TO: HEALTH OVERVIEW AND SCRUTINY PANEL
27 SEPTEMBER 2012

PUBLIC HEALTH UPDATE
Director of Adult Social Care, Health and Housing

1. PURPOSE OF REPORT

1.1 The purpose of this report is to provide a further update to the Health Overview and Scrutiny Panel on the emerging arrangements for the transfer of Public Health functions to Local Authorities in April 2013. The last update was on 26 April 2012, although the Working Group on NHS Reforms has had a progress report.

2. RECOMMENDATION

2.1 The Health Overview and Scrutiny Panel are asked to note this update report.

3. BACKGROUND AND CONTEXT

3.1 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 1 April 2013.

3.2 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

3.3 The Act has major implications for the local health system and the relationship between that system and local government. In particular it provides for the:

- Abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs) and the establishment of Clinical Commissioning Groups (CCGs), led by GPs, to commission health services locally;
- Transfers responsibility for public health to local government; and
- Places a responsibility on Local Government to provide Public Health advice and intelligence back to CCGs and the NHS Commissioning Board;
- Requires councils to establish Health and Wellbeing Boards;
- GPs will have responsibility for commissioning a wide range of healthcare services, with some exceptions. The Act allows GPs to join together in consortia, and to commission services in the ways that they judge will deliver the best outcomes for patients

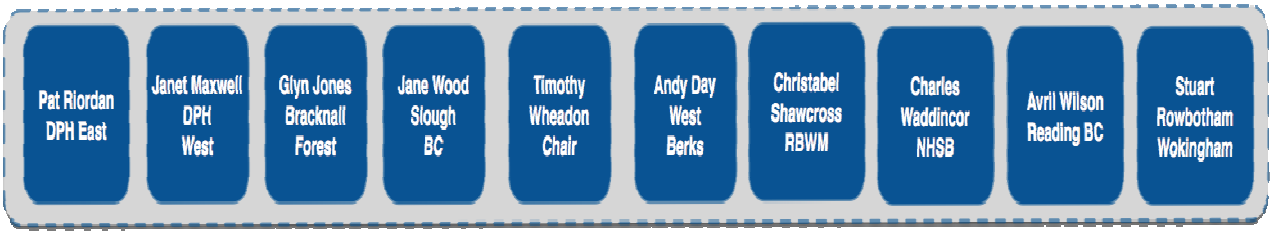
4. PROGRESS SO FAR

4.1 Members of the Panel will be aware that early consideration was given to a model based upon a single Strategic Director of Public Health (SDPH) across Berkshire. The preferred position of the Unitary Authorities was for a single SDPH, this was communicated to Charles Waddicor, Chief Executive of the PCT in a letter from Timothy Wheadon dated 14 February 2012. Since this, it has been agreed by the six UAs that Bracknell Forest Council will host the SDPH and Care Team on behalf of the partnership.

4.2 The six UAs are working in a spirit of collaboration to develop a framework that would lead to an effective and efficient Public Health model that would have two key objectives:

- To provide real focus and interventions for the local issues and concerns, not only around the health element but also to consider the wider determinants of health as highlighted in the Marmot Report published in February 2010;
- To establish a public health function that could work across Berkshire and deliver real collaborative sustainable change and efficiencies that would make a real difference to health outcomes and demonstrate real value for money.

4.3 The Transition Board has led the transition programme since its inception. The structure of the Board is described in Fig 1 below, which is chaired by Timothy Wheadon, Chief Executive, Bracknell Forest Council:



4.4 The Board has been supported by two Programme Managers who were engaged to support the transition programme on an East and West basis:

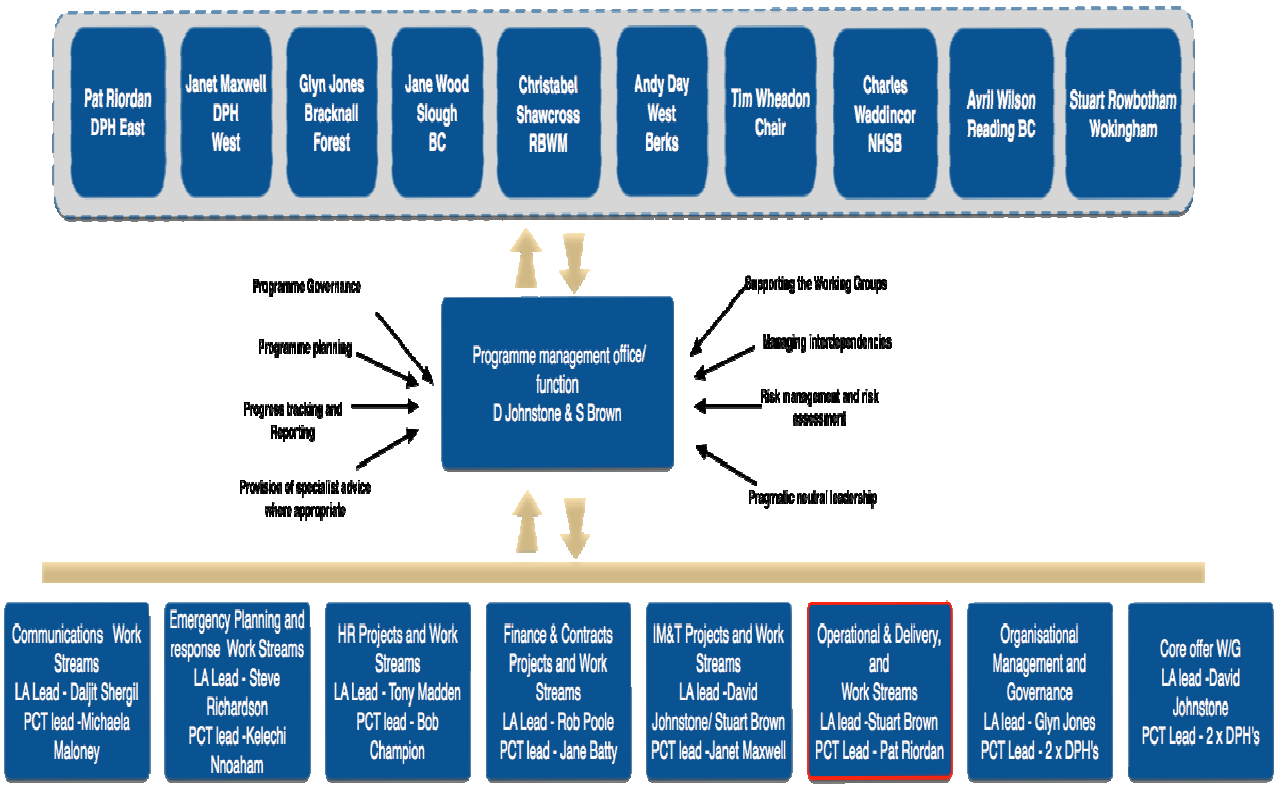
- David Johnstone - supporting the UAs in the West of Berkshire
- Stuart Brown - supporting the UAs in the East of Berkshire

4.5 The CCGs are also represented on the Transition Board as key stakeholders and partners in the new world. They first attended the Transition Board meeting on the 8 May and have been continuously represented since.

4.6 The Working Group Approach

4.6.1 Because of the complexity and the enormity of the tasks that needed to be undertaken if we were to deliver ***a safe and stable public health service*** into local authorities by 31 March 2013, it was decided to establish a number of working groups. The membership of the groups is drawn from all six UAs and includes at least one representative from Public Health.

4.6.2 This approach has proved to be a success with each of the UA assured that they are more than adequately represented. Fig 2 below describes the Board and the sub structure Working Group:



4.7 Governance and Structures Working Group

4.7.1 This group was established following the Transition Board meeting in April and tasked with designing the proposed structures for the PH teams that will be embedded in each of the UAs as of the 1 April 2013.

4.7.2 The group, consisting of the two DPHs, The Director of Adult Social Care, Health and Housing at Bracknell Forest Council and the two Programme Managers has held a series of workshops and meetings and has developed a proposed structure which was presented to the Transition Board on 12 June for formal approval. This then also formed the basis for discussions at the Chief Executive's Forum and the Berkshire Leaders Forum.

4.7.3 The group also completed the production of the Job Descriptions and Person Specifications for the Strategic Director of Public Health for Berkshire and the Lead Consultant role that will be located within each of the Unitary Authorities. Formal consultation on the proposed roles and the core structure commenced on the 23 July 2012.

4.7.4 Detailed work to define the specialisms and capacity that would be required within each of the Unitary Authorities began in early August and will complete in time for staff consultations to commence on 1 October.

4.8 Information Management & Technology Working Group

4.8.1 This workstream has made good progress since its inception and has already started to take on additional work around the core offer of Public Health advice to the NHS as the programme gathers momentum. A high level product breakdown structure has been completed which will define the deliverables and allow proper planning. Sub

workstream leads and working groups have been established for the following areas:

- Information governance & 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

4.8.2 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, lead by Professor John Newton.

4.8.3 There are indications that the public health data and intelligence databases will transfer to the new Commissioning Support Units (CSUs) - this has raised some concerns in local government about the possibility of CSUs wanting to charge for the provision of this information in the future - with local authorities having a mandatory duty to supply the Core Offer to CCGs free of charge this places a financial burden on local authorities because the substance of the core offer is dependent on the provision of reliable and accurate data and intelligence which Public Health currently have access to as part of the public health functions and resources.

4.8.4 It is anticipated that we will be able to resolve the issues around patient identifiable data and access the other challenge is around the IT infrastructure required to provide the intelligence service. Initial discussions with Berkshire Shared Services have explored the possibility of extending the current service level agreement.

4.9 Finance and Contract Working Group

4.9.1 During the last period, 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 program spend and not staffing spend). These work groups are as follows:

- Acute Contracts
- Community Contracts
- GP provided services
- Other (inc. Drug, smoking etc.)

4.9.2 Each workstream 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.

4.9.3 The initial data for 2011/12 has been produced by the PCT and this has been converted into a data pack (in the same formats that were produced for the 2010/11 data returned to DH) for each of the sub groups to use to ensure that the control total is maintained. Each of the working groups will be completing a detailed template (which has been reviewed and slightly amended following feedback from the working groups) to capture the required information in a consentient format. This may not capture all the data required, but should provide a more detailed picture of the likely commitments and contracts.

4.9.4 Currently work is progressing as planned, but with some slippage in terms of timescales has occurred which is causing some concern at Transition Board level. Based on this, the SHA are able to provide resource support funding, a mini business

case to the SHA was submitted in support of a request for funding to the tune of £30K which will be used to deliver a number of specific objectives around the finance/budgets and the contracts that we will inherit in 2013. The SHA have contacted the Programme Manager and given an assurance that they will indeed underwrite this amount.

4.10 Emergency Planning Working Group

4.10.1 The Emergency Planning Working Group was, at the time of submission of the transition plan, deemed to be of a lower priority for the UAs whilst planning and testing of plans for London 2012 was reaching a critical stage.

4.10.2 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.

4.11 Finance & Funding

4.11.1 Clarity is still some way off about what the final allocations will be for each of the UAs for 2013/14. Some work has been done by the SHA around identifying a fairer and more realistic set of allocation figures which would rebalance the initial proposed allocations to give greater fairness and to some degree a figure based on some consideration of needs in each borough. It is anticipated that by December, we will be notified of final allocations.

5. FORWARD PLANNING 2013/14

5.1 Commissioning Intentions

5.1.1 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.

5.1.2 This will be achieved in a number of ways, not least of all through the JSNAs and Health and Wellbeing Boards, but also via the mainstream public health functions on a day to day basis.

5.1.3 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 or may not continue to be the alignment going forward.

5.2 Core Offer

5.2.1 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 clear need to continue to provide this service to the new commissioning structures post 31 March 2013.

5.2.2 A Working Group was established and a number of key principles proposed. Recently, progress accelerated and a draft Memorandum of Understanding (MOU) has been produced by David Johnstone and will be discussed in detail at the next Core Offer

working group meeting towards the end of September.

5.2.3 Following which, a formal paper and draft MOU will be presented to the October Transition Board meeting.

5.3 Joint Strategic Needs Assessment (JSNA)

5.3.1 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 31 March 2013

5.3.2 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.

5.3.3 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 and 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.

5.4 Risks and Issues

5.4.1 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 UAs may have to implement post transition contract adjustments to ensure that services are delivered in an affordable way for UAs.

6. CONCLUSION

6.1 Considerable progress has been made on the arrangements for transfer via the Working Groups.

6.2 It is a very sensitive time for staff as we prepare to consult on the detailed arrangements of posts and grades in the new structure. The next period will also continue to recruit to roles in the structure.

6.3 The priority remains as set out in 4.6.1 to ensure a safe and stable Public Health Service on 1 April 2013. Once this has been achieved then it will be possible to look at the synergies of being in local government, and how this can provide opportunities for further collaboration and improved commissioning.

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