriate clinical governance arrangements are put in place. The mandatory functions as stated are set out in prescribed fact sheets. These can be found on the Department of Health website at:
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf

2.15 **Core Public Health Offer by Local Authorities to CCGs**

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 and agreed with CCGs, and in RBWM this relates to Windsor & Maidenhead CCG.

2.16 **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 UA 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.

2.17 **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 there are some risks around contracts being novated in 2013, 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 UAs.

2.18 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; and
- 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. RBWM implements the agreement to the Berkshire model for public health and the sharing of financial risk on Joint Contracts in 2013/14. **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

3.1 The Health and Wellbeing Strategy will encompass a range of different strategies such as those for Children's Services, Adults and the CCG. The key ones to be delivered through the public health fund transfer will contribute to the public health outcomes indicators. The requirements for this are being finalised to ensure targets can be measured accurately through respective agencies. The basis of this is agreeing the Health and Wellbeing Strategy which will not just encompass priorities for 2014 but years beyond by agreement. The essence being to concentrate on priorities that will maximise the health and well being of residents, such as reducing hospital admissions, and prevention and better management of long term conditions and dementia identification and support.

Defined Outcomes	**Unmet**	**Met**	**Exceeded**	**Significantly Exceeded**	**Date they should be delivered by**
Final Joint Health and Wellbeing Strategy setting out RBWM and CCG priorities	Priorities not agreed and final strategy not published within 12 months of issuance of DH Guidance.	Priorities agreed and final strategy published within 12 months of issuance of DH Guidance.	Priorities agreed and final strategy published within 9 months of issuance of DH Guidance	Priorities agreed and final strategy published within 6 months of issuance of DH Guidance	Issuance date for DH Guidance has slipped to end March 2013.
Public Health priorities in RBWM are met	Significant under-achievement in one or more PH Domain as specified in PH Outcomes Framework	Adequate progress in achievement in all PH Domains.	At least adequate achievement in all 4 PH Domains, and exceed targets in one Domain.	Exceed targets in more than one PH Domain.	Will be delivered throughout the 2013/14 financial year.

4. Financial Details

a) Financial impact on the budget.

There is no impact on the local authority budget for 2012/13.

The final allocation for RBWM is £3,191,600 in 2013/14 and £3,510,700 in 2014/15. The total allocation across Berkshire unitaries is detailed in Appendix 2.

The grant funding for 2013/14 is ring-fenced to public health and so must be spent to deliver public health outcomes or repaid to the Department of Health. With the continuation of the 2012/13 contracts into at least 2013/14 it is possible to take a view as to the likely commitment on a Berkshire basis. However there is uncertainty as the assumptions for 2013/14 will be made upon the latest available full year activity and costs, which will be for 2011/12. A further risk is that the activity within Berkshire has not been analysed by Unitary Authority on an historical basis, and is therefore difficult to estimate for the coming year. Indeed there will be difficulties in ascertaining actual activity by Unitary Authority in future years, for example data protection requirements may make it difficult to determine residency when accounting for sexual health occurancies.

It has been agreed in principle by the Transition Board that the 6 Berkshire Unitary Authorities will contribute towards the cost of joint contracts in accordance with the proportion of their ring-fenced allocation. This agreement will avoid the latter risk noted above of an uncertain pattern of public health activity within Berkshire, and overcome the unavailability of data by UA in the first year. It is anticipated that residence information will improve with time, and that contracts will be clarified or amended to ensure this is the case. The recommendation within this report is therefore to agree to this element of risk sharing for the 2013/14 financial year.

During 2013/14 work will be undertaken not only to clarify the residency of recipients of PH services, but also to clarify and update service and contract specifications. It will not be possible to cover all PH contracts in this first year, and therefore there will be focus on those areas of highest risk. There is a contractual requirement to give a years notice on existing contracts, however it is envisaged that we will not be in position to agree which contracts to give notice on, and commence re-tendering for, until well into 2013/14. With improved activity data is should be possible to allocate actual costs to each authority for 2014/15. Therefore although it is likely that many existing contracts will continue in 2014/15, it is considered unlikely that a risk sharing agreement will be required for that year. For subsequent years contracts should be let according to local requirement rather than on an historical basis.

The DOH public health allocation was assessed upon baseline spending in 2011/12 updated to 2013/14 giving a funding requirement of £2.5 billion nationally. Nationally a 5.5% cash increase has been added to this sum for 2013/14 and another 5% for 2014/15. With this increase in funding and recent savings in local contracts such as smoking cessation, it is considered that this year RBWM will be able to meet its contractual commitments within its ring fenced grant, this will be assisted by the risk sharing agreement noted above.

	2013/14	**2014/15**	**2015/16**
	Revenue £000	Revenue £000	Revenue £000
Additional income (-)	-3,191.6	-3,510.7	Not yet known
Additional spend (+)	3,191.6	3,510.7	Not yet known.

b) Financial Background

The detail of the public health spend for 2010/11 was reported to Cabinet in December 2011. The first draft of the DH allocation was detailed in spending estimates issued in February 2011. It stated that there was the opportunity for further validation with the PCT and SHA before final allocations were made in January 2013. There was 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 made representations to NHS Berkshire and the SHA about the allocations. The overall distribution nationally showed huge variations explained only in part by population health inequalities. In South Central, West Berkshire unitaries received £25 per head, East Berkshire receives £21 per head and Portsmouth £68 per head.

The allocation for RBWM in 2014/15 of £3,510,700 reflects an increase from a 2013/14 baseline of £20 per head of population to a 2013/14 allocation level of £22, and a 2014/15 level of £23. Whereas all authorities receive more in 2014/15 than 2013/14, those whose baseline allocation is further below a formula allocation, receive a greater increase. The formula, recommended by the Advisory Committee on Resource Allocation (ACRA)

provides the DOH with a target per head allocation, which for RBWM is £37 in 2013/14. It is unclear over what time period the DH intends to close the gap between the actual allocation and its stated target allocation.

Currently many 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.

The pattern of expenditure in 2010/11 and 2011/12 informed the Department of Health's allocations for 2013/14. As noted above it is not possible to accurately give historical spend in respect of the individual Berkshire UA's. On a Berkshire wide basis analysis of historical spend shows broadly that Berkshire Health Foundation Trust received 25% of the funding for a range of activities including Nutritional Obesity & Physical Activity, Sexual Health, Smoking Cessation and services for children including school nurses, Acute Hospitals received 15% (mainly for sexual health purposes, of which Royal Berkshire Hospital received 90%), Drug and Alcohol support received 35%, GPs received 5% for a wide range or purposes, and 20% was spent on Leadership, infrastructure, & administration.

Health Premium

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 Shadow Health & Wellbeing Boards (SHWB) the 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. The new statutory requirements on public health will need to be added to the council's constitution with appropriate delegation. Work is being undertaken on this through the Berkshire board.

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 Act* and Public Health requirements.	Low	Retain links to the Early Implementer network and continue cross Berkshire collaboration and ensure that Cabinet are aware of implications of Public Health Transfer and its operation within RBWM.	Having controls will ensure that local implementation is correctly managed and any risks are reduced.
That expenditure will exceed budget	High	Work to clarify contractual commitments, and set up process to monitor activity and to accurately forecast annual commitment on a timely basis. This will enable measures to taken where potential overspends are identified. Identification of high risk areas for early consideration for contract review.	Low

9. Links to Strategic Objectives

The work of the SHWB meets all of the strategic objectives of putting residents first through achieving health and 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. The job description had to be agreed by the Institute of Public Health who also determine the technical competence of the applicant. An external appointment has been made commencing January 2nd.

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.

11.2 Consultants in Public Health & Health Protection Consultant

The structural design that has been developed has a 'Lead Consultant' in public health that is employed by the individual UA 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. The post holder will manage a team of 5 FTE comprising of a Programme Manager, 3 Programme Officers and a Programme Administrator.

11.3 HR & Recruitment of the Tier 3 staff roles

The DOH 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 UAs 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. RBWM public health staff will be based at York House Windsor and space has been identified. If possible they will move in during March 2013.

13. Any other implications

As this is a new function for the council a series of awareness training for officers and members will be arranged.

14. Consultation

The Health & Wellbeing Board has been involved in all the proposals and endorses the recommendations in the report.

15. Timetable for Implementation

From January 2013 there is 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 – Final Allocations
Appendix 3 – Public Health Functions

17. Background Information

17.1 There have been several guidance documents from the DOH regarding the roles and responsibilities of 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 Public Health Outcomes Framework (PHOF); and
- 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 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 February 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.

17.5 The DOH 2013 circular issued in January on the ring fenced Public Health grant sets out the requirements and conditions of the grant. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf

APPENDIX 1

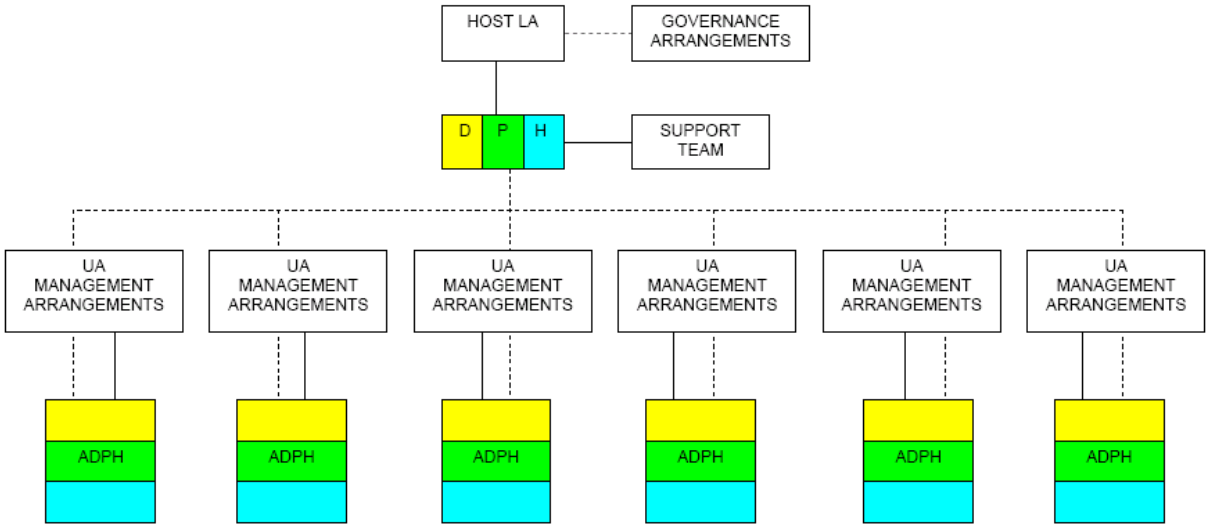
BERKSHIRE HIGH LEVEL ORGANISATION STRUCTURE AND GOVERNANCE ARRANGEMENTS

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

DOH Final Allocations of Public Health budgets.

The Berkshire allocation is:

	2013/14	**2014/15**
Reading	7,465,500	8,212,100
Slough	4,987,700	5,486,500
West Berks	4,381,000	4,819,100
Wokingham	3,838,900	4,222,800
(RBWM	**3,191,600**	**3,510,700)**
Bracknell	2,771,600	3,048,800
Totals	**26,636,300**	**29,300,000**
Berks East	10,950,900	12,046,000
Berks West	15,685,400	17,254,000

DOH Circular on PUBLIC HEALTH FUNCTIONS January 2013

Prescribed:

1) Sexual health services – STI testing and treatment
2) Sexual health services – contraception
3) NHS Health Check programme
4) Local authority role in health protection
5) Public health advice
6) National Child Measurement Programme

Non-prescribed:

7) Sexual health services – advice, prevention and promotion
8) Obesity – adults
9) Obesity – children
10) Physical activity – adults
11) Physical activity – children
12) Drug misuse – adults
13) Alcohol misuse – adults
14) Substance misuse (drugs and alcohol) – youth services
15) Stop smoking services and interventions
16) Wider tobacco control
17) Children 5 – 19 public health programme
18) Miscellaneous, which includes:
    - non-mandatory elements of the NHS Health Check programme
    - nutrition initiatives
    - health at work
    - programmes to prevent accidents
    - public mental health
    - general prevention activities
    - community safety, violence prevention & social exclusion
    - dental public health
    - fluoridation
    - local authority role in surveillance and control of infectious disease
    - information and intelligence
    - any public health spend on environmental hazards protection
    - local initiatives to reduce excess deaths from seasonal mortality
    - population level interventions to reduce and prevent birth defects (supporting role)
    - wider determinants