REPORT FOR: CABINET

Date of Meeting:	20 June 2012
Subject:	Shared Public Health Service – Outline Business Case
Key Decision:	Yes [Financial and impacting across all Wards]
Responsible Officer:	Paul Najsarek, Corporate Director Community, Health and Wellbeing
Portfolio Holder:	Councillor Margaret Davine, Portfolio Holder for Adult Social Care, Health and Wellbeing
Exempt:	No
Decision subject to Call-in:	Yes
Enclosures:	Appendices 1 & 2, Public Health Requirements Specification & NHS Vital Sign Indicator Report 2012/12

Section 1 – Summary and Recommendations

The outline business case proposes an agreement in principle between Harrow Council and the London Borough of Barnet to develop and implement plans for a shared public health function. The shared public health team will discharge the statutory public health responsibilities that will transfer from the NHS to local authorities on the 1st April 2013.

Recommendations:

1. Cabinet is requested to:

- To approve the outline business case and agree to the in principle development of a shared public health service for Harrow Council and Barnet Council

- To authorise the Portfolio Holder for Adult Social Care, Health and Wellbeing and Corporate Director for Community, Health and Wellbeing to develop the operating model and structures between the two authorities

2. That a further report be submitted to Cabinet with a view to agreeing the final operating model and inter authority agreement.

Reason: (For recommendation)

To implement the required transfer of Public Health to Local Government.

Section 2 – Report

1.1. Local authorities will receive a ring-fenced budget for public health which is based on historical NHS spend for this activity. Past investment in public health in Harrow and Barnet has been much lower than most of London because of the historically challenged financial position of the local NHS health economies in these locations. This is reflected in the low level of funding for public health that both local authorities expect to receive in 2013/14.

1.2. Harrow and Barnet Councils' have an established strategic partnership and already have a shared legal service. The development of a shared public health function fits with the strategic intentions of both organisations and is supported by both Chief Executives.

1.3. A shared public health team offers the best solution to address the challenges of establishing a local authority public health function, which is affordable and has sufficient capacity and specialist expertise to respond to both organisations' ambitions for local health improvement and also meet the new statutory responsibilities.

1.4. Whilst there are a number of opportunities of a shared public health function we are also aware of the limitations and risks of over extending the director of public health role. It is felt that a shared director of public health role covering two boroughs would be feasible if their time is allocated equally between the two boroughs and there is an appropriate enhanced public health leadership structure to support this arrangement. This might include borough based deputy directors of public health. It is felt that a single director of public health covering more than two boroughs would not be viable.

1.5. The latest borough health profiles (2011) identify that the population health and wellbeing challenges for both Harrow and Barnet are very similar and this is reflected in the similar outcome measure achievement level positions against both London and England averages. (Appendix 2)

1.6. The business case acknowledges that the NHS including the system of public health is undergoing the biggest change to its governance, delivery and funding structures in the last sixty years and some aspects of the new system are still in the process of being defined. There are also outstanding issues including the adequacy of the final public health funding allocation that local authorities will receive from 2013/14 and the NHS approach to the transfer of public health

contracts. These are currently being worked through and are unlikely to be resolved until later in the year. These factors are not expected to significantly affect the business case assumptions or the final design of a shared public health operating model and staffing structures. However, they may impact on the approach and pace of implementation plans to prepare for the transfer of public health functions and staff to a shared local authority public health operating model.

2. Resource Implications

2.1. Financial Implications

The ring-fenced allocations that local authorities will receive in 2013/14 to fund their new public health responsibilities will not be confirmed until December 2012 at the latest. Local authorities are being advised by the Department of Health that public health budgets will not be less than actual 2012/13 funding levels.

There remains a risk that the public health funding formula that is being developed by the Department of Health in conjunction with ACRA (Advisory Committee on Resource Allocation) will not address the errors in the initial public health baseline funding figures that have been notified to local authorities or the substantial variation in allocations between areas that have had financially challenged Primary Care Trusts and those that have been in surplus. The current position suggests that Harrow could have a worst case potential funding shortfall of £438K for Harrow and a positive variance of £57k for Barnet based on the delivery of the mandatory public health functions only.

The following tables sets out the profile of the annual historical spend for staffing and health improvement service commissioning costs and highlights that the majority of the expected local authority allocation will be committed to funding health improvement provider services which accounts for between 87% and 90% of the public health cost base.

LOCAL AUTHORITY PUBLIC HEALTH ALLOCATION BASELINE PROFILE - 2012/13

Local Authority Public Health 2012/13 Shadow Baseline	BARNET		HARROW	
	Outturn Total £000s	Percentage Of Total Allocation	Outturn Total £000s	Percentage Of Total Allocation
Public Health Staffing Budgets	1,119	9.5%	1,056	13.4%
Health Improvement Service Budgets	10,677	90.5%	6,806	86.6%
LOCAL AUTHORITY ALLOCATION TOTAL	11,796	100.0%	7,862	100.0%

2.2. Procurement Implications

Both Harrow and Barnet with the other members of the West London Alliance (WLA) have committed to investing in a West London Alliance procurement hub to address expected gaps in public health procurement capacity. This will also open up opportunities for contract efficiencies savings through harmonisation and joint procurements. The procurement hub will provide a managed procurement and contract management service. Scope to maximise public health contracts with Council contracts prior to inclusion with the joint procurement hub. This will need to be determined locally.

Arrangements for the novation of public health provider contracts from the NHS Clusters and provision for delegated authorities to procure shared public health service for both Harrow and Barnet will need to be defined and managed through some form of joint agreement. This will be defined and developed within the scope of a transition project. Consideration will need to be given as to whether contracts novate/transfer directly to the host authority in the event that the shared service is developed further.

2.3. Staffing Implications

This proposal currently assumes that there will be a designated host local authority for a shared public health function and staff will transfer from NHS Harrow and NHS Barnet to the agreed host local authority as part of the public health transition plans.

Further mapping will need to be undertaken to identify any additional public health functions that are currently shared or hosted outside of the existing two borough public health teams within the Cluster structures of North West London and North Central London.

It is assumed that existing public health staff will be accommodated within an agreed shared public organisation structure.

The proposal assumes that there will be a single Director of Public Health role and this will be the accountable officer for public health across both local authorities. The appointment of the Director of Public Health will be a key early priority. Discussions will need to take place with NHS colleagues as well as the two Council's on agreeing a recruitment process.

The detail regarding the approach to transferring public health staff from NHS organisations has yet to be defined and agreed. The conditions of the transfer of staff will determine the process and advise any potential redundancy implications.

3. Legal Issues

3.1 Pursuant to s30 of the Health and Social Care Act 2012, each local authority must appoint, jointly with the Secretary of State, a Director of

Public Health who will have responsibility for the exercise by the authority of its functions relating to Public Health. The Director of Public Health will be required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority will be required to publish that report. Section 300 and Schedules 22 and 23 of the Health and Social Care Act 2012 make provision for rights and liabilities with regard to property and staff respectively to be transferred between the relevant bodies (i.e. from the PCT to the local authority in this case). Regulations as to the exercise by local authorities of certain public health functions are yet to be issued by the government.

3.2 This report makes reference to a designated host local authority for a shared Public Health function with a view to transferring staff from NHS PCT organisations to the agreed host local authority as part of the Public Health transition plan.

3.3 As the intention is for there to be a host local authority the relevant legal framework will be the same as that employed in the shared legal services model. The proposal would be effected by a delegation by one local authority of its executive functions (in this instance its Public Health functions) to the host local authority pursuant to section 101 of the Local Government Act 1972. The detail regarding this shared Public Health service proposal is yet to be defined and agreed and this will of course inform the terms of the arrangement. Although still to be clarified by the Department of Health, it is likely that TUPE or TUPE principles via a Transition Order will be applicable and staff in scope will transfer to the host local authority's employment and be made available to the transferring authority pursuant to s113 of the Local Government Act 1972 which will enable each council to delegate decisions to them as if they were their own staff.

3.4 The Committee has a fiduciary duty to council tax payers and must be satisfied when considering this proposal that it represents value for money and adequately protects the council's position.

3.5 An Equalities Impact Assessment (EIA) will be conducted for the proposed shared Public Health service and organisation structure so that due regard can be given by decision makers to the impact on local populations and staff.

3.6 Any equalities issues that are identified will be addressed through the EIA monitoring process and will form part of the reporting process.

4. Background

4.1. The statutory responsibilities for local health improvement and health protection will transfer from NHS Primary Care Trust Clusters to local authorities on the 01 April 2013. Local authorities will also have a

statutory responsibility to provide a healthcare public health advice core offer service to local NHS Clinical Commissioning Groups (CCG) and their commissioning support organisations. Public Health England will be established as the new national body responsible for overseeing delivery of public health responsibilities and championing health and wellbeing priorities nationally and certain public health services such as immunisation and cancer screening will be commissioning nationally or regionally via NHS Commissioning Boards

4.2. Local authorities are tasked with developing a new local system of public health that will support delivery of statutory public health improvement, health protection and healthcare public health advice requirements. This will include the establishment and management of interfaces with Public Health England and the NHS Commissioning Board who will be responsible for commissioning some elements of the local public health system such as health visiting, immunisation and health screening. Local authorities will need to set up effective local governance and assurance arrangements to ensure any responsibilities which are being carried out on their behalf at national and regional level fulfil all their statutory obligations for health improvement and protection.

4.3. The potential benefits of a shared public health leadership and operating model as a viable and enhanced alternative to a standalone model is recognised and is reflected in Harrow's and Barnet's respective public health transition plans. The commitment between the two councils to work together is also clearly demonstrated in their active participation in the West London Alliance public health design group and commitment to invest in a shared public health contract management and procurement hub.

4.4. The existing local public health teams in Harrow and Barnet are relatively small compared with other teams in the both the North West and North Central London areas. They are unlikely to be able to provide the full range and depth of public health coverage that will be required to support both existing and new public health requirements, in a borough based standalone structure. Staff retention, talent management and opportunities for professional development are also likely to be problematic in an isolated standalone function.

4.5. A shared model has more scope to address these issues and increase the capacity and capability of local authority public health teams in the future. It also opens up other opportunities for developing additional value adding public health products and services and increases the scope to be able to meet any CCG requirements for an enhanced public health commissioning advice service proposition.

5. Strategic Case For A Shared Public Health Model

5.1. Harrow and Barnet have a common ambition to place public health at the heart of local government policy, commissioning and service delivery, by establishing a leading edge public health leadership and service offer that has the capability and capacity to achieve this. A shared public health leadership and specialist public health operating model maybe the only affordable option for both local authorities to achieve this and meet their new statutory obligations within the expected ring-fenced funding allocations, particularly if the baseline assumptions prove to be substantially understated.

5.2. Both organisations have set out their ambition for public health and its leading role in protecting and improving the health and wellbeing of their populations which is captured in the following vision statements and intentions:

5.3. Harrow Council's Intentions For Public Health

- *Harrow has established a community, health and wellbeing directorate to respond to the health and wellbeing agenda*
- *The 'refresh' of the JSNA and the emerging Health and Wellbeing strategy will direct activity across all partners to improve health and health care in Harrow*
- *The new national 'Public Health Outcomes framework' is being utilised to inform future planning and to understand how each Directorate of Harrow Council leads, and is accountable for, delivery of health improvement priorities*
- *The 'one council' approach to improving health and reducing health inequalities will require every directorate to consider its contribution to improve public health and wellbeing. A process is underway to refresh the existing Harrow 'Health Inequalities strategy' based on the 'Marmot' framework.*

5.4. Barnet Council's Vision For Public Health

Public Health will lead the health and wellbeing agenda for Barnet, underpinned by a strong evidence based approach and the JSNA; supporting the NHS and the wider Council to play their part in improving the health and wellbeing of Barnet's residents and reducing health inequalities. Through the right multi-disciplinary workforce, the Public Health function will make sure that the risk of avoidable harm is reduced through promoting healthy lifestyle choice and protecting the health of the population

6. Operational Case for a Shared Public Health Model

6.1. The public health design options for consideration can be grouped into the following two categories:

- Standalone Borough Public Health Operating Model that supports the full range of public health functions delivered by a team of directly employed staff.
- Shared Borough Public Health Operating Model that shares all or certain functions with another borough

6.2. The main benefits and risks are set out below and can be grouped into the following themes:

- Public health outcome achievement, quality and performance
- Leadership and governance
- Community engagement and relationships
- Organisational and people development
- Service development and operational resilience
- Financial
- Transition

6.3. Benefits of a Shared Public Health Function

The following section sets out the advantages of a shared public health function over a standalone borough model.

Benefits
Public Health Outcome Achievement, Quality And Performance • Greater capacity to provide public health leadership across all aspects of local authority activity and influence the wider determinants of health and tackle health inequalities • Opportunities to pool resources and deliver greater impact and progress in the achievement of outcomes • Increased capacity and opportunities to maximise the impact of health promotion activity and deliver greater efficiencies for reinvestment in future campaigns • Increased opportunities for specialisation and to share specialist public health capacity and expertise to lead and improve specific population public health outcomes • Increased opportunities to increase public health intelligence capacity, build knowledge collateral and share learning to improve outcomes Leadership And Governance • More capacity and opportunities to shape the development of health sustaining communities and influence regeneration policy

Benefits

Community Engagement And Relationships

- Increased capacity for greater and more sustained community engagement

Organisational And People Development

- Greater flexibility and resilience from an increased public health team and specialist skills base
- Public health in the local authority is more likely to attract and retain the most talented public health professionals through increased opportunities for career progression and professional development
- Greater opportunities to establish a pipeline of public health talent and training hubs to nurture this
- Increase opportunities to share learning, knowledge and experience gained from working in difference locations and with different communities

Service Development And Operational Resilience

- Great opportunities to streamline and consolidate operational processes
- Opportunities to establish and increase public health specialist capability
- Increased capacity to support the new healthcare public advice core offer and an enhanced services for CCGs and NHS commissioners
- Greater opportunities to influence and shape the provider market through joint commissioning of integrated health and wellbeing early intervention and prevention pathways and services
- Increase resilience to business continuity and disaster recovery incidents
- Shared response to common public health issues
- Enable risk sharing and increase capacity to reduce outcome underachievement, operational and financial risk

Financial

- Increases the scope to identify solutions to address any immediate funding shortfalls in the borough public health funding allocations
- Greater opportunities for operational and provider contract efficiencies
- Increased savings potential through economies of scale
- Pooled resources and opportunities for optimisation
- Opportunities to minimise back office and infrastructure costs e.g. IT systems, licensing and data costs

Transition Opportunities

- Increased opportunities for local authorities to pool resources, reduce effort and risk share delivery of public health transition plans

6.4. Risks Associated With A Shared Public Health Function

The following section sets out the risks of a shared borough public health function over a standalone single borough model. All identified risks are assessed as low impact after mitigation.

Risk	Mitigation
<u>Public Health Outcome Achievement, Quality And Performance</u> • Loss of key relationships and ability to influence local providers and manage up outcome achievement and respond to public health priorities • Outcome benefits from pooled resources may not be evenly distributed	A shared function will provide greater capacity and flexibility to manage and protect local relationships and create opportunities to streamline contractual relationships and the number of provider contracts in the future. Clearly defined shared service agreements and governance arrangements will mitigate any risk of imbalances in focus, performance and benefit distribution.
<u>Leadership And Governance</u> • Differences in local authority political priorities for public health • Insufficient local control or ability to influence a shared public health function • Director of public health role overstretched and unable to develop the necessary key relationships with elected members, senior officers and local key stakeholders e.g. Clinical Commissioning Group, Commissioning Support Organisation • Imbalances in the ability of individual boroughs to influence the prioritisation and allocation of resources in a shared arrangement, particularly if it consists of more than two local authorities	The borough profiles and evidence base suggest that many of the challenges between both boroughs are similar. Clearly defined borough service level agreements for public health services. The DPH role will be evenly divided between both boroughs and the increase public health function would support the establishment of an enhanced leadership team and a deputy borough DPH role. The preferred option is for a two borough shared arrangement.
<u>Community Engagement And Relationships</u> • Loss of established local public health relationships with GP practices, community and acute providers, voluntary sector organisations and other key stakeholders that have been developed over time	A shared borough public health team would increase capacity and flexibility to protect local relationships.

Risk	Mitigation
<u>Organisational Development</u> • Location and hosting arrangements of a shared public health function may result in staff retention issues and loss of key staff • Loss of local knowledge and corporate memory within the established borough based public health teams	Staff would be consulted on hosting arrangements and both local authorities would seek to try and resolve individual issues. This is a risk for both shared and standalone options. Both borough transition plans seek to retain staff. A shared public health function would increase the opportunities for careers progression, continuous profession development and the scope to create a larger community of interest for public health specialists within a local authority public health function.
<u>Service Development And Operational Resilience</u> • Insufficient Director of Public Health capacity to attend all statutory Board (e.g. Health and Wellbeing Board, Commissioning Support Service Organisation Board), Committee (Cabinet, Overview and Scrutiny) and corporate management meetings (Chief Executive and senior management meetings)	The intention is to enhance the public health leadership structure so there is greater coverage at borough level through establishment of deputy borough directors of public health.
<u>Financial</u> • Increased exposure to public health cost pressures within partner organisation	It is hoped or anticipated that combining public health services could deliver greater financial benefits in the longer term e.g. shared staff resources and wider contract efficiencies. Wider financial issues will need to be explored in much more depth as part of a shared agreement to reduce the risk to each Council.
<u>Transition Risks</u> • Increased complexity and risk of delivering public health transition plans with multiple borough and PCT Cluster stakeholders • Lack of clear accountability and increase scope for delay in decision	Many aspects of transition plans are common to all plans. A shared plan would increase the scope for combining and optimising local authority transition resources. A clearly defined and agreed joint

Risk	Mitigation
making from an extended project governance structure which is dependent on multiple stakeholders	programme delivery governance structure will be established if the decision is taken to proceed with a shared public health function.

7. Financial Case

7.1. Funding Allocation Overview

The funding allocation that both local authorities are likely to receive is expected to be insufficient to operate an effective public health function that delivers all statutory public health responsibilities, maintains outcome performance and achieves local priorities. It is also unclear at this stage what the real cost implications are for providing a commissioning advice service for CCGs, meeting local health protection resilience and response requirements and managing the various interfaces within the new local and national public health system. These areas are not currently reflected in the shadow public health baseline budgets that have been notified to local authorities.

The following table sets out the baseline funding assumptions that will inform the actual public health allocations that Harrow and Barnet could receive in 2013/14. ACRA are developing a funding formula for public health which may address some of the issues, but this is unlikely to take account of the new requirements which are not reflected in the baseline assumptions.

PUBLIC HEALTH SHADOW ALLOCATION 2012/13	2012/13 Shadow Public Health Budget Allocations	
	BARNET	HARROW
	£000	£000
Local Authority Allocation	11,796	7,862
NHS Commissioning Board Allocation	9,015	6,366
Public Health England Allocation		
TOTAL CONFIRMED PUBLIC HEALTH ALLOCATION	**20,811**	**14,228**

7.2. Funding Shortfall

In it's calculations of the proposed funding allocations to Local Government the DH has acknowledged that they have removed too much money for the provision of Termination of Pregnancies (a function that will be delivered by Clinical Commissioning Boards in the future). DH has agreed that they will rectify this error which will be in favour of both Harrow and Barnet Councils and will close the expected

funding gap. However we are unable to quantify the adjustment until the actual allocations are announced later in the year.

The current expected funding allocations identify a worst case shortfall of £438K in Harrow and a positive variance of £57K in Barnet. This is based on the provision of Public Health mandatory services only.

The mandatory services and steps that were identified in *Healthy Lives, Healthy People: update and way forward* included:

- Appropriate access to sexual health services
- 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
- The National Child Measurement Programme
- NHS Health Check assessment

PUBLIC HEALTH SHADOW ALLOCATION 12/13	2012/13 Shadow Public Health Budget Allocations	
	BARNET	HARROW
	£000's	£000's
Local Authority Shadow Allocation	11,796	7,862
Local Authority Requirement to deliver the mandatory Public Health functions	11,739	8,300
WORST CASE FUNDING ALLOCATION SHORTFALL	57	438

7.3. The main issue that is driving the funding shortfall for both boroughs is the additional funding requirement for NHS health checks. This will be a mandatory requirement for local authority public health investment which has been substantially underfunded in both Harrow and Barnet in the past.

7.4. All London authorities will be required to contribute a minimum 3% top slice to the London Health Improvement Board from their allocations which is not factored into the DH baseline assumptions at present. The worst case scenarios presented above include the minimum 3% top slice.

7.5. Historical Investment in Public Health

NHS Harrow and NHS Barnet are both financially challenged and this has led to a history of underinvestment in public health in order to relieve cost pressures in other parts of the local health system. This is reflected in baseline budget assumptions which have been derived from historical actual full year outturn figures for 2010-11.

7.6. The notional baseline capitation funding allocations notified by the Department of Health for both Harrow (£33 per head of population) and Barnet (£32 per head of population) is substantially lower than other boroughs in London (London average - £57) and in other parts of the country (England average £40).

Department of Health Public Health Local Authority Allocation Spend Per Head Analysis				
Public Health Baseline Data 2010/11 Benchmarking	**Local Authority 2010/11 Baseline £000**	**Population (1000s)**	**Allocated Spend Per Population Head**	**London Position**
Barnet	11,236	348.2	**£32**	5th Lowest
Harrow	7,489	230.1	**£33**	6th Lowest
London Highest (Tower Hamlets)	27,756	237.9	**£117**	Highest out of 32 Locations
London Lowest (Bexley)	4,435	228.0	**£19**	Lowest out of 32 Locations
London Average			**£57**	
England Average			**£40**	

8. Local Public Health Requirements

8.1. This section summarises the mandatory public health requirements that local authorities will be responsible for from the 1st April 2013 and which need to be addressed in the design of the public health target operating model.

8.2. Local Authority Statutory Responsibilities

Local authorities will have statutory responsibilities for the following key domains of public health and this target operating model has been developed as a shared response to these requirements:

- Health improvement
- Health protection
- Healthcare public health
- Improving the wider determinates of health

8.3. They will also be responsible for the commissioning of public health services and will have a mandatory responsibility to make provision for the following:

- Appropriate access to sexual health services
- Ensure there are plans in place and take steps to protect the health of the local population
- Provide NHS commissioners with the advice that they need
- National Child Measurement Programme
- NHS Health Check assessments

8.4. Commissioning priorities and allocation of resources will continue to be informed by the needs identified in the Joint Strategic Needs Assessment and guided by the Joint Health and Wellbeing Strategy and Public Health Outcomes Framework.

8.5. New National Public Health Outcomes Framework

The new National Public Health Outcomes Framework is intended to refocus the whole system around the achievement of positive health outcomes for the population and reducing health inequalities, rather than an emphasis on the delivery of process targets. Although there has been a stated commitment not to use outcome measures to performance manage local areas, there is a local expectation existing outcome achievement levels will be protected and maintained.

8.6. The framework is focused on the following two overarching health outcomes to be achieved across the public health system:

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

8.7. The supporting public health indicators are grouped into four domains:

Domain 1 – Improving the wider determinates of health (e.g. tackling health inequalities - through housing, employment, environmental heath etc.)

Domain 2 – Health improvement (e.g. smoking cessation, screening, weight management)

Domain 3 – Health protection (e.g. immunisation, health emergency planning and resilience)

Domain 4 – Healthcare public health and preventing premature mortality (e.g. specialist local public health function that conducts local needs assessment, gap analysis, evidence appraisal to inform local decommissioning and recommissioning)

9. Shared Operating Model Proposal

The development of the proposed operating model has been informed by the published Department of Health policy on the public health roles, responsibilities and functions of Local Government and the options definition and analysis that has been conducted by the West London Alliance Public Health Design Group. A design process has been carried out to define in some detail the responsibilities that will transfer to local authorities and logical structure in which to group them.

9.1. Design Principles

The definition of the proposed target operating model outline has been developed using the following design principles:

a) Structures are consistent with national guidance and the transfer of Public Health leadership from the NHS to Local Government

b) The designated Director of Public Health role is a statutory member of the Health & Well Being Board and the local authority's lead officer for health and championing health across all aspects of the authority's business

c) Effort required to operate each aspect of the system is minimised and there is no duplication

d) Makes the best use of available resources and specialist public health skills and knowledge

e) Is affordable and sustainable and provides the best return on investment in local public health

f) Demonstrates a focus on delivering health improvement for the population through a system that is driven by addressing local needs (identified in the JSNA) and the priorities local Health and Wellbeing strategies

g) Harnesses and builds on existing good practice, local experience and measureable achievement each borough location

h) The new local public health system is fully Integrated with effective interfaces between Local Authorities, Clinical Commissioning Groups, Public Health England, the National Commissioning Board, HealthWatch, the voluntary sector and others public health key stakeholders

i) Integration with existing local authority leadership and operational functions so public health is embedded within the organisation e.g. environmental health services, licensing and trading standards; physical activity and leisure services; planning; housing; corporate policy.

j) Protects historical local public health outcome achievements and delivers improved performance and outcomes in line with the public health outcomes framework, based on local needs and priorities

k) Protects and builds on established and trusted local relationships with GP Clinical Commissioning Groups, Council Members, healthcare providers, voluntary sector organisations and other strategic partners and strengthens local community engagement

l) Creates the right skill mix, capacity and capability ensuring that a specialist public health team has a 'critical mass' to reduce threats to business continuity (recruitment and retention) and allow specialisation

m) Minimises the risk of destabilising the local system of care

9.2. Operating Model Description

This section provides an illustrative description of a proposed operating model structure and is intended to give an insight into the concept and structure of a shared public health operating model. This will need to be developed, costed and tested as part any agreed implementation plan.

The proposed operating model structure has six functional domains and would be delivered by a single shared specialist public health team which would support both Harrow and Barnet boroughs. The team would be led by a Director of Public Health supported by a team of public health consultants with a portfolio of responsibilities which will be both borough and cross borough based. It is expected that certain functions and roles would be located in particular boroughs and others would include working across multiple sites. The shared public health would include the following resource and skills mix.

- Director of Public Health
- Public Health Consultant
- Public Health Improvement Specialist
- Public Health Analyst
- Health Improvement Commissioning/Procurement/Contract Management
- Public Health Project Management
- Administration

1. Strategic Leadership And Governance	
Overview	**Outline Specification**
Shared public health leadership team led by a single Director of Public Health. The time allocation will be divided equally between each borough.	• Local authority health and wellbeing leadership and public health advocacy • Health strategy and policy development and strategic planning to address the wider determinants of health • Statutory membership of the Health and Wellbeing Board • Lead officer for public health and advisor to elected members and senior officers • Attendance at Portfolio holder meetings • Member of borough Chief Executive leadership team • CCG membership role • Production of Annual Public Health Report

2. Core Offer Commissioning Advice And Support	
Overview	**Outline Specification**
Each borough would have an	Mandatory service to provide public health

2. Core Offer Commissioning Advice And Support	
Overview	**Outline Specification**
identified Consultant in Public Health to lead this activity and it is expected that they would be based with local borough clinical commissioners for the majority of their time. The Consultant would be supported by the public health analytical team and would call on other specialist support from the wider public health team as required. The extent of the support would be determined by the core offer specification and formal agreement with each CCG.	commission advice to CCGs and other NHS commissioners – Proposition will need to be defined in response to local requirements as part of the design but are likely to include public health support for the following: <u>Strategic planning</u> • Using and interpreting data to assess population health needs • Advice on commissioning to address health inequalities and variation • Advice and tools to support prioritisation <u>Procuring services</u> • Specialist advice on effectiveness of particular interventions • Service review methodology • Specialist input on pathway development <u>Monitoring and evaluation</u> • Advice on monitoring and evaluation frameworks • Health equity audits and assessments

3. Health Improvement, Commissioning And Contract Management	
Overview	**Outline Specification**
Shared cross borough commissioning function for statutory and priority public health improvement commissioning. This would include strategy development and leadership for the key public health prevention themes. Procurement and contract management activity would be would be purchased from the WLA health improvement service Procurement Hub.	Public health service planning, design, procurement, contract quality and performance management of public health services: • Sexual health • Health checks • Childhood measurement • School Nursing • Smoking cessation • Alcohol and substance misuse services • Others commissioned services to be confirmed

4. Local Health Protection, Emergency Preparedness And Resilience	
Overview	**Outline Specification**
Cross borough function led by a public health consultant.	• Public health protection activities, e.g. emergency public health plans and resilience testing. • Monitoring of Serious Incidents (SI) • Management of key relationships with Public Health England, area Health Protection Units, NHS Commissioning Board, Clinical Commissioning Groups and acute and community healthcare providers

5. Public Health Intelligence	
Overview	**Outline Specification**
Shared cross borough knowledge and intelligence function	• Public health informatics and analytics • Clinical pathway evaluation • Local insight development and knowledge management • Local health needs analysis including production of the Joint Strategic Needs Assessment (JSNA) • Public health outcomes, quality and performance evaluation and reporting • Demand management insight

6. Public Health Improvement Leadership	
Overview	**Outline Specification**
Shared cross borough function that provides public health consultant and specialist resources to lead and support local health improvement and prevention strategic initiatives.	• Public health prevention project management and delivery • Public health improvement campaign design and delivery • Health Impact Assessments and equalities audits • Provide public health knowledge and thought leadership local authority strategic initiatives, and business case development

10. Proposed Next Steps

Development of the governance and alignment of the transition plans between Harrow and Barnet will be taking place in parallel to the Cabinet process.

Milestone	Target Date
Portfolio Holder Briefing with the Leader, PH Adult Social Care, Health and Wellbeing and PH Children's Services (a	22 May

Milestone	Target Date
similar process will be undertaken by Barnet Council)	
Cabinet Briefing (a similar process will be undertaken by Barnet Council)	31 May
Joint Public Health Transition project delivery/governance arrangements and project delivery processes defined and established	31 May
Barnet and Harrow Public Health Transition Plans aligned and joint target operating model workstream plans are produced for sign-off	31 May
Joint Project Delivery Board set-up to quality assure and scrutinise the shared public health target operating model design specification	15 June
Cabinet in principle agreement to progress a shared public health function approved (dependency on earliest available Cabinet meeting dates) (a similar process is in place at Barnet Council)	20 June
Shared Public Health Operating Model submitted to Department of Health	30 June
Shared Public Health Target Operating Model design/governance proposal signed-off by Joint Project Delivery Board	31 July

11. Governance and Agreement

11.1. The proposal for a shared public health function would be undertaken in accordance with the relevant provisions in the Health and Social Care Act relating to local authorities responsibilities for public health and delegated authority. This will need to be defined as part of the implementation plan for a shared public health function and development of a target operating model.

11.2. The terms of an agreement for the hosting and delegation of authority to support the operation of a shared public health function will also include details of the following which will be defined as part of any plans to take this proposal forward:

- Core terms and service level requirements for each local authority from a shared public health function
- Staffing levels and core operating hours
- Overheads and set up costs
- Pension arrangements for staff transferring to the hosting organisation
- Cross charging and billing arrangements

- Treatment of any surpluses
- Local relationship management requirements and reporting i.e. performance and statistical returns
- Budget setting in future years
- Exit arrangements if either party decide at a later date to move away from the shared arrangements

Financial Implications

The ring-fenced allocations that local authorities will receive in 2013/14 to fund their new public health responsibilities will not be confirmed until December 2012 at the latest. Local authorities are being advised by the Department of Health that public health budgets will not be less than actual 2012/13 funding levels.

There remains a risk that the public health funding formula that is being developed by the Department of Health in conjunction with ACRA (Advisory Committee on Resource Allocation) will not address the errors in the initial public health baseline funding figures that have been notified to local authorities or the substantial variation in allocations between areas that have had financially challenged Primary Care Trusts and those that have been in surplus. The current position suggests that Harrow could have a worst case potential funding shortfall of £438K and a positive variance of £57K for Barnet based on the delivery of the mandatory Public Health functions only.

Given the shortfall in funding for both the local authorities, further discussion/consideration and agreement will need to be taken around how any efficiencies and or costs associated with the merging of these functions are allocated. These discussions extend to transfer arrangements and costs.

This report is seeking an agreement in principle to further discussions of a shared service. It is important to be mindful of operational decisions yet to be made by the Department of Health and the potential financial implications as a result for either participant in a shared service. These issues will need to be resolved as part of the boroughs joint transition plan. Any financial implications will be made clear once known to assist decision making.

Performance Issues

The integration of Public Health and the requirement to deliver the Public Health Outcomes Framework will be considered as part of the Council's performance management framework.

Environmental Impact

There are no direct environmental impacts arising from this business case.

Risk Management Implications

Initial risks have been identified, which are included in this report. A risk register will be developed and monitored as part of the Joint Public Health Transition Plan.

Equalities implications

An Equalities Impact Assessment (EIA) will be conducted for a shared public health service and organisation structure to assess the impact on local populations and staff and determine any requirements for adjustment. The in scope staff will be compared against the staff profiles for both local authorities as part of the transition project. Any equalities issues that are subsequently identified will be addressed through an agreed monitoring process.

Discussions will be held with the agreed host organisation and trade unions and staff representative organisations regarding any plans that may require the relocation of public health staff to consider any issues and appropriate solutions.

Corporate Priorities

The transition of public health to the Council will influence aspects of all of the Council's Corporate Priorities.

Section 3 - Statutory Officer Clearance

Name: Donna Edwards Date: 29 May 2012	X	on behalf of the Chief Financial Officer
Name: Linda Cohen Date: 25 May 2012	X	on behalf of the Monitoring Officer

Section 4 – Performance Officer Clearance

Name: Alex Dewsnap Date: 25 May 2012	X	Divisional Director Partnership, Development and Performance

Section 5 – Environmental Impact Officer Clearance

Name: Andrew Baker Date: 24 May 2012	X	on behalf of the Divisional Director (Environmental Services)

Section 6 - Contact Details and Background Papers

Contact: Trina Thompson, Senior Policy Officer, 0208 4209324

Background Papers:
National Public Health Outcomes Framework
Health and Social Care Act 2012
Department of Health – Public Health in Local Government Factsheets

Call-In Waived by the Chairman of Overview and Scrutiny Committee	**NOT APPLICABLE** *[Call-in applies]*

APPENDIX 1 – Public Health Requirements Specification

1. New Local Government Responsibilities

1.1 Local authorities will have responsibility for the following key domains of public health:

12. Health improvement
13. Health protection
14. Healthcare public health
15. Improving the wider determinates of health

1.2 The new local authority public health function will also include new statutory duties to protect the health of the local population and ensure that NHS commissioners (Clinical Commissioning Groups, NHS Commissioning Board) receive the public health advice they need to design and commission care pathways and services which deliver good local population health outcomes, reduce health inequalities and support the achievement of local health and wellbeing strategic priorities.

1.3 Local authorities will be responsible for the commissioning of public health services and will have a mandatory responsibility to make provision for the following:

16. Appropriate access to sexual health services
17. Ensure there are plans in place and take steps to protect the health of the local population
18. Provide NHS commissioners with the advice that they need
19. National Child Measurement Programme
20. NHS Health Check assessments

1.4 The following tables set out the public health improvement activities that local authorities will be responsible for commissioning:

	Mandatory Public Health Commissioning Responsibilities
1	National Child Measurement Programme
2	NHS Health Check assessments
3	Comprehensive sexual health services (including testing and treatment for sexually transmitted infections (STI), contraception outside of the GP contract and sexual health promotion and disease prevention)
4	Local authority role in dealing with health protection incidents, outbreaks and emergencies

	Other Public Health Commissioning Responsibilities
5	Tobacco control and smoking cessation services
6	Alcohol and drug misuse services

	Other Public Health Commissioning Responsibilities
7	Public health services for children and young people aged 5-19
8	Interventions to tackle obesity
9	Locally led nutrition initiatives
10	Increasing levels of physical activity in the local population
11	Public mental health services
12	Dental public health services
13	Accidental injury prevention
14	Population level interventions to reduce and prevent birth defects
15	Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
16	Local initiatives on workplace health
17	Support, review and challenge the delivery of public health funded and NHS delivered services such as immunisation and screening programmes
18	Local initiatives to reduce excess deaths as a result of seasonal mortality
19	Public health aspects of promotion of community safety, violence prevention and response
20	Public health aspects of local initiatives to tackle social exclusion
21	Local initiatives that reduce public health impacts of environmental risks

1.5 Commissioning priorities and allocation of resources will continue to be informed by the needs identified in the Joint Strategic Needs Assessment and guided by the Joint Health and Wellbeing Strategy and Public Health Outcomes Framework

2. National Public Health Outcomes Framework

2.2 The new National Public Health Outcomes Framework was published on the 23 January 2012 and sets out the vision and desired outcomes for public health and how these will be measured. The whole system will be refocused around the achievement of positive health outcomes for the population and reducing health inequalities, rather than an emphasis on the delivery of process targets and will not be used to performance manage local areas.

2.3 The framework is underpinned by a vision for public health and is focused on the following two overarching health outcomes to be achieved across the public health system:

Vision*: To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest.*

21. Increased healthy life expectancy
22. Reduced differences in life expectancy and healthy life expectancy between communities

2.4 These key outcomes recognise the importance of not only how long people live, but on how well they live at all stages of their life. The second outcome is particularly focused on reducing health inequalities between people, communities and areas. The use of measures of both life expectancy and healthy life expectancy is expected to provide the most reliable information to better understand the nature of health inequalities both within a particular location and between areas.

2.5 The design of the outcomes framework acknowledges that substantial improvements in the two key public health outcome areas will take years or even decades to materialise. In order to track progress, a set of supporting public health indicators have been developed which are intended help to understand the pace and scale of improvement in the things that matter most to public health.

2.6 The supporting public health indicators are grouped into four domains:

Domain 1 – Improving the wider determinates of health (e.g. tackling health inequalities - through housing, employment, environmental heath etc.)

Domain 2 – Health improvement (e.g. smoking cessation, screening, weight management)

Domain 3 – Health protection (e.g. immunisation, health emergency planning and resilience)

Domain 4 – Healthcare public health and preventing premature mortality (e.g. specialist local public health function that conducts local needs assessment, gap analysis, evidence appraisal to inform local decommissioning and recommissioning)

2.7 The Department of Health intends to improve the range of information over the coming year with continued engagement and involvement of partners at local and national level.

3. Local Public Health Leadership

3.1 The Director of Public Health will be a key leadership role in enabling local authorities to carry out their new public health responsibilities and functions. There is also a requirement in the proposed Health and Social Care Bill that each authority must, acting jointly with the Secretary of State for Health, appoint a Director of Public Health who will have responsibility for its new public health functions and will be the lead officer for health and championing health across all aspects of the authority's business. It is also proposed that Directors of Public Health

will be added to the list of statutory chief officers in the Local Government and Housing Act 1989 and there will be direct accountability between the Director of Public Health and the local authority Chief Executive for the undertaking the local authority's public health responsibilities.

3.2 The Director of Public Health will be responsible for the following:

23. Local authority's new public health functions
24. Production of an annual report on the health of the population
25. Statutory member of the local Health and Wellbeing Board
26. As lead officer for health, provide advice to elected members and senior officers
27. Ensure health and wellbeing services are integrated across the locality
28. Delegated responsibility for the public health ring-fenced grant

3.4 The Department of Health's guidance for public health in local authorities suggests that resourcing of the Director of Public Health role could be shared with another local authority where that makes sense.

Appendix 2

NHS VITAL SIGNS INDICATOR REPORTING 2010-12 - BENCHMARKING ANALYSIS

Legend

Above both London and England Averages

Above either the London or England average

Below both the London and England averages

REF:	NHS VITAL SIGN INDICATORS 2010-11	Data Period	BARNET	HARROW	Variance Harrow vs Barnet +/(-)	London	England
VSB01	All Age All Cause Mortality Rate Per 100,000 Population - Men	2009	**569.88**	**512.37**	**58**	632.66	652.28
	All Age All Cause Mortality Rate Per 100,000 Population - Women	2009	**398.04**	**373.52**	**25**	431.20	459.71
VSB02	Cardiovascular Related Disease Mortality Rate Per 100,000 Population Under 75	2009	**50.41**	**46.82**	**4**	70.09	66.10

VSB03	Cancer Mortality Rate Per 100,000 Population Under 75	2009	**99.22**	**80.42**	**19**	107.62	109.97
VSB04	Mortality Rate Per 100,000 Population From Suicide And Injury	2009	**4.43**	**5.84**	**(1)**	6.92	8.09
REF:	**NHS VITAL SIGN INDICATORS 2010-11**	**Data Period**	**BARNET**	**HARROW**	**Variance Harrow vs Barnet +/(-)**	**London**	**England**
VSB05	Smoking Quitters Per 100,000 Population Aged 16 And Over	2010/11	**744**	**488**	**256**	813	911
VSC26	Rate Of Hospital Admissions For Alcohol Related Harm Per 100,000 Population For All Ages	2009/10	**1,444**	**1,407**	**37**	1,684	1,743
VSB14	Number Of Drug Users Using Crack And/Or Opiates Recorded In Structured Drug Treatment who were discharged from treatment after 12 weeks or more, or that remain in treatment for 12 weeks or more, or who were discharged from treatment	2009/10	**576**	**402**	**174**	25,985	164,802

VSB08	Teenage Conception Rate Per 1000 Aged 15 - 17	2008	**26.2**	**21.8**	**4**	44.6	40.5
VSB13	Percentage Of Population Aged 15 - 24 Screened Or Tested For Chlamydia	2010/11	**15.9%**	**11.5%**	**4.4%**	29.4%	25.2%
VSC22	Percentage Of People With Learning Disabilities Receiving Health Checks	2010/11	**83.7%**	**53.6%**	**30.1%**	46.4%	48.7%
VSB09	Percentage Of Reception Age Children With Height And Weight Recorded Who Are Obese	2009/10	**10.5%**	**10.6%**	**(0.1)%**	11.6%	9.8%
	Percentage Of Children In Reception With Height And Weight Recorded	2009/10	**94.2%**	**90.5%**	**3.7%**	91.8%	92.9%
	Percentage Of Children In Year 6 With Height And Weight Recorded Who Are Obese	2009/10	**17.7%**	**18.7%**	**(1.0)%**	21.9%	18.7%
	Percentage Of Children In Year 6 With Height And Weight Recorded	2009/10	**90.0%**	**90.3%**	**(0.3)%**	91.5%	89.9%

REF:	NHS VITAL SIGN INDICATORS 2010-11	Data Period	BARNET	HARROW	Variance Harrow vs Barnet +/(-)	London	England
VSB10	Immunisation Rate For Children Age 1 - who have completed immunisation for diphtheria, tetanus, polio, pertussis, *Haemophilus influenzae* type b (Hib) - i.e. all 3 doses of DTaP/IPV/Hib	2009/10	**93.2%**	**96.3%**	**(3.1)%**	88.7%	93.6%
	Immunisation Rate For Children Age 2 - Who have completed immunisation for pneumococcal infection - i.e. received Pneumococcal booster (PCV)	2009/10	**83.5%**	**85.6%**	**(2.1)%**	78.1%	87.6%
	Immunisation Rate For Children Age 2 - Who have completed immunisation for *Haemophilus influenzae* type b (Hib) and meningitis C (MenC) - i.e. received Hib/MenC booster	2009/10	**88.2%**	**94.8%**	**(6.6)%**	81.9%	90.0%
	Immunisation Rate For Children Age 2 - Who have completed immunisation for measles, mumps and rubella (MMR) - i.e. 1 dose of MMR	2009/10	**87.7%**	**88.1%**	**(0.4)%**	81.9%	88.2%
	Immunisation Rate For Children Aged 5 - Who have completed immunisation for diphtheria, tetanus, polio and pertussis (DTaP/IPV) - i.e. all 4 doses	2009/10	**83.7%**	**77.8%**	**5.9%**	71.8%	84.8%

	Immunisation Rate For Children Age 5 - Who have completed immunisation for measles, mumps and rubella (MMR) - i.e. 2 doses of MMR	2009/10	**81.8%**	**78.4%**	**3.4%**	72.2%	82.7%
	Immunisation Rate For Girls 12-13 Years - Who have completed immunisation for human papillomavirus vaccine (HPV) - i.e. all 3 doses	2010/11	**59.4%**	**63.5%**	**(4.1)%**	66.6%	76.4%
	Number Of Children Aged 13 - 18 - Who have been immunised with a booster of tetanus, diphtheria and polio (Td/IPV)	2009/10	**1,229**	**1,104**	**125**	45,794	413,497

INTEGRATED PERFORMANCE MEASURES RETURN (IPMR) - Q3 YTD 2011-12

REF:	NHS IPMR INDICATORS 2011-12	Data Period	BARNET	HARROW	Variance Harrow vs Barnet +/(-)
	Number of people eligible for a NHS Health Check	Q3 YTD 2011/12	**114,883**	**76,840**	**38,043**
	Number of people who were offered a NHS Health Check	Q3 YTD 2011/12	**1,852**	**0**	**1,852**

	Number of people that received a NHS Health Check	Q3 YTD 2011/12	**982**	**0**	**982**
	Percentage of eligible people that were offered a NHS Health Check	Q3 YTD 2011/12	**1.6%**	**0.0%**	**1.6%**