Meeting	Cabinet Resources Committee
Date	20 June 2012
Subject	**Public Health Shared Function**
Report of	Cabinet Member For Public Health
Summary	This report seeks approval of the outline business case to develop a shared specialist Public Health function service and Director of Public Health with the London Borough of Harrow.

Officer Contributors	Kate Kennally, Director of Adult Social Care and Health Rohan Wardena, Programme Lead Adult Social Care and Health
Status (public or exempt)	Public
Wards Affected	All
Key Decision	
Reason for urgency / exemption from call-in	Not applicable
Function of	Adult Social Care and Health
Enclosures	Outline Business Case and appendices
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1. RECOMMENDATIONS

Cabinet Resources Committee is asked to:

1.1 Approve the outline business case for and agree in principle to the development of a shared Public Health service for the London Borough of Barnet and the London Borough of Harrow for a period of up to three years.

1.2 Approve the commitment of resources to develop joint Public Health transition plans to implement a shared Public Health target operating model and organisation structure and prepare for and manage the transfer of Public Health responsibilities from the NHS.

1.3 Instruct the relevant officers to develop and finalise in consultation with the Barnet Clinical Commissioning Group, the arrangements for the shared Public Health service into a proposed Inter Authority Agreement to be entered into by the London Boroughs of Barnet and Harrow.

1.4 Instruct the relevant officers to report back to this Committee on the finalised terms of the proposed Inter Authority Agreement and seek authorisation for its completion.

2. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

2.1 These proposals will ensure the delivery of a public health function that is fit for purpose and has the capacity and capability to support the Council's statutory public health responsibilities when these transfer from the NHS to the Council on the 1st April 2013.

2.2 The Public Health function will be responsible for overseeing the implementation of the Barnet Health and Wellbeing Strategy which supports the delivery of the Barnet Sustainable Community Strategy priority of 'Healthy and Independent Living'.

3. RISK MANAGEMENT ISSUES

3.1 Risks will be actively managed in line with the corporate risk management approach.

3.2 The key risks in respect of the establishment of a shared Public Health service and Director of Public Health are as follows:

Ref.	Risk	Mitigation
1.	A shared Director of Public Health (DPH) may be less accessible for Members and Officers in Barnet.	The DPH role would be evenly divided between both Boroughs and a combined Public Health function would enable the establishment of an enhanced leadership team and a Deputy Borough DPH role
2.	Unequal allocation of Public Health resources	Well specified Service Agreements and operating arrangements to ensure equal

Ref.	Risk	Mitigation
	and benefits of a shared Public Health function.	coverage and allocation of benefits to Local Authority partners.
3.	Physical access to Public Health staff may be affected by hosting arrangements.	Service agreements with identified Public Health contacts for each Borough and hot desk arrangements to support a regular physical presence in both Boroughs.
4.	Risk of a loss of local knowledge and lack of support from local NHS colleagues.	Local knowledge will be retained within a larger specialised Public Health team and staff engagement and retention plans will be implemented to minimise the loss of staff during the transition of Public Health to the Local Authority

4. EQUALITIES AND DIVERSITY ISSUES

4.1 An Equalities Assessment (EQA) 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.

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

5. RESOURCE IMPLICATIONS

5.1 Financial Implications

5.1.1 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 shadow Public Health budgets published in February 2012 by the Department of Health. There remains a substantial 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 (2010/11 outturn) that have been notified to local authorities or the substantial variation in allocations between areas that have had severely financially challenged Primary Care Trusts and those that have been in surplus. The current position suggests that both Barnet and Harrow could have a worst case potential funding shortfall of £814,000 for Barnet and £438,000 for Harrow. As the Public Health baseline is updated to reflect the 2011/12 outturn, there may be a further impact on the Barnet allocation.

5.1.2 The following tables set 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 around 87% 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	1,386	11.7%	1,056	13.4%
Health Improvement Service Budgets	10,410	88.3%	6,806	86.6%
LOCAL AUTHORITY ALLOCATION TOTAL	11,796	100.0%	7,862	100.0%

5.2 Procurement Implications

5.2.1 Both Barnet and Harrow 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 efficiency savings through harmonisation and joint procurements. The procurement hub will provide a managed procurement and contract management service.

5.2.2 There will be a need to define and manage through a joint agreement, the arrangements for the novation of Public Health provider contracts from the NHS to the accountable Local Authority to allow for the establishment of a shared procurement hub across West London for Public Health contracting and procurement. This will be defined and developed within the scope of a transition project.

5.4 Staffing Implications

5.4.1 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 Cluster PCT organisations to the agreed host Local Authority as part of the Public Health transition plans.

5.4.2 The detail regarding the approach to transferring Public Health staff from NHS organisations has yet to defined and agreed, but it is assumed that TUPE principles will be adopted.

5.4.3 All financial and statutory responsibilities formally pass to Local Authorities on 1st April 2013. This means that the shared Public Health function will need to go live on the same date. The proposed design and organisation of this new function within the context of the associated financial constraints are set out in this paper.

5.4.4 In scope staff and relevant recognised Trade Unions will be consulted about the design of the shared Public Health function via the representatives on the Public Health Transition Team. The current design proposal set out in Appendix 1, section 6, assumes that there will be a single Director of Public Health role who will be the accountable officer for Public Health across both Local Authorities. Consultation with staff and Trade Unions will also include any plans that may require the relocation of Public Health staff so that the host Borough can better

understand and consider any issues and appropriate mitigation. Staffing matters are a Council function and, where required, they will be referred to the General Functions Committee for decision.

6. LEGAL ISSUES

6.1 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.

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

6.3 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. It is likely that TUPE principles will be applicable and in scope staff 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.

6.4 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.

7. CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

7.1 The Council's Constitution in Part 3 Responsibility for Functions, paragraph 3.6 states the terms of reference of the Cabinet Resources Committee including 'approval of schemes not in performance management plans but not outsider the Council's budget or policy framework.'

8. BACKGROUND INFORMATION

8.1 The outline business case proposes an agreement in principle between the London Borough of Barnet and the London of Borough of Harrow to develop and implement plans to establish a shared Public Health function to discharge the

statutory Public Health responsibilities that will transfer from the NHS to Local Authorities on the 1st April 2013.

8.2 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 both in Barnet and Harrow 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.

8.3 Barnet and Harrow Councils have an established strategic partnership and have developed plans for a shared legal service as well as already having a shared Emergency Duty Team for social care. The development of a shared Public Health function fits with the strategic intentions of both organisations and has the full support of both Chief Executives. It 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 all of their new statutory responsibilities. It will also ensure that there is a sufficient critical mass of specialist public health staff to provide a comprehensive core offer advice service to the Clinical Commissioning Groups in Barnet and Harrow which helps them to be effective commissioners.

8.4 Both parties recognise the opportunities of a shared Public Health function and are committed to pursuing this option, but they are also fully aware of the limitations and risks of over extending the Director of Public Health role. There is complete agreement 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. There is however broad agreement that a single Director of Public Health covering more than two Boroughs would not be viable.

8.5 The latest Borough health profiles (2011) identify that the population health and wellbeing challenges for the populations of both Barnet and Harrow are very similar and this is reflected in the achievement of similar levels of performance against key Public Health indictors when compared against both London and England averages.

8.6 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 inadequacy of the final Public Health funding allocation 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.

Outline Business Case

1. BACKGROUND

1.1 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. It will also be responsible for certain Public Health services such as immunisation and cancer screening which will be commissioned nationally or regionally via NHS Commissioning Boards.

1.2 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.

1.3 Both Barnet and Harrow Councils recognise the potential benefits of a shared Public Health leadership and operating model and their intention to explore this as a viable and enhanced alternative to a standalone model is already reflected in their respective Public Health transition plans. It 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.

1.4 The existing local Public Health teams in Barnet and Harrow are relatively small compared with other teams in 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. 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.

2. STRATEGIC CASE FOR A SHARED PUBLIC HEALTH MODEL

2.1 Barnet and Harrow 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 may be 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 inadequate.

2.2 Both organisations have set out their ambitions for Public Health and its leading role in protecting and improving the health and wellbeing of their populations. These are captured in the following vision statements and intentions:

2.3 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, reducing health inequalities and delivering the Health and Wellbeing Strategy. Through a skilled multi-disciplinary workforce, the Public Health function will make sure that the risk of avoidable harm is reduced through promoting healthy lifestyle choices and protecting the health of the population.*

2.4 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*

3. OPERATIONAL CASE FOR A SHARED PUBLIC HEALTH MODEL

3.1 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

3.2 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

3.3 Transfer of NHS NCL Barnet Public Health Team To Barnet Council

Options appraisal for a standalone borough Public Health function:

The following is a summary of the advantages and disadvantages of Public Health function over a shared borough model.

Benefits:

- Local Director of Public Health who is able to lead full time on the health and well-being agenda in Barnet
- Strong established relationships in place between local Public Health team and Barnet Clinical Commissioning Group
- Team physically located in Barnet Council so maybe more accessible
- Staff continuity with reduced risk to key relationships and loss of local knowledge

Disadvantages

- Insufficient resources and skills mix to support a viable standalone universal Public Health function and meet statutory Local Authority requirements
- Insufficient specialist Public Health resources to provide the necessary health improvement knowledge and leadership
- Very limited opportunities to deliver operational and contract efficiencies
- Limited professional development and career progression opportunities for Public Health staff in a small standalone team structure

3.4 Shared Public Health Function With Another Local Authority

Options appraisal for a shared borough 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

Benefits
• 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 good Public Health 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 • Greater opportunities to increase Public Health intelligence capacity, build knowledge collateral and share learning to improve outcomes <u>Leadership And Governance</u> • More capacity and opportunities to shape the development of health sustaining communities and influence regeneration policy <u>Community Engagement And Relationships</u> • Increased capacity for greater and more sustained community engagement <u>Organisational And People Development</u> • 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 different locations and with different communities <u>Service Development And Operational Resilience</u> • Substantial 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 <u>Financial</u> • Increases the scope to identify solutions to address any immediate funding

Benefits
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

3.4 Risks Associated With A Shared Public Health Function

The following section sets out the disadvantages and 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
Public Health Outcome Achievement, Quality And Performance • 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.
Leadership And Governance • 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,	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 increased Public Health function would support the establishment of an enhanced leadership team and a deputy borough DPH role.

Risk	Mitigation
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 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.
<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 career progression, continuous professional 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.

Risk	Mitigation
Financial • Increased exposure to Public Health cost pressures within partner organisation	The opportunities for operational and contract efficiencies outweigh the potential risk cost pressure exposure.
Transition Risks • Increased complexity and risk of delivering Public Health transition plans with multiple borough and PCT Cluster stakeholders • Lack of clear accountability and increased scope for delay in decision making from an extended project governance structure which is dependent on multiple stakeholders	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 programme delivery governance structure will be established if the decision is taken to proceed with a shared Public Health function.

4. FINANCIAL CASE

4.1 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 Barnet and Harrow 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**

4.2 Funding Shortfall

The current expected funding allocations identify a worst case shortfall of £814,000 in Barnet and £438,000 in Harrow. In its 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 will rectify this error which will be in favour of both Barnet and Harrow Councils and will close the expected funding gap.

PUBLIC HEALTH SHADOW ALLOCATION 2012/13	2012/13 Shadow Public Health Budget Allocations	
	BARNET	HARROW
	£000	£000
Local Authority Shadow Allocation	11,796	7,862
Local Authority Allocation Requirement	12,610	8,300
WORST CASE FUNDING ALLOCATION SHORTFALL	814	438

4.3 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 Barnet and Harrow in the past.

4.4 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. This is included in the Barnet funding shortfall calculation but not in the Harrow figure.

4.5 A number of Public Health commissioning, contract procurement and information functions are currently delivered by centralised teams and functions in the North Central London Cluster PCT. The costs associated with this activity are not included in the Barnet Local Authority baseline and this may also be the case for Harrow. The estimated impact for Barnet is £400,000 which is included in the worst case funding allocation.

4.6 Historical Investment In Public Health

Barnet and Harrow PCTs 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 2010-12.

4.7 The notional baseline capitation funding allocations notified by the Department of Health for both Barnet (£32 per head of population) and Harrow (£33 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**	

5. LOCAL PUBLIC HEALTH REQUIREMENTS

5.1 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.

5.2 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

5.3 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 commissioning advice
- National Child Measurement Programme
- NHS Health Check assessments

5.4 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.

5.5 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.

5.6 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

5.7 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)

6. SHARED OPERATING MODEL PROPOSAL

6.1 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.

6.2 <u>Design Principles</u>

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 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. In the case of a shared service this will apply to both Health and Well Being Boards and will be the lead officer for both Local Authorities.

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 in 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

6.3 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 of 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 Barnet and Harrow 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 individual borough and cross borough based. It is expected that certain functions and roles would be located in individual boroughs and others would include working across multiple sites. The shared Public Health team 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 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. It is expected that the ratio of specialist Public Health time would not exceed more than 1 WTE per a population size of 270,000.	New requirement to provide Public Health 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>

2. Core Offer Commissioning Advice And Support	
Overview	**Outline Specification**
	• 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

5. Public Health Intelligence	
Overview	**Outline Specification**
	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

7. PROPOSED NEXT STEPS

7.1 The proposed approach recognises that public health transition plans have already been developed and signed off by local project boards and between Local Authorities and NHS Clusters. These also include arrangements for shadow working during the transition year and are supported by locally agreed Memoranda of Understanding. The proposed approach suggests the following project delivery structure to realign and where possible combine existing plans and governance arrangements. It is expected that the detailed approach and plan delivery governance arrangements will be defined and agreed as part of the first stage of a joint Barnet and Harrow transition project.

Stage	Outputs And Outcomes
1. Alignment And Definition Stage **(MAY 12 to JUL 12)**	• Joint project governance arrangements defined • Joint Project Delivery Board set up • Shared Option Business Case approved by Barnet and Harrow Councils • Agreement on hosting arrangements • Staff transfer approach defined and agreed • Plan realignment impact and risk assessment conducted • Project definition document and plan produced and signed off • NHS Cluster MOUs revised to support a multi-cluster and borough Public Health transition • Plan delivery resources defined and secured
2. Development Stage	• Audit and definition of current Public Health functions and activities

Stage	Outputs And Outcomes
(JUL 12 to AUG 12)	• Mapping of existing Public Health relationships and stakeholder interfaces • Design specification for a shared specialist Public Health and single Director of Public Health target operating model • Design specification for a shared CCG Public Health advice core offer • Shared procurement hub service business case approved • Definition of operational interfaces with PHE, NHSCB, CCGs, Commissioning Support Services, Health Protection Unit • Organisation structure design and role specifications • Staff transfer approach defined and agreed • Equalities Impact Assessments
3. Delivery Stage **(SEP 12 to APR 13**	• Appointment of shared Director of Public Health • Build and testing of Public Health operating systems, processes and management reporting • Transfer of Public Health staff to the host Local Authority • Production and sign-off of Local Authority and CCG service agreements • Novation and transfer of Public Health improvement contracts to Local Authorities • Confirmation of Local Authority Public Health funding allocation • Launch of the new local system of Public Health • Regulatory compliance and quality assurance audits and reviews
4. Stabilisation Stage **(APR 13 to JUN 13)**	• Post-implementation review • Project completion and handover to delivery operations

8. Governance And Agreement

8.1 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.

8.2 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

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:

- Health improvement
- Health protection
- Healthcare Public Health
- 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:

- 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

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
7	Public Health services for children and young people aged 5-19

	Other Public Health Commissioning Responsibilities
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.*

- Increased healthy life expectancy
- 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 have 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 Health and Social Care Act 2012 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:

- Local Authority's new Public Health functions
- Production of an annual report on the health of the population
- Statutory member of the local Health and Wellbeing Board

- As lead officer for health, provide advice to elected members and senior officers
- Ensure health and wellbeing services are integrated across the locality
- 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.