Health Partnerships Overview & Scrutiny Committee
27th March 2012

Report from the Director of Strategy, Partnerships & Improvement

For Action | Wards Affected: ALL

Public Health Transfer Update

1. Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has requested an update on the transfer of public health functions from NHS Brent to the council. This report sets out the developments in the transfer to date and the national policy context. As things stand, council's will formally take on their public health responsibilities on the 1st April 2013, subject to the successful passage through Parliament of the Health and Social Care Bill 2011.

1.2 At the committee meeting, Phil Newby, Director of Strategy, Partnership and Improvement (and Transfer Project Sponsor), Simon Bowen, Acting Director of Public Health and Andrew Davies, Policy and Performance Officer (Project Manager) will be present to answer questions about the transfer.

2. Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to:

(i). Consider the update on the public health transfer

(ii). Question officers from the council and NHS Brent on the progress to date with the transfer and the plans to develop a new public health service in Brent during the transition year in preparation for the council taking on responsibilities from 1st April 2013.

3. Detail

3.1 Local government responsibilities

3.2 The Government originally published its plans for public health in the White Paper, *Healthy Lives, Healthy People* and these have been confirmed in the Health and Social Care Bill 2011. Subject to parliamentary approval of the Bill, each upper tier local authority will take on the duty to improve the health of people in its area and with it, acquire many of the public health services currently the responsibility of the NHS. Councils will be funded by a ring fenced budget that will be allocated based on relative health inequalities and deprivation to deliver public health services. The Government believes that by embedding public health within local government it will be easier to create local solutions in order to meet varying local health needs. It will

also enable joint approaches to be taken with other areas of local government's work and with key partners to tackle health inequalities.

3.3 Once the transfer takes place, local government will be expected to put health and wellbeing at the heart of everything it does. This will mean:

- Including health in all policies so that each decision seeks the most health benefit for the investment, and asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?"
- Encouraging health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- Supporting local communities – promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people), and the Big Society. This will bring a focus on what a healthy population can do for the local community, not least in terms of regeneration
- Tailoring services to individual needs – based on a holistic approach, focusing on wellness services that address multiple needs, rather than commissioning a plethora of single issue services.

3.4 It's acknowledged that local political leadership will be critical in ensuring that public health receives the focus it needs across local authorities.

3.5 Already local government fulfils its new duty in a number of ways, such as through the provision of leisure services, through the planning system, and in providing services such as housing. Ensuring the health needs of disadvantaged communities are addressed will be central to the new responsibilities.

3.6 It has taken some time since the publication of the Public Health White Paper and Health and Social Care Bill to clarify local government responsibilities, the Public Health Outcomes Framework and the budget allocation for public health that council's will be receiving. This has meant that local authorities haven't been clear about exactly what it is they will be taking on, what they will be expected to deliver and the amount of money available to do it. Despite the recent publication of the baseline spending estimates for public health and the Outcomes Framework, important information in relation to both is still missing, such as the way that the Health Premium will work (the Health Premium is funding that will be allocated to council's based on achievement against performance indicators in the Public Health Outcomes Framework) and how priorities will be set using the Public Health Outcomes Framework.

3.7 However, commissioning responsibilities have become clearer and we now know that local government will be responsible for the following services:

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- **The National Child Measurement Programme**
- Interventions to tackle obesity such as community lifestyle and weight management services
- Locally-led nutrition initiatives
- Increasing levels of physical activity in the local population

- **NHS Health Check assessments – assessments will be mandated, provision of lifestyle advice and interventions will not be but there is an expectation that there will be adequate follow up following an assessment**
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- **Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)**
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- **The local authority role in dealing with health protection incidents, outbreaks and emergencies – council's will be mandated to ensure plans are in place to protect the local population. CCG will have a duty of cooperation with local government on health protection**
- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion
- Local initiatives that reduce public health impacts of environmental risks.
- **Provide population level healthcare advice to CCGs and the NHS**

3.8 Those services in **bold will be mandatory for local government**. Other services will discretionary, but guided by the Public Health Outcomes Framework, the local JSNA and Health and Wellbeing Strategy.

3.9 The Government has a number of expectations with regard to local government's public health service responsibilities:

- Services should meet the needs of disadvantaged and vulnerable groups
- Local authorities should work with CCGs to integrate across clinical pathways where ever possible
- Local government should commission rather than directly provide these services, engaging local communities and the third sector where possible and adopting a diverse provider model where possible.

3.10 Apart from the mandatory services and the Government's expectations set out above, council's will be free to develop a public health service that best meets the health and wellbeing needs of the borough. The new Joint Strategic Needs Assessment has been drafted and consultation closed on the 23rd March 2012. A new health and wellbeing strategy for Brent is to be developed which will identify those needs. Clearly the Outcomes Framework will also influence the shape of the new service and its priorities for health improvement. This is why council's need to know how priorities from the Outcomes Framework will be selected and whether council's will get to do this, or if Government will set national priorities or whether it will be a mixture of local and national priorities.

3.11 The public health system

3.12 There are three other elements of the new public health system. A number of public health services are to remain an NHS responsibility. The NHS Commissioning Board will be responsible for the following public health services:

- Abortion services
- Sexual assault services including sexual assault referral centres
- Promotion of early diagnosis services
- Public health services for children under 5, including health visiting, the Healthy Child Programme and the Family Nurse Partnership – Local government will assume responsibility for these services by 2015.
- Commissioning Child Health Information Systems
- Immunisation services
- Screening services
- HIV treatment services

3.13 The second element is the establishment of Public Health England which will take on the responsibilities of a number of agencies that are to close, such as the Health Protection Agency and Drug Treatment Agency, provide specialist health protection services including, coordination of outbreak control, and access to national expert infrastructure as and when necessary and provide national public health leadership. Finally, the Department of Health will retain a budget for and manage national public health "campaigns".

3.14 The role of the Director of Public Health

3.15 The Health and Social Care Bill has safeguarded the Director of Public Health role. They will play a crucial role in ensuring that the public health needs of the borough will be recognised in all aspects of the council's services. Each local authority must, appoint a Director of Public Health. This post can be shared with other councils where it makes sense to do so. Further guidance on the appointments of DPHs is to be published and will build on the existing appointments process, which is consistent with Faculty of Public Health standards and includes the use of appointments advisory committees and faculty assessors.

3.16 Funding

3.17 The baseline spending estimate for public health (the amount that Brent Council would have been allocated for 2012/13 if it was taking on responsibilities) is £16,007,000. This figure has been worked out on the basis of spending in 2010/11. NHS Brent estimated this to be £17,891,000. The revised figure takes into account changes in commissioning responsibilities that have been made since the NHS Brent figure was worked out – abortion services and some contraceptive services will not become local government responsibilities, reducing the amount of funding that will transfer to the council. Similarly, the revised figure does not include income to public health from Government departments other than the Department of Health. This means that over £1m is not included in the revised figure as it is income from the Home Office for drug treatment services. Officers are working through the implications of the baseline estimate. The allocation for public health for local government won't be finally confirmed until December 2012, but the baseline estimate is to be used for planning purposes.

3.18 The overall settlement for public health is £5.2bn, but as can be seen in the table below, only £2.2bn will be allocated to local government.

Organisations	Estimated baseline expenditure	Uplifted to 2012-13
Local Authorities	£2.1bn	£2.2bn
NHS Commissioning Board	£2.0bn	£2.2bn
Public Health England	£210m	£210m
Department of Health	£620m	£620m
Total	£5.0bn	£5.2bn

3.19 Work in Brent

3.20 Brent has been engaged in two strands of work to develop a new model of public health for the borough. Firstly, the public health transfer has been added to the One Council Programme. A project board has been established, its members are:

- Phil Newby, Director of Strategy, Partnerships and Improvement (Project Sponsor)
- Alison Elliott, Assistant Director of Adult Social Care
- Cathy Tyson, Assistant Director of Policy
- Andrew Davies, Policy and Performance Officer (Project Manager)
- Jo Ohlson, Borough Director, NHS Brent
- Simon Bowen, Acting Director of Public Health
- Imran Choudhury, Consultant in Public Health

3.21 Analysis has taken place looking at the performance of the existing public health services, its budgets, contract obligations, staff numbers etc, in order to build up a baseline of local activity. An initial view has been taken by the Public Health Transition Project Board on the future model for public health, looking at what should be done in borough and what could be shared with other boroughs, or through integrated health and social care commissioning arrangements. This needs to be further refined, but the local model is starting to emerge.

3.22 What develops locally will be influenced by what emerges with regard to health and social care integration and joint commissioning. But another factor at play is the work of the West London Alliance, led by Andrew Howe, Director of Public Health in Harrow, to see what scope there is for a West London public health service. Brent is keen to share public health responsibilities where it makes sense to do so and is in discussions with other boroughs about sharing the procurement of some services.

3.23 The Public Health Transfer Project has a number of dependencies, not least the future commissioning arrangements for health and social care services. Much of Brent's public health budget that will be transferring to the council is spent on commissioned "health" services, such as drug and alcohol treatment services and sexual health services. Logic suggests that public health is included in any joint health and social care commissioning arrangement that the council signs up to rather than developing separate commissioning arrangements. The time taken to develop joint commissioning arrangements has meant that it has not yet been possible to finalise the model for public health that Brent will implement.

3.24 By the end of March 2012 councils and PCTs will be expected to agree a public health transition plan and a memorandum of understanding to manage the transfer. Whilst the plan doesn't have to include a definitive version of the new model for public health, or details on staff transfers, it is hoped that there is more clarity about

the emerging health and social care commissioning landscape which can be reflected in the transition plan.

3.25 In the coming months it will become clearer how public health teams and staff are to be integrated into the council. There will be full consultation with affected staff and Trade Unions on the transfer and decisions over structure and the model in Brent will be approved by members so they are clear how the new service will operate and be run once it is transferred to the local authority. At this stage, as the preferred model and structure is not finalised it would be inappropriate to go into details because of the need to follow the process and ensure staff are informed and consulted.

4. Conclusions

4.1 The Health Partnerships Overview and Scrutiny Committee should consider this update and question officers on progress with the transfer of public health functions to the council. Further updates can be presented to the committee later in the year, so that members are able to scrutinise plans for the emerging model and service.

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