City of Westminster

Cabinet Report

Decision Maker:	**Cabinet Committee**
Date:	**22 October 2012**
Classification:	**General Release**
Title:	**Establishment of a Tri-borough Public Health Service**
Wards Affected:	**All**
Policy Context:	**Development of Tri-borough**
Financial Summary:	**DH will not inform local authorities of their public health allocation until December but have confirmed that funding allocations for 2013/14 will be no less than baseline estimates announced earlier this year, with an uplift based on the GDP deflator. We have made a prudent planning assumption to use the February 2012 finance base. Based on a number of assumptions, at this point we are working on a probable funding shortfall of £4.3m for 2013/14. The public health grant is ring-fenced and all expenditure will be managed and balanced within the ring-fenced grant.**
Report of:	**Mike More, Chief Executive**

1. Executive Summary

1. From April 2013 there is a statutory transfer of public health functions to local authorities. A ring-fenced grant will be received to discharge the new responsibilities, and staff carrying out these functions will transfer into the local authorities from the PCTs.

2. A single tri-borough public health service is recommended with the retention of individual borough sovereignty in relation to public health decision-making and priorities. It is recommended that Westminster council is the lead authority, and that officers begin discussions in terms of a section 113 agreement between the three authorities relating to the new tri-borough service

3. DH will inform local authorities of their public health allocation in December, but have confirmed that funding allocations for 2013/14 will be no less than baseline estimates announced earlier this year. In addition, some transition funding has been received (£0.2m), any shortfall will be charged to the Public Health budget in 2013/14.

4. Based on a number of assumptions, at this point we are looking at a probable funding shortfall of £4.3m for 13/14. Work is underway to balance the ring fenced public health budget.

5. The transfer of staff from the PCT to Councils is part of a larger restructure of the health system and is a PCT owned process. DH and the LGA have advised that the process is TUPE-like with protection of PCT staff terms and conditions with staff remaining in the NHS Pensions scheme.

6. A new organisational structure is recommended to ensure the service 'lands safely'. This has been developed through engagement with staff from the PCT, the tri-borough councils and the three Member Public Health Portfolio holders and delivers efficiencies of 10% - 15%. During 2013/14 it is planned to focus on maximising the opportunities of an in-house public health function to ensure synergies across the tri-borough councils are best exploited and further efficiencies will be possible.

7. The transfer of contract liabilities is a DH and PCT owned process. A PCT contracts register of all clinical contracts (which includes Public Health contracts) is timetabled to be completed by the end of September. The confirmation on the destination of contracts and handling of block contracts will take place during October - December.

8. Officers are procuring an external forensic examination of the number and values of contracts to reconcile the PCT Contract register to the most recent PCT finance submission. This will provide assurance that the three councils will have all the relevant information on contract liabilities

9. The risks around certainty of the financial allocation and the exact magnitude of liabilities are being managed as indicated by the actions above and the statutory guidance provided on particular aspects of the process.

10. It is recommended that officers continue discussions with NHS bodies on the details of transition arrangements, particularly with respect to finance, staffing and contracts, and to report back to cabinet later this year after the formal notification of the funding allocation from the DH.

2. Recommendations

That the Cabinet Committee:

- Note the statutory transfer of public health functions to local authorities from 1 April 2013 and agree to the establishment of a single tri-borough Public Health service with Westminster City Council as lead authority.

- Agree subject to the PCT engagement process the organisational structure for the tri-borough Public Health Service.

- Authorise officers to continue discussions with NHS bodies on the details of transition arrangements, particularly with respect to finance, staffing and contracts, and to report back to Cabinet later this year after the formal notification of funding allocation from the Department of Health.

- Authorise officers to begin discussions on the terms of a Section 113 Agreement between the three authorities (WCC, K&C and HAF) relating to the new tri-borough service.

3. Reasons for decision

3.1 Public health functions are transferring to local authorities from April 2013. Local authorities will receive a ring-fenced grant to discharge their new responsibilities, and staff carrying out these functions will transfer into the local authorities from the PCTs. Public health transition planning is on-going and NHS human resource processes and deadlines require local authorities to agree an organisational structure for the new public health service by the end of October.

4. The scope of transfer

4.1 Existing PCT public health functions will split between Public Health England (a new national body), local authorities, NHS Commissioning Boards, and the CCGs. Local Authorities will be responsible for:

- Appropriate access to sexual health services;

- Commissioning services such as tobacco control, alcohol and drug misuse, increasing activity programmes, home and workplace accidents, testing for sexual health, obesity programmes

- Ensuring NHS commissioners receive the public health advice they need;

- The National Child Measurement Programme (weighing and measuring reception and year 6 children in state primary schools);

- NHS Health Checks;
- Elements of the Healthy Child Programme.

4. 2 Some of these services, such as Health Checks and the Healthy Child programme, are the subject of statutory duties, and are in effect mandated. For others there is more flexibility in how duties are discharged, for instance the commissioning of prevention programmes, and giving advice to CCGs. Other services are demand-led such as sexual health services.

4.3 The reform of the public health system is part of the overall health reform programme, and the creation of Clinical Commissioning Groups. As such timetables for implementation follow national Department of Health (DH) timelines, and the transition process leading up to April 2013 is being led by DH.

5. Local authority transition planning

5.1 Transition planning is covering two main aspects of work:

- Working through the ambition for the new service with stakeholders in all three Boroughs.
- Detailed transition planning in relation to the 'mechanics' of the move.

5.2 Transition is governed by a tri-borough Adults Member Group and the officer Public Health Transition Board with representatives from across the 3 Councils and the PCT. Six Task & Finish working groups covering Communications & Engagement, HR & employee transfer, Finance & Procurement, Commissioning & Contracts, IT & Information Governance, and Property & Facilities are planning the logistics of the transfer, and again consist of staff from across the three Councils and the PCT.

6. The Tri-Borough Public Health Service

6.1 A health and wellbeing strategy is being developed by the shadow Health and Wellbeing Board of each authority, it being a legal duty from April to agree such a strategy in co-operation with relevant NHS bodies. That strategy will define the public health vision in the authority. There are clear synergies with work already being undertaken within councils- environmental health, Children's and Adults' services, land-use planning, housing, transport, sports and leisure and libraries all have clear impacts on health and well-being.

6.2 The public health service within the Inner North West London is already arranged on a tri-borough basis, with a single Director of Public Health. Within a tri-borough public health service, in line with all other tri-borough services, each borough will retain its own sovereignty in relation to public

health decision-making and priorities. This can be expressed either through health and wellbeing strategies or in the form of a Mandate.

6.3 As described in section 11 on finance, we are making a prudent planning assumption that funding may be reduced by 10%, and that efficiencies will be delivered from the synergies with existing activity within the councils.

6.4 In light of this, a process of identifying functions and capabilities has been conducted in order to develop an organisational structure that delivers efficiencies of 10-15%, and ensure that the new service fits within existing councils operating models and duplications are reduced.

6.5 During 2013/4 a second stage of review will focus on maximising the opportunities of an in-house public health function and ensuring that synergies are best exploited. At this time further efficiencies will be possible.

7. Human Resource

7.1 The transfer of staff from the PCT to councils is part of a large restructure of the health system (creation of CCGs, Public Health England and NHS Commissioning Board etc). The process is a PCT owned process with defined timescales. The PCT are responsible for the transfer of staff, the three councils are the 'receiving organisations'. As such communications with staff and providers has all been managed by the PCT. Guidance on the councils' role as 'receiving organisations', timelines, and under what rules we will receive staff are all set by the DH.

7.2 DH and the Local Government Association wrote to PCTs and local authorities on the next steps on 2nd August on the transfer of public health staff to local authorities. The process is TUPE-like with PCT staff contractual terms and conditions protected, and staff will remain within the NHS Pensions scheme (which the local authorities will have to become admitted bodies to). The timelines are clarified and the NHS will provide a list of the staff transferring to the council in December under a Transfer Order / Scheme.

7.3 The local authorities have developed organisational structures for the new service in consultation with the PCT. To fit within the whole health service redesign, a draft structure for the public health service within local authorities has been developed in consultation with staff from the PCT, local authorities and the three Portfolio holders for Public Health from the three boroughs. This was made available to PCT staff at the end of September for formal engagement in the HR process (in line with structures for all other staff destinations) with the proviso of 'subject to council approval'.

7.4 Annex 1 consists of the existing structure for public health within the PCT, and the proposed structure of the tri-borough public service. The structure shows a reduction from 42.8 FTE to 37 posts (35.8FTE).

7.5 The tri-borough service will be managed by a single Director of Public Health (DPH). Each Borough will have a Deputy Director of Public Health who will act as the Deputy to the Director (not a Borough Director). The Deputy DsPH will play the important function of sitting on CCG Boards, and helping to discharge the function of providing advice to the CCGs. Three portfolios will be managed by the three Deputy DsPH:

- Health intelligence and advice across the range of local authority functions.
- Families, children and young people, healthy weight, mental health protection and promotion.
- Adults, sexual health, behaviour change, health protection, assurance of CB commissioning.

In addition a business support function will be created.

7.6 The service will explore working with existing contract management and procurement teams within Adult Social Care and Family and Children's Services to ensure that synergies are exploited in existing contracts to aid further integration in public health and existing council service provision.

8. Commissioning and contracts

8.1 The process of transfer of contracts will be through a Transfer schedule- where the PCT will identify relevant public health contracts to be transferred. The PCT is undertaking a process of 'contract stocktake, stabilisation and shift' in preparation for contract transfer to local authorities and other receiving organisations, and formal guidance on the process for the "shift" phase is awaited and expected shortly. A contracts register of all clinical contracts (which public health contracts are classified) is timetabled to be completed by the end of September 2012.

8.2 A thorough bottom-up analysis of contracts has been made working with existing public health commissioners in the PCT, and further work is on-going looking across PCT contracts to identify contracts likely to transfer.

8.3 Officers are procuring an external forensic examination of the number and value of contracts that will be transferred. The forensic audit will establish the number and value of contracts within Public Health, and reconcile the value and number of contracts per the local authority's Public Health contracts register and the most recent PCT submission. The three councils cannot decline to take on contract

liabilities. The purpose of the forensic audit is to assure the three councils that on transfer all relevant information on the contracts is available and that with this information the councils' future strategy on contracts and commissioning can be developed.

9. Risk Management

9.1 The Public Health Transition Board maintains a risk register in relation to the transition, actively managing risks and closing as appropriate. Transition is a complex process, and the management and remediation of many of the risks is based upon statutory guidance on particular aspects of the process. The major outstanding risks are:

- Lack of certainty on the financial allocation. The indicative allocation had been challenged by the three councils and DH has confirmed that they will correct all the material errors. The three councils are basing their planning on the best available worst case estimates of finance allocation to mitigate this risk.

- Lack of certainty at this point in the process on the exact magnitude of liabilities. The NHS process outlines that the contracts stocktake has taken place but confirmation on destination of contracts and handling of block contracts will take place over October- December. The three councils are working closely with PCT and examining the contracts register, and are procuring a forensic audit of contracts. In addition to mitigate the risk we are using worst case estimates in planning assumptions.

10. Equalities Implications

10.1 With regard to staff, the HR process is owned by the NHS and they have carried out equalities impact assessments of the process.

10.2 Once confirmation of finance is obtained in December, a balanced budget will be set. If, at this point it should become necessary to reduce spending in some areas, an EIA of budget proposals will be a core part of decision making process.

11. Financial implications

11.1 Although Department of Health will not inform local authorities of their public health allocation until December, the Department has confirmed (through the London Public Health Transition Delivery Board) that funding allocations for 2013/14 will be no less than baseline estimates announced earlier this year, with an uplift based on the GDP deflator.

11.2 Those funding allocations were based on PCT submissions from autumn 2011, in which there were errors (on both the PCT side and the DH). The DH has agreed to correct the material errors, but confirmation of the corrected allocation is not expected until December 2012.

11.3 Local authority and PCT finance are undertaking a process of reconciliation of known committed spend (e.g. contracts, liabilities and headcount) back to the most recent PCT submission (which was based upon ledger). Whilst this reconciliation process is being conducted and discussions are on-going with DH on the baseline, we still have to meet the challenging deadlines on HR. We have made a prudent planning assumption to use the February 2012 finance base in designing structures. Based on a number of assumptions, at this point we are working on a probable funding shortfall of £4.3m for 2013/14.

10.4 The councils made a request to NHS London and INWL PCT for transition funding of £0.6m. DH has confirmed transition funding of £0.2m. The shortfall in funding has been charged by Westminster to the Public Health budget in 2013/14.

10.5 The public health grant is ring-fenced and all expenditure will be managed within the ring-fenced grant. It has been agreed by the Public Health Transition Board that the Public Health budget should be balanced by virtue of a reduction in budgeted contract expenditure, a reduction in budgeted headcount or a combination of both.

11. Legal Implications

11.1 The Health and Social Care Act 2012 has made major changes to the National Health Service Act 2006, to reform the NHS. In relation to public health functions, the Act allows the Secretary of State to make Regulations requiring local authorities to exercise public health functions. Details of the Regulations are still awaited.

11.2 Authorities are also to be required to appoint, jointly with the Secretary of State, a Director of Public Health to be responsible for the discharge of public health functions.

11.3 In the transition period to the transfer of functions in April 2013 PCT clusters are required to identify public health spends, contracts which have been commissioned to deliver public health functions, and staff engaged in public health work, in preparation for the transfer. It is expected that Transfer Orders will be made by DH identifying staff and contracts transferring to local authorities. This process is being closely monitored, and any issues or difficulties arising which may have financial consequences will be reported to Cabinet in due course.

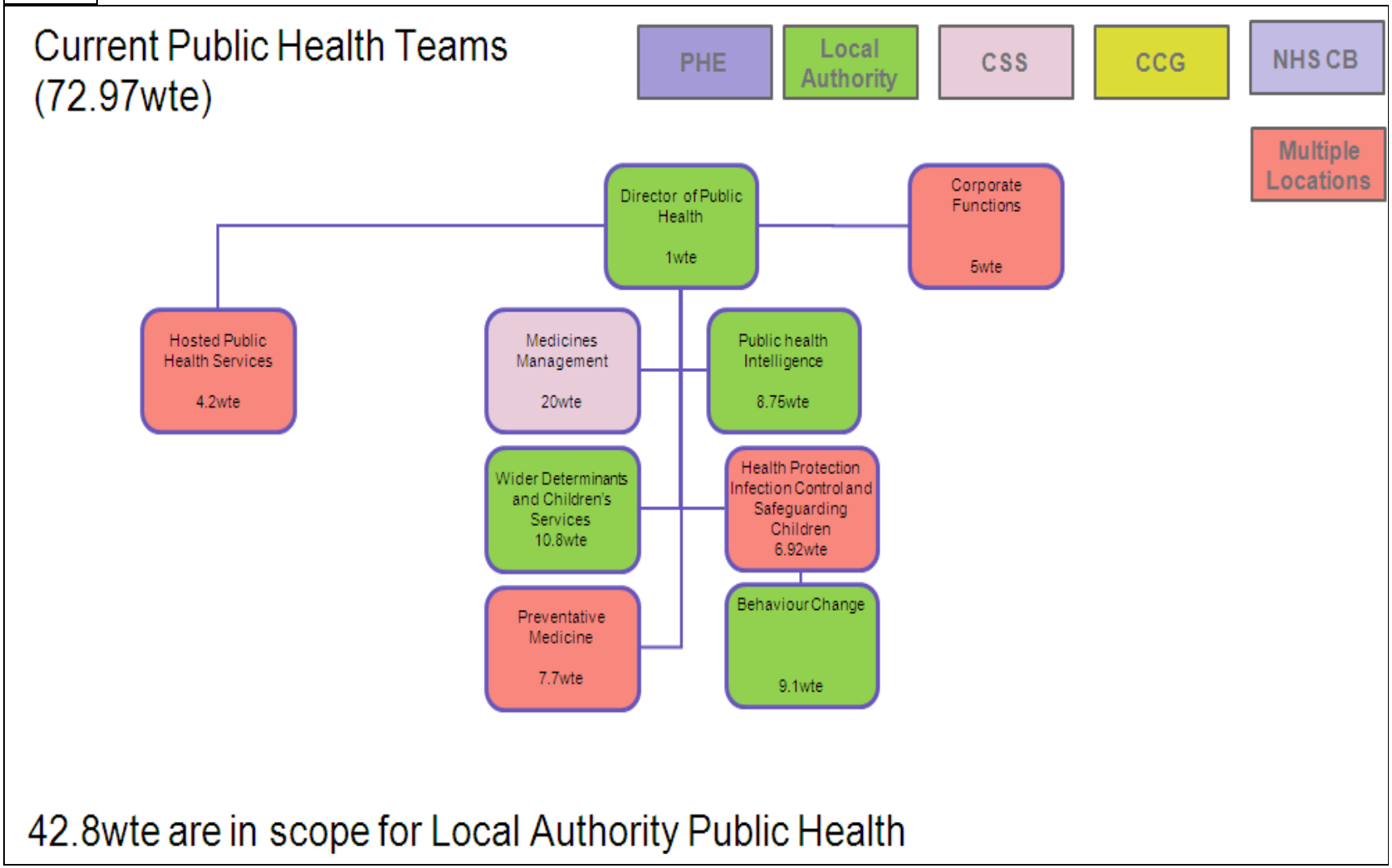
If you have any queries about this Report or wish to inspect any of the Background Papers please contact Robyn Fairman, Assistant Chief Executive: Tel: 020 7641 2361

LOCAL GOVERNMENT ACT 1972
LIST OF BACKGROUND PAPERS

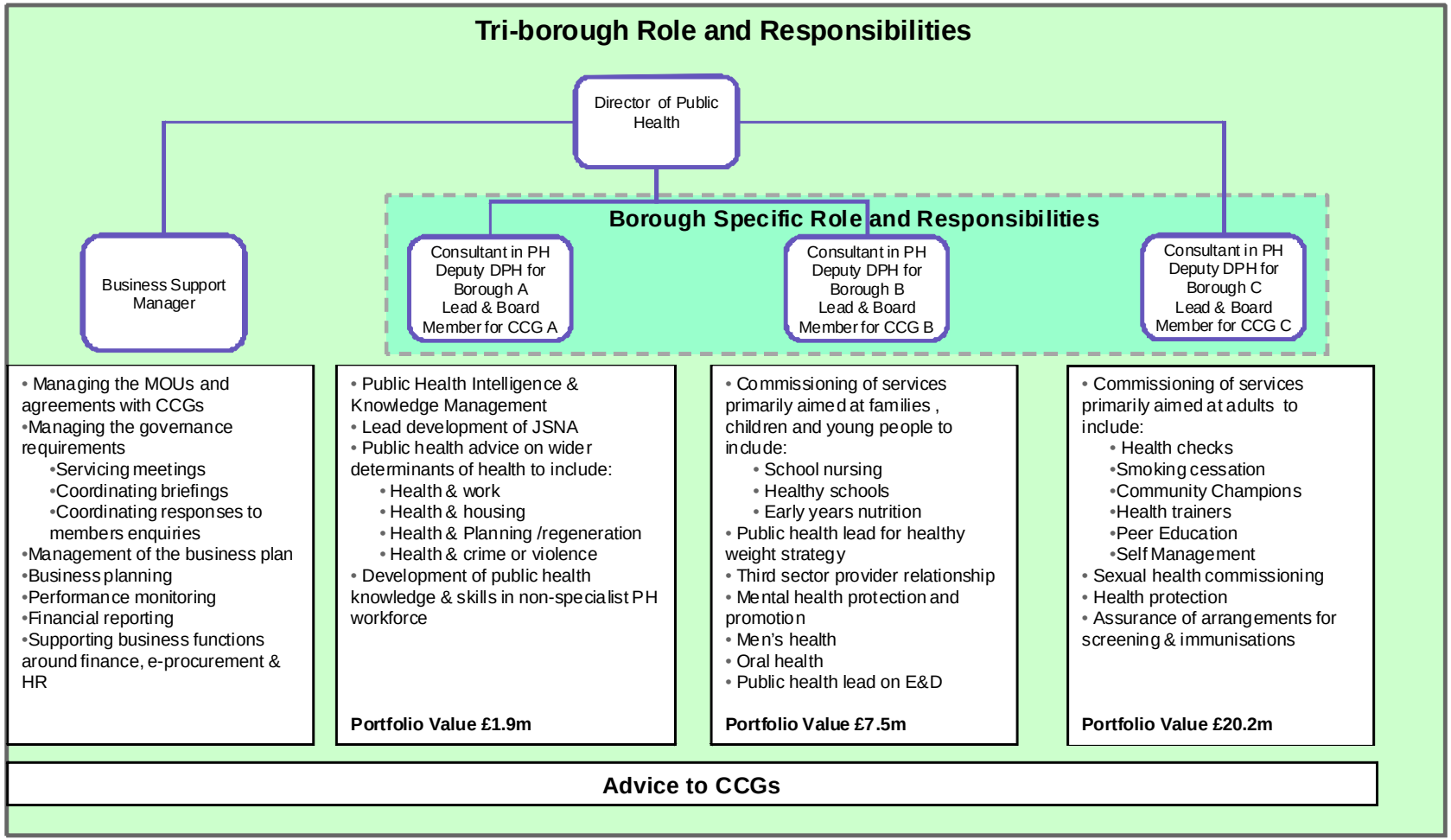
CONTACT OFFICER: Lynne Horne	07715170640
Area	**Document**
HR	Public Health Transfer To Local Government – Treatment Of Pensions, DH, 17 May 2012
	Transitional Workforce Guidance, DH, 12 June 2012
	Transfer of Public Health Staff to Local Authorities – Next Steps, DH & LGA, 1 Aug 2012
	People Transition- national Policy and Process on Filling of Posts in Receiving Organisations, DH & others, 1 Aug 2012
Finance	Public Health Transitional Support Funds for Local Authorities, DH, 18 Sep 2012
NHS Transition Guidance	Planning for Contract Transfer, DH, 10 Nov 2011
	Contracts Transition PCT implementation Plan, DH, November 2011
	Planning for Contract Transfer – Stabilisation Phase, DH, 24 May 2012
	Planning for Contract Transfer – Shift Phase, DH, Due in Autumn 2012

NB: The Background Documents are available on the DH website.

Annex 1


Current Public Health Teams
(72.97wte)
PHE
Local Authority
CSS
CCG
NHS CB
Multiple Locations
Director of Public Health
1wte
Corporate Functions
5wte
Hosted Public Health Services
4.2wte
Medicines Management
20wte
Public health Intelligence
8.75wte
Wider Determinants and Children's Services
10.8wte
Health Protection Infection Control and Safeguarding Children
6.92wte
Preventative Medicine
7.7wte
Behaviour Change
9.1wte
42.8wte are in scope for Local Authority Public Health

Proposed Triborough Public Health Department



Proposed Triborough Public Health