Public Health Dorset

Agenda Item:

Joint Public Health Board

Bournemouth, Poole and Dorset councils working together to improve and protect health

Insert Item No.

Date of Meeting	9 November 2015
Officer	Chief Financial Officer and Director of Public Health
Subject of Report	**Draft estimates 2016/17 and financial report September 2015**
Executive Summary	The draft revenue estimate for Public Health Dorset in 2016/17 is £31.6M. The sums to be borne by each partner under cost-sharing arrangements are set out in an appendix 1. The Public Health agreement requires the Joint Board to approve the draft budget for the following year in November, so that each constituent authority has time to include this in each council's budget strategy. The report explains the main drivers and factors influencing the estimates, including sensitivity and risks relating to the budget and the opportunities that there may be to redistribute the budget both within the service and across other council activities. The report also gives an update on the Public Health Grant. There is an update on the position in the current year, which explains movements on various budget headings but does not suggest a change in the overall projected underspend but outlines the risk on cost and volumes in relation to demand led contracts. Public Health Dorset has a revenue budget of £26.3M in 2015/16, as agreed by the Joint Public Health Board. Budget monitoring so far this year has highlighted some variances from the budget on some major contract areas.

	Our latest forecast is that Public Health Dorset will underspend overall, in 2015/16 by around £0.2M after the proposed reduction of 6.2% or £2.023M. This has been a structured response to the Treasury announcement of the cuts to the Public Health budget.
Impact Assessment: *Please refer to the protocol for writing reports.*	Equalities Impact Assessment: An equality impact assessment is carried out each year on the medium term financial strategy.
	Use of Evidence: This report has been compiled from the budget monitoring information provided within the Corporate Performance Monitoring Information (CPMI).
	Budget: The forecast outturn figures currently show a projected underspend for Public Health Dorset at the end of the financial year of around £0.2M after the proposed reduction of 6.2% or £2.023M
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: MEDIUM Residual Risk LOW As all authorities financial performance continues to be monitored against a backdrop of reducing funding and continuing austerity. Failure to manage within the current year's budget not only impacts on reserves and general balances of the three local authorities but also has knock-on effects for the Medium Term Financial Plan and puts future service provision at risk.
	Other Implications: As noted in the report
Recommendation	The Joint Board is asked to consider the information in this report and: (i) recommend the draft estimates for 2016/17 to Partner Councils, for consideration; (ii) agree the approach to managing reductions in the budget, based on the principles described in the report; (iii) agree to hold the Public Health reserve to mitigate the effect of the impending spending review.
Reason for Recommendation	Close monitoring of the budget position is an essential requirement to ensure that money and resources are used efficiently and effectively.
Appendices	Appendix 1 – Budget Forecast 2015/16 Appendix 2 – Prioritisation Process Appendix 3 – Budget 2015/16 and 2016/17

Background Papers	CPMI – September 2015 and Public Health Agreement
Report Originator and Contact	Name: Phil Rook, Group Finance Manager Tel: 01305-225131 Email: p.j.rook@dorsetcc.gov.uk

1. Background

1.1 The Health and Social Care Act 2012 established new statutory arrangements for Public Health which came into effect on April 2013. This includes the creation of a new body responsible for Public Health at national level – Public Health England and the transfer of significant responsibilities to local councils from the NHS. NHS England and Clinical Commissioning Groups have some continuing responsibilities for public health functions.

1.2 The nationally mandated goals of public health in local authorities are to:

- Improve the health and wellbeing of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State;
- Reduce health inequalities across the life course, including within hard to reach groups;
- Ensure the provision of population healthcare advice.

1.3 The agreed aims which underpin the work of Public Health Dorset are to:

- Address Inequalities;
- Deliver mandatory and core Public Health programmes in an equitable, effective and efficient manner;
- Improve local and national priority public health outcomes as defined by the Health and Wellbeing strategy and national Public Health Outcomes Framework;
- Transform existing programmes and approaches to population health to include better coordination of action across and within all public service agencies.

1.4 The agreed principles underpinning our commissioning to deliver the above aims are improving effectiveness, efficiency and equity. This has been reflected in our on-going re-procurement and overall work-plan to date.

1.5 In addition to the cuts outlined below, there is also now a clear expectation that the Public Health Grant will be considered alongside all other local authority funding, hence it will be subject to further reductions over the next three years, the extent of which will remain unknown until the 25 November 2015 Comprehensive Spending Review announcement but is likely to be between 15 and 40%. This paper therefore sets out potential options and scenarios for managing these reductions, using the same principles to guide our recommendations.

Public Health Grant 2015/16

1.6 On 4 June, the Chancellor announced that the Government's in-year budget review had concluded with the identification of a further £4.5bn of measures towards debt reduction. This included £200m in year from the 2015/16 Local Authority Public Health grant.

1.7 The proposal is for a 6.2% cut to the national Public Health Grant for 2015/16 [and beyond]. This equates to a minimum £2.023M reduction in 2015/16 for Public Health Dorset. We are still awaiting the outcome from the consultation on the reduction; the implications of the grant reductions are as follows if the 6.2% is applied across the board:

Public Health Allocations	2015/16 £000's	Estimate Cut £000's	Revised Grant £000's
Poole	7,345	456	6,889
Bournemouth	10,114	627	9,487
Dorset	15,156	940	14,216
	32,615	**2,023**	**30,592**

2. Looking Forward

2.1 The budgets inherited from the NHS were developed based on a national mapping of public health spend and contracts over the 2-3 years prior to transfer, and were grouped primarily to support the then required quarterly reporting to the Department of Health on existing DH programmes within the ring-fenced grant. It is now recommended that we move away from this approach to one that is more aligned with core functions and local priorities rather than DH programmes. This will support a new way of working that will:

- Enable us to build a more coherent set of activities within each 'area';
- Improve opportunities for joint action on priority public health functions, and
- Ensure delivery of quality, value for money, services reflecting need in our local populations.

2.2 This will not impact on the overall structure of the public health team which already works in a matrix way across programme and function areas, but will support transformation within commissioned services to enable savings to be found.

2.3 The table below shows these new reporting structures and how they currently report, with some detail of what each area covers.

Clinical Treatment Services	Sexual Health Substance Misuse
Early Intervention 0-19	Children 5-19 (School Nursing) Children 0-5 (Health Visitors) Nutrition and breastfeeding
Health Improvement	NHS Health Checks Health Improvement (LiveWell) Sexual Health (education and prevention element) Adult Obesity Smoking and Tobacco,
Health Protection	Risk reduction (e.g. Cardiff Model, BBV reduction) EH & trading standards – esp, comm dis control and env hazards for human health
Public Health Intelligence	Public Health Advice to NHS National Child Measurement Programme Dental Epidemiology Survey
Public Health Team	Leadership and advocacy role
Resilience and Inequalities	Current work on inequalities and community resilience e.g. mental wellbeing

2.4 Within each area we have looked at current activity and spend to identify options to deliver savings and these are discussed for each area below. Savings will not necessarily be delivered uniformly across all programmes each year, as savings in some areas may take longer to realise in some areas than in others. A more detailed map of specific options and the pros and cons of different choices is being developed. The rationale behind the decision making processes is outlined in appendix two, by reference to early work on options in health improvement programmes. It should be highlighted that all service budgets, including the sums retained and rebated to LAs, have been protected from reductions this year due to further active savings plans in the service to try to rebase the budget in anticipation of government cuts.

2.5 Currently we are forecasting sufficient savings to cover the known in-year reductions required within 2015/16 (6.2%). It is likely that current work will enable further savings to ensure delivery of the 9% savings in 16/17 (required for the 15% scenario proposed by CSR i.e. 6+3+3+3). However there is greater risk to achievement of 12% in 16/17 (needed for the 25% scenario i.e. 6+6+6+6), and 17% saving may not be achievable in 16/17 without very significant impact on services (needed for 40% scenario i.e. 6% + 11+11+11). Current work should continue to release further savings in future years (unless 40% scenario delivered in 2016/17, when limited further plans in place at this time).

3. Clinical Treatment Services

3.1 This area covers sexual health and drugs and alcohol and unchanged would account for nearly 40% of the spend in 2016/17. Between 2013/14 and 2014/15 we have made modest savings in these areas, primarily in the drugs and alcohol area.

3.2 In 2015/16 we are forecasting further significant savings in drugs and alcohol, of at least £620k, possibly £770k. The exact figure is unclear given changes to commissioning arrangements as per agreement at the JPHB in February 2015. There will be subsequent changes to the pooled budget from 2016, with £137k (Poole), £276k (Bournemouth) and £2.1M (Dorset) of the grant previously retained to cover the Pooled Treatment Budget and DAAT team costs now included in the Public Health Dorset pooled budget. There are likely to be further savings that can be made across this broader budget, however some of these savings may not be realisable until most services are reprocured in 2017/18.

3.3 Savings on sexual health in 2015/16 were to be delivered through re-procurement of the service; this has now been halted and it is therefore unclear what the in year impact will be. In the meantime we have advised current providers that savings will need to be factored into new DCC contracts from 1st December to best reflect the outcome of the Comprehensive Spending Review.

3.4 Based on savings to date and plans already in action, we should be able to make savings to support some of the possible Comprehensive Spending Review scenarios.

4 Early Intervention 0-19

4.1 This area covers health visitors, school nurses and the current breastfeeding contracts. There has not been any saving within public health around this area to date. The Health Visitor contract has only just transferred, and this area had been highlighted for potential investment from within public health, as it would not only benefit major public health outcomes around giving every child the best start in life, but is also an important set of interventions in tackling inequalities in health.

4.2 There is however real potential for significant transformation around a core workforce and integration with other local services, in line with the ambitious plans in each local authorities. In the interim, we have put a halt on continued expansion of HV workforce, making a saving of £225k in 15/16 and £660k in 2016/17 (i.e. 6% full year effect).

4.3 School nursing will also be part of the transformation. In the interim current providers have been advised that appropriate savings will need to be factored into contracts for 2016/17.

5 Health Improvement

5.1 A major transformation programme has already begun in health improvement with the commissioning of the LiveWell Dorset service. Having one service has generated economies of scale in administration, engagement and customer service, and the investment pro bono by the service provider in developing a new digital behaviour change platform has already generated local recurrent savings of £75k per annum.

5.2 Going forward there are several options that could be considered in reducing the overall cost of health improvement services in Dorset. The current favoured option is to preserve as much as possible the current pathway, which starts with the NHS Health Check assessment, followed by support from LiveWell Dorset.

5.3 However rather than driving activity across all areas of Dorset the team would strongly incentivise delivery in the 40 per cent of areas classified as most deprived. This would generate substantial savings on the total cost of providing NHS Health Checks, with more of a focus on providing services based on population need.

5.4 From an equity perspective, it satisfies the challenge of increasing the scale and impact of ill health prevention services, particularly if services are focused on areas broader than just the most deprived postcodes which, in Dorset, do not cover where most of the population live. Focusing on the 40 per cent most deprived areas will reach significant proportions of the population, especially in the urban areas of Bournemouth, Poole, and Weymouth and Portland. This approach could also release recurrent savings on the PbR element of the LiveWell Dorset contract, and on fewer smoking and weight management interventions in more affluent areas. Based on this the health improvement budget should be able to reduce by £600k in 2016/17.

6 Health Protection

6.1 Health protection remains a core role and statutory function for both top tier and district councils and is an area that has seen recent key challenges and a high profile. Internationally we have seen the Ebola outbreak in West Africa and its ramifications for local preparedness and services and more locally we have seen an extra-ordinary outbreak of E. coli. This emphasises the need for a competent local workforce and coordinated local approaches. Recent publications have re-emphasised the linkages of local environmental hazards to human health e.g. air quality.

6.2 Locally we have had a Dorset wide health protection network since April 2013. The network has led a fundamental look at what we do across all local authorities in health protection, how we do it and how this relates to national and local core public health outcomes. This provides an evidence base for identifying core services which most demonstrably link to priority outcomes and which have the strongest evidence base.

6.3 Support to the effective delivery of these services had been highlighted for potential investment from within public health, in terms of mitigating risk and improving resilience – especially for communicable disease events e.g. pandemic flu, and also improving specific outcomes, for which a number of projects had been worked up as a result. Most of these have now been put on hold, generating £250k of savings in 2015/16.

6.4 One project that continues is a 3yr project, funded by the National Lottery to look at the potential health impacts from climate change on the older population of West Dorset in the future. The project is also looking at how best to communicate this 'future' problem to engage the Dorset community and local policy makers in implementing adaptation techniques.

7 Public Health Intelligence

7.1 Another mandatory strand of work for the public health team is the provision of healthcare advice to the NHS. For the most part this does not require investment from Public Health, nor would it be appropriate to do so, given the resources of the NHS. However the public health intelligence work that supports the JSNA, and focuses on building our understanding as a whole health economy, also underpins our understanding of the broader systems challenges across local authorities and the NHS, including the Better Care/Better Together programmes and the Clinical Services Review. This work will continue to be refined and reframed to reflect these challenges.

7.2 There is the opportunity to make savings on the dental epidemiology survey as we negotiate the contract price for 2016/17.

8 Community Resilience to Tackle Inequalities

8.1 Public Health Dorset has invested small amounts of money indirectly e.g. through H&WBs, in building capacity of communities in some of the more deprived neighbourhoods. This is expected to be self-sustaining over time. Additional small amounts of revenue have been used to train and develop local workforce in specific issues that have a disproportionate impact on health, such as mental health and wellbeing.

8.2 Much of the work around inequalities in health undertaken by the public health team involves advising local authorities on how best to meet the six priority objectives highlighted by the Marmot review of inequalities. Going forwards this is most likely to be the most effective way to reduce inequalities in health, as it focuses on some of the big societal drivers that affect health such as getting the best start in life, education, creating worthwhile jobs, improving the scale and impact of ill health prevention, and environmental issues such as housing and transport.

9 Public Heath Team

9.1 No change is proposed within the public health team, as all the work above is contingent on current staffing levels and practice. Increasingly we will look to potential for income generation, possibly working with local academic partners to bring in funding for research and evaluation.

9.2 We will also look to make savings in on costs and non-core payments, e.g. on call, mileage. At the same time we will continue to maintain our very low sickness levels and high productivity.

10 Conclusion

10.1 The situation we find ourselves in was not anticipated locally or nationally and we will not be clear as to the extent of the savings needed until the CSR is published in December with the local government financial settlement. As such all the comments in this paper are conditional, however it would seem prudent to have plans for the most likely scenarios. These have a sound rationale which uses the principles we in PH have adopted since our transfer to LAs. It should be highlighted that we will need to treat all parts of the grant, be it retained or other, the same for planning purposes. We have left the retained budgets as they are for 2015/16 and have not imposed the 6.2% cut to minimise disruption to existing plans.

10.2 Based on our current understanding the 2016/17 impact of a 15% cut over 3 years is likely to be achievable. There will be greater risk to achievement of 12% in 2016/17 (needed for 25% scenario), and 17% saving may not be achievable in 2016/17 without very significant impact on services (needed for 40% scenario). Some savings are not likely to be realised until 2017/18, and we may need to consider renegotiation of retained budgets, and/or use of public health reserves to offset any differences until these changes take effect.

Richard Bates
Chief Financial Officer
November 2015

FINANCIAL UPDATE 9 NOVEMBER 2015 APPENDIX 1

	2013/14 £000's	2014/15 £000's	2015/16 £000's	Increase £000's	
Public Health Allocations					
- Poole	5,892	6,057	6,057	0	0.0%
- Bournemouth	7,542	8,296	8,296	0	0.0%
- Dorset	12,538	12,889	12,889	0	0.0%
	25,972	**27,242**	**27,242**	**0**	0.0%

	Poole	Bmth	Dorset	Total
Population as per Formula Funding 000's	**148.1**	**183.5**	**413.8**	**745.4**
%	**19.9%**	**24.6%**	**55.5%**	**100.0%**

Public Health allocation 2015/16	Poole £000's	Bmth £000's	Dorset £000's	Total £000's
2015/16 Grant Allocation	6,057	8,296	12,889	27,242
Children's Commisioning 2015/16 Half year	1,288	1,818	2,267	5,373
Less Commisioning Costs	(15)	(15)	(15)	(45)
Less Pooled Treatment Budget and DAAT Team costs	(1,449)	(3,098)	(2,600)	(7,147)
Public Health Incresae 2014/15 back to Councils	(199)	(246)	(555)	(1,000)
Public Health Incresae 2015/16 back to Councils	(100)	(125)	(275)	(500)
Joint Service Budget Partner Contributions	**5,582**	**6,630**	**11,711**	**23,923**

Public Health allocation 2016/17	Poole £000's	Bmth £000's	Dorset £000's	Total £000's
2016/17 Grant Allocation	6,057	8,296	12,889	27,242
Children's Commisioning 2015/16 Full Year	2,576	3,636	4,534	10,746
Less Commisioning Costs	(30)	(30)	(30)	(90)
Less Pooled Treatment Budget and DAAT Team costs	(1,449)	(3,098)	(170)	(4,717)
Public Health Incresae 2014/15 back to Councils	(199)	(246)	(555)	(1,000)
Public Health Incresae 2015/16 back to Councils	(100)	(125)	(275)	(500)
Joint Service Budget Partner Contributions	**6,855**	**8,433**	**16,393**	**31,681**
Public Health Grant Reduction 6.2%	(456)	(627)	(940)	(2,023)
Expected Budget 2016/17	**6,399**	**7,806**	**15,453**	**29,658**

APPENDIX 2

PRIORITISATION PROCESS

The first stage of the priority setting approach being used looks at the technical efficiency of how resources are currently invested within programmes, for example, population need, costs and cost effectiveness, impact and reach of the interventions. This information was used to formulate an internal view of priorities for investment, i.e. to maximise population health gain what is it most important to invest in or preserve, and what might be disinvested in with minimal impacts on health.

The next step was to use this information to formulate options for changing the way that resources are invested. The approach describes the options, with intended savings, impacts and consequences as best as possible. Each option is then plotted on a chart with two axes, giving four quadrants.

The first axis values where the options are in terms of what we know about likely public health benefit with the second axis a range of more organisational and pragmatic criteria including:

- Feasibility
- Overall cost saving (small, medium or large)
- Political sensitivity incl. risks
- Impact including interdependencies

Plotting the options this way gives us the proposed options for each programme in four quadrants:

- Top left - options of low public health value, feasible to do, and potentially large savings;
- Top right - options of high public health value that are feasible;
- Bottom left - low public health value but difficult to do;
- Bottom right - high public health value and difficult (e.g. tobacco).

This not only shows where the more feasible low value public health interventions lie relative to others but allows comparison across programmes. This is reflected for Health Improvement below.