By: Graham Gibbens, Cabinet Member for Adult Social Care & Public Health

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To: Social Care and Public Health Cabinet Committee – 12 July 2012

Subject: **Public Health Transition**

Classification: Unrestricted

Summary: This report provides an update on the progress of the transition of the locality-led element of the new national Public Health system to the County Council in April 2013. It also summarises the Government's recent announcements on future Public Health budgets under the new system and explores the implications for the Authority.

For Decision: The Cabinet Committee are asked to consider this report and either endorse or make further recommendations in shaping the Cabinet Member's outline response to the Department of Health's consultation paper 'Healthy Lives, Healthy People: Update on Public Health Funding'.

Introduction

1. (1) This is the latest update to Members of this Committee (which also builds on reports to the now decommissioned Adults Social Care and Public Health Policy Overview and Scrutiny Committee) on the proposals to change how Public Health in England is to be organised and the implications of these changes for the County Council.

Health and Social Care Bill - 27 March 2012

2. (1) The enactment of the Health and Social Care Bill gives KCC, as an upper tier Authority, a new duty "to take appropriate steps to improve the health of the people."

(2) As well as the Act introducing a generic duty, it also requires KCC to undertake a number of specific steps including:

- Establishing a Health and Wellbeing Board
- The development of an enhanced Joint Strategic Needs Assessment (JSNA) under the auspices of the Health and Wellbeing Board
- Commissioning Kent HealthWatch
- Assuming statutory responsibility for some of the key elements of the new national Public Health System
- Appointing (by statute) a Director of Public Health

(3) The Act introduces a new national Public Health system consisting of four elements:

- National Commissioning Board

- Public Health England
- Clinical Commissioning Groups
- Upper Tier Local Authorities

(4) In effect, this means that KCC becomes an integral part of this new national system providing locality-led leadership and oversight of Public Health (PH) in the County, together with responsibilities in delivering some key PH services from the 1 April 2013. To support these new responsibilities the Authority will receive a ring-fenced budget and the transfer of most of the existing NHS staff currently working in PH in Kent.

Public Health Work in 2013 and Beyond

3. (1) It is anticipated the work that will be transferred will include the shaping and delivery of over 20 Public Health programme/services of which, going forward, the following will be mandated from next year:

- Appropriate access to sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention).
- Steps to be taken to protect the health of the population, in particular giving the local authority a duty to ensure there are plans in place to protect the health of the population.
- Ensuring NHS commissioners receive the Public Health advice they need.
- NHS Health Check assessments.
- The National Child Measurement Programme.

(2) Outside of these mandated services, other services will be discretionary (although the Secretary of State holds reserve powers over the direction of other services) with the Health and Well Being Strategy and the JSNA guiding delivery against these other areas. However, performance will also be judged against the national Public Health Outcomes Framework which will influence the allocation of future resources through the proposed Public Health premium system (see later in this report).

(3) The Act also makes it clear that the Authority has a responsibility for taking appropriate steps to protect the health of the population and to ensure the safety of Public Health services.

The Transition Process

4. (1) It is incumbent on the NHS to identify those exact functions and resources that will transfer to KCC and there are complex sets of Department of Health policies and guidance and reporting arrangements to achieve this. However, given the rate of change within the NHS, a KCC project team has been developed to oversee the transition process and to ensure KCC's best interests are protected. A high level list of programme milestones is attached as appendix 1 for information.

Reshaping the Public Health Team

5. (1) After consultation with KCC, the Director of Public Health (DPH) on behalf of the NHS, has decided to initiate the process of the reshaping of all existing PH staff resources (both NHS and KCC staff) to ensure a better fit with current and future policy frameworks and service priorities. This consultation commenced in mid June with the launch an informal consultation document. This process will last until July followed by formal consultation over the summer. The intention is to make the appropriate appointments or slotting of staff in September/October, with a 'shadow' team in place by October. There are still some negotiations to be finalised, but the expectation is that in total, excluding the DPH there are some 61 posts (not FTEs) in scope (54 posts currently in the NHS, 7 currently employed by KCC). The FTE figure is 46.97 for the NHS and 7 for KCC.

(2) In April 2013, NHS staff will be transferred under TUPE or the Cabinet Office equivalent policy guidelines.

(3) Some of the core principles driving the proposed change include:

- Delivery of the Ambitions set out in Bold Steps for Kent
- Ensuring the safe delivery of Public Health programmes
- An intelligence-led commissioning approach, focusing on areas and groups of greatest need
- A strategic commissioning approach
- An integrated approach to joint commissioning and work both with County Council Directorates and between the County Council and District Councils
- An alignment with sub-County locality arrangements
- Integration with CCGs and other health commissioners
- Ensuring we remain linked to NHS clinical networks so that we can productively advise on health care standards and practice
- Collaborative work with Medway Council
- Tailoring services to population needs and developing a wellness service that address multiple needs and aims to reduce inequalities

(4) As part of the overall informal consultation, staff have been asked to comment on proposals on how the various functions of Public Health might be grouped in the new team. A summary of this is attached as appendix 2 for information.

Finance and Budgets

6. (1) Perhaps one of the more complex aspects of transition is to map and identify the actual budgets that will transfer to the four components of the new Public Health system including the Local Authority. This complexity stems from:

- traditionally Public Health budgets within the NHS have not been clearly delineated from other budgets
- the precise details have yet to be finalised as to which organisation in the new PH system will responsible for exactly what element of each PH programmes and services
- to date, it is historic information that is being used and not contemporary (i.e., it has not been 2012/13 budgets being analysed).

(2) After April 2013, PH will be funded by a new Public Health budget, separate from the budget managed through the NHS National Commissioning Board (NCB) for healthcare. This budget will be made up of:

- ring-fenced grants to upper tier and unitary authorities
- through the NHS National Commissioning Board: and
- Public Health England commissioning or providing services itself
- It has been estimated that in 2012-13 approximately £5.2 billion will be spent on the future responsibilities of the PH system, including £2.2 billion on services that will be the responsibility of local authorities.

Progress to date

7. (1) Initially work focused on establishing the baseline for any budget transfers. This process looked at budget spend 2010/11 and led to the publication in February 2012 of initial figures for each element of Public Health spend by each component of the new system. Under this system the baseline analysis suggested that KCC would receive a transfer of approximately £24 per head (figures adjusted to reflect 12/13 budget estimate). By way of comparison, the predicted local authority spend per head ranged from a high of £117 per head (Tower Hamlets) to the lowest figure of £15 per head (Buckinghamshire). The East Kent PCT figure was £29 per head, West Kent £19 per head. Across the English regions the figures ranged from £27 per head (in the South East and South West) through to £65 per head (London).

(2) Work is currently underway on analysing 2011/12 audited PCT expenditure as an update to the baseline published in February. The Kent and Medway PCT Cluster will make their submissions to the Strategic Health Authority (SHA) for the Eastern and Coastal Kent, and West Kent, PCTs on 9 July so details may be available to update these details by the time of the meeting of this Committee. Submission to the DH and the NHS Commissioning Body Special Health Authority will be made by the SHA on 23\ July.

(3) This process, despite its flaws also highlighted how eclectic the allocations of funding for Public Health have been across the country and between Primary Care Trusts (PCTs).

(4) Work is on-going to challenge the proposed future funding arrangements for the South East Region with the Department for Health.

'Healthy Lives, Healthy People: Update on Public Health Funding'.

8. (1) On the 14 June 2012 the Department of Health published the above paper setting out current Government thinking on the funding of PH post April 2013. In particular it sets out:

- the next steps on moving from the estimates of baseline spending published in February 2012 to actual allocations for 2013-14 that are expected to be published by the end of 2012:
- provides further information on the high level design of the Public Health budget allocation system including the use of a Public Health premium for 2013/14 and:
- conditions on the ring-fenced Public Health grant which state how the grant may be used; including proposals for local authority financial reporting requirements on Public Health spend.

(2) The Department of Health (DH) has yet to fully commit to exactly what level of budgets will be transferred apart from the paper stating that the amount allocated to local

authorities for 2013-14 'will not fall below these estimates in real terms, other than in exceptional circumstances'.

The High Level Design of The Allocation of Public Health Budgets

9. (1) By common consent the budget allocations for PH work varies by an extraordinary amount between and within areas. The Government has proposed that this should be subject to further analysis to derive a more equitable set of allocations across England. They commissioned the Advisory Committee on Resource Allocation (ACRA) to develop a formula for the allocation of the PH budget to local authorities relative to population health need, to enable action to improve population wide health and reduce health inequalities.

(2) ACRA's interim recommendation is based on the use of standardised mortality ratio (SMR) for those aged under 75 years. This is a measure of how many more or fewer deaths there are in a local area compared with the national average, having adjusted for the differences between the age profiles of the local areas compared with the national average.

(3) ACRA also recommended that the formula should include an adjustment for unavoidable differences in the costs of delivering services across the country which are due to location alone, such as higher staff costs, and not need. ACRA recommended that, for consistency, an appropriate Area Cost Adjustment (ACA) based on that used in the local government funding formula should be used. Any ACA however needs to reflect up to date information as far as possible, and it should be noted that the adjustment does occasionally throw up strange results.

(4) However, the update makes it clear that this is an interim recommendation and ACRA have identified some areas needing further work before making its recommendations for the formula for allocations in 2013-14

(5) The Government has said that, although they wish to see progress towards a new system in the allocation of PH resources, it will not commit to an exact timetable (or what they call the 'pace of change'). In part this is understandable as it will still take some time to fully understand the overall resources available and the splits between the various components of the new PH system. The Government has said that it 'will protect investment in each authority in real terms' during the current spending review period. If so, and given there is no predicted increase in overall resources for Public Health it seems likely that it will take several years to move a to a needs-based basis rather than a pattern based on PCT's historic spending.

(6) The paper also considers the proposed use of a health premium (i.e., a reward or incentive for success) but concludes "We recognise that the significant data lag on many of the indicators in the Public Health outcomes framework would mean that if it was paid in 2013-14 we would be rewarding local authorities for decisions taken by PCTs. We are therefore planning to delay the first payments until 2015-16, the third year of local authority responsibility for PH responsibilities".

Conditions on The Ring-Fenced Public Health Grant

10. (1) The PH grant to local authorities will be made under Section 31 of the Local Government Act 2003 and, as with other ring-fenced grants, will carry conditions about how it may be used. Thus, the grant continues to be NHS money.

(2) The government had promised to restrict the conditions on the grant so as to maximise flexibility. That said the draft guidance stretches to 4 sides of text. The core

conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the Public Health functions for which it has been given, and ensuring a transparent accounting process.

(3) The intention is for the grant to be spent on activities whose main or primary purpose is to impact positively on the health and wellbeing of local populations, with the aim of reducing health inequalities in local communities. Those activities include:

- improving significantly the health and wellbeing of local populations carrying out health protection functions delegated from the Secretary of State;
- reducing health inequalities across the life course; and
- ensuring the provision of population healthcare advice.

(4) The DH intends to test the conditions on the grant further, before finalising them and issuing them with actual allocations for 2012-13.

(5) The update stresses that the preferred distribution of resources is going to take time to perfect and the DH would welcome feedback on how it can be improved in both the short and long term. They expect that the preferred distribution will evolve over the next two to three years. They intend to publish actual allocations for local authorities before the end of 2012.

Next Steps

11. (1) The Healthy Lives, Healthy People: Update on Public Health Funding paper invites comment and feedback and it is important that KCC does respond. In part this will be a technical analysis of the criteria used in ACRA's draft recommendation in distributing resources on a needs basis. This analysis has not yet been completed so I intend, if possible, to provide a verbal update at this meeting.

(2) However, there are also a number of more general or points of principle that should shape a KCC response. These include:

- the under 75s standardised mortality ratio indicator being proposed as the basis for a new system of allocation of funding is positive in that the data is known but it does look limited on its own;
- our current belief that the overall quantum of money spent on Public Health nationally is an under-estimate and the share of that figure that been identified as transferring to local authorities is also undercounted;
- concern over the time it might take to before funding is distributed largely on a needs led basis (i.e., those resources that have been earmarked to be allocated to cover any contingency costs associated with the changes to the NHS);
- querying why the document is silent over any transfer of a proportion of the money saved under the NHS's Nicholson Challenge to the PH budget. These savings have been effectively allocated as a contingency budget to support the overall changes to the NHS;
- concerns over the effectiveness of the area cost adjustment formula that looks like this disadvantages Kent;
- the belief that 2011 Census population details when available should be used and not the Office of National Statistics 2011 estimates;
- An overly prescriptive set of conditions for the proposed ring-fenced grant;

- Observations and comments from this Committee would be very welcome.

Conclusion

12. (1) This report informs the Committee of the progress being made in the transition of PH responsibilities in April 2013. It seeks endorsement by the Committee in the Cabinet Member responding to the 'Healthy Lives, Healthy People: Update on Public Health Funding' document published by Government along the lines set out in paragraph x and incorporating any comments made at this meeting.

Recommendations

13. (1) To note the progress made in the transition of Public Health responsibilities to the County Council in April 2013

(2) To endorse the Cabinet Members intention to formally respond to the consultation by Government on the future of Public Health Funding

Background Documents

Healthy Lives, Healthy People: Update on Public Health Funding
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134580.pdf

Contact details

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Appendix 1

INDICATIVE HIGH LEVEL PROJECT MILESTONES

Project Elements	Date
Project Initiation	
Scope, objectives, principles and timescales agreed	June
Stakeholder management and communications plans in place	June
Creating the New Team	
Informal consultation starts	June
Formal consultation launched	July
Final structure published	September
Appointments made	September/ October
In shadow operational form	November
Goes 'live'	April
Finance	
Budgets to be transferred identified and mapped	June
Final verification and quality checking of budgets to be transferred	September
KCC budget build for 2013/14 and business planning cycle starts and runs through to the new calendar year	Summer - March
County Council approves final KCC budgets	February
Ring-fenced Public Health budget transferred to KCC as part of the central Government local authority settlement	April
Cabinet approval of business plans	April
Workforce and HR	
Confirm legal basis of transfer (TUPE or COSOP)	June
Induction and training and development plan developed (transition and post transfer)	September
Confirm and set-up pension arrangements	June and onwards
Enter staff details in to KCC Personnel IT systems	February
Issue new contracts / letters of welcome	February
Contracting and Legal	
Contracts to be transferred identified and mapped	June
Forward procurement plan developed	September
Ability of KCC in using existing NHS contract templates and processes tested	September

Project Elements	Date
Existing contracts terminated, novated, re-tendered as required in line with procurement plan	September to March
Communication and Engagement	
Staff communication plan developed	June
Reporting schedule to KCC political governance framework developed	June
Wider stakeholder transition communication plan developed	July
KCC Public Health communication and engagement plan for post transition developed	October
Launch of new Public Health web site	December
Information Technology and assets	
Existing assets and requirements mapped	June
Forward implementation plan developed	September
IT/IS Training programme implemented	December
Reprovision of KCC equipment or the transfer of NHS owned assets made	February
New KCC IT accounts created	February
Accommodation identified/ provided	February
Information Governance	
Essential and obligatory NHS requirements identified and recorded	July
KCC systems and procedures adapted where necessary	July - March
NHS Information Governance Toolkit assessment submitted by KCC	February
Performance Monitoring and Reporting	
Reporting requirements within and without KCC mapped	September
KCC corporate requirements integrated in to a new PH performance monitoring system	February
New system goes live	April

Appendix 2

DRAFT FUNCTION CHART FOR PUBLIC HEALTH

Director of Public Health (statutory appointment)
Member of Corporate Management Team and Corporate Board

Health Intelligence and Operational Research
- Consultant Lead
Needs assessment
Healthcare, Public Health Kent and Medway Health Observatory (joint with Medway)
Epidemiology population analysis
Health Economic
Joint Strategic Needs Assessment
CCG profiles
Annual Public Health report
Long-term conditions risk profiling
Strategic linkages with Public Health England and NHS Commissioning Board

Health Improvement
- Consultant Lead
Needs Assessment
Health Inequalities Action Planning
Commissioning Public Health programmes
Healthy Lifestyles programmes
Programme development – tobacco control, alcohol and drugs, healthy weight, National Child measurement Programme, physical activity, health checks, mental well-being, workplace health, seasonal health
Public Health training
Public Health champions

Health Protection
- Consultant Lead
Needs Assessment
Commissioning sexual health services
Monitoring quality of immunisation and screening programmes and Healthcare Associated Infections
Response to Public Health incidents
Surveillance of infectious diseases
Public Health training
Advice to National Commissioning Board

Business and Commercial Management
Budget and financial management
Business planning and business strategy
Performance management
Partnership and democratic processes
Health and Wellbeing Board
Patient experience
Office administration and support
Contract management
Public Health media and public engagement
Market Development - social enterprise, voluntary

Nominated senior lead to link with current and emerging locality structures and groups including Locality Boards, Community Safety Partnerships, Margate task force and so forth

Partner and Locality working and co-operation, joint commissioning and advice where appropriate across the function with Clinical Commissioning Groups, District Councils, NHS Commissioning Board, other NHS bodies, Public Health England, voluntary and

Wider Kent County Council support to the function
Information and Communications Technology, Personnel, Communications and Engagement, Legal, Procurement, Facilities Management

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