Public Health Dorset

Agenda Item:

10

Joint Public Health Board

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

Date of Meeting	8 February 2016
Officer	Chief Financial Officer and Director of Public Health
Subject of Report	**Draft estimates 2016/17 and financial report December 2015**
Executive Summary	The draft revenue budget for Public Health Dorset in 2016/17 is £28.96M. This is based upon an indicative Grant Allocation of £35.177M. The budget assumptions and 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. However the since the Public Health allocations were part of the Spending Review it was agreed to consider this implications with final grant information in February 2016. At the time of writing the allocations are still to be confirmed. The announcement is expected on 3 February. 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. There is an update on the position in the current year, which explains movements on various budget headings and outlines the risk on cost and volumes in relation to demand led contracts. Budget monitoring so far this year has highlighted variances from the budget on some major contract areas. The latest forecast, as at the end of December, shows that the Public Health Dorset

	budget will underspend by around £0.86M after taking account of the in-year reduction in grant of £2.019M. It is proposed that this underspend is transferred to the reserve to mitigate future savings requirements.
Impact Assessment:	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 £0.8M after the reduction of 6.2% or £2.019M
	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 to: (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; and (iii) agree to transfer the underspend into the Public Health reserve and hold the balance to mitigate the effect of the 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 – Budget 2015/16 and 2016/17
Background Papers	CPMI – December 2015 and Public Health Agreement
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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 2015/16 grant reduction, there is also now a clear understanding that the Public Health Grant, akin to all other local authority funding, will be subject to further reductions over the next three years. This paper therefore sets out potential options and scenarios for managing these reductions, using the same principles as above to guide our recommendations.

2. Public Health Grant 2015/16 & Beyond

2.1 On 4 June 2015, 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. This equated to a £2.019M reduction in 2015/16 for Public Health Dorset. The service has absorbed this reduction without transferring the cuts to existing core contracts services or other retained LA budgets. The service is forecast to underspend in in 2015/16 by £0.86M. The detail is shown at appendix 1 and described in the report below.

2.2 As anticipated, there will also be reductions for 2016/17 and beyond. The CSR describes savings in the public health grant, which will be an average real terms saving of 3.9% each year to 2020/21. This translates into an effective cash reduction for 2016/17 of 9.6% from the original 15/16 allocation plus further savings of 2.5% in 17/18, 2.6% in each of the two following years, and flat cash in 20/21.

2.3 The draft revenue budget for Public Health Dorset in 2016/17 is £28.96M. This is based upon an indicative Grant Allocation of £35.177M. The budget assumptions and the sums to be borne by each partner under cost-sharing arrangements are set out in an appendix 2.

3. Looking Forward

3.1 It is important to recognise that 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 the 2013 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. This was not linked to outcomes or existing local authority activities or priorities.

3.2 It is suggested that we move progressively move away from this current approach, with its lack of inherent rationale or links to local authority core work, to one that is more aligned with core functions and local priorities. This will support a new way of working that will:

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

3.3 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 and promote better alignment with local priorities.

3.4 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
Health Improvement	**Adults:** • LiveWell – including Tobacco, Obesity and NHS Health Checks **Children & Young People:** • Sexual Health (education and prevention) • Public health nursing (incl. Health Visiting & School Nursing • Childhood Nutrition incl. national child measurement programme, obesity and breastfeeding
Health Protection	• Risk reduction (e.g. Drugs & Alcohol) • Environmental Health & Trading Standards – including communicable disease
Public Health Intelligence	• Public Health Advice to NHS • Dental Epidemiology Survey • Research Collaboration
Strategic Leadership and Advocacy	• Health in All Policies • Inequalities • Community Resilience

3.5 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. 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.

3.6 Currently we are forecasting sufficient savings to cover the known in-year reductions required within 2015/16 (6.2%). Current work will enable further savings to ensure delivery of the approx.9.5% savings in 16/17. Current work should continue to release further savings in future years as per the Treasury schedule.

3.7 It is also timely to look at how we wish to spend the PH grant when the ring fence goes– as discussed, there is little rationale for the current five mandatory services and their current levels of spend.

3.8 We suggest it is timely to consider an approach based on the JSNA, reflecting localities and outcomes, with priority action based on the most cost effective interventions for any outcome, best aligned to other local authority and public service partner work. This could include asking other agencies, e.g. NHS, to commission services with little/no alignment to local authority work e.g. clinical treatment services.

3.9 This would allow us to have a clear rationale for a materially different budget reflecting genuinely local priorities.

4. Clinical Treatment Services

4.1 This area covers sexual health and drugs and alcohol and unchanged would account for nearly 40% of 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.

4.2 In 2015/16 there are further significant savings forecast in drugs and alcohol, of around £790k. There will also 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.

4.3 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.

4.4 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.

5. Health Improvement (Adults)

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 Improvement (Children & Young People)

6.1 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.

6.2 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).

6.3 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.

7. Health Protection

7.1 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.

7.2 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.

7.3 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.

7.4 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.

8. Public Health Intelligence

8.1 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.

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

9. Strategic Leadership and Advocacy

9.1 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.

9.2 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.

10. Public Health Team

10.1 No change is proposed within the public health team, as all the work above is contingent on current staffing levels and practice, vacancies have been actively managed to achieve an outturn on staffing costs substantially lower than budget. Increasingly we will look to potential for income generation, possibly working with local academic partners to bring in funding for research and evaluation.

10.2 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.

11. Reserves

11.1 The table below shows the use the updated reserve position. This remains unchanged since last reported.

Public Health Reserve	**£000's**
Public Health Underspend 2013/14	1,447
DAAT Underspend 2013/14 one off (DCC)	111
PTB underspend 2013/14 one off (DCC)	177
Use of 2013/14 underspend Poole	(287)
Use of 2013/14 underspend Bournemouth	(356)
Use of 2013/14 underspend Dorset	(700)
Public Health Underspend 2014/15	1,381
PTB underspend 2014/15 one off (DCC)	20
Total	**1,793**

12. Conclusion

12.1 Public Health Dorset in anticipation of the budget challenges both to the central public health grant and the wider local authority budgets has worked to ensure further significant savings in 2015/16.As a consequence moving in 2016/17 and beyond grant reductions will be manageable without compromising existing local authority commitments. While continuing to pursue further efficiency gains through re-commissioning the service we will look to restructuring public health activity and spend to provide as much convergence with other local authority priorities as practical.

Richard Bates
Chief Financial Officer

Dr David Phillips
Director of Public Health

February 2016

APPENDIX 1

Forecast Outturn 2015/16

		Actual budget 2015-2016	Forecast Outturn 2015-2016	Underspend 2015/16
Public Health Function				
Clinical Treatment Services		£12,489,700	£11,183,547	£1,306,153
Health Improvement (C&YP)		£6,890,000	£6,579,300	£310,700
Health Improvement (Adults)		£3,599,600	£2,719,008	£880,592
Health Protection		£145,000	£75,000	£70,000
Public Health Intelligence		£271,600	£329,700	-£58,100
Resilience and Inequalities		£205,000	£30,000	£175,000
Public Health Team		£2,752,600	£2,551,532	£201,068
Reduction in grant projection			£2,023,000	-£2,023,000
	Total	**£26,353,500**	**£25,491,087**	**£862,413**

APPENDIX 2

PUBLIC HEALTH GRANT AND BUDGET

Public Health allocation 2015/16	**Poole**	**Bmth**	**Dorset**	**Total**
	£000's	**£000's**	**£000's**	**£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
Public Health Grant In-year Reduction 6.2%	(455)	(626)	(938)	(2,019)
Total Grant Allocation 2015/16	**6,890**	**9,488**	**14,218**	**30,596**
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 Increase 2014/15 back to Councils	(199)	(246)	(555)	(1,000)
Public Health Increase 2015/16 back to Councils	(100)	(125)	(275)	(500)
Joint Service Budget Partner Contributions	**12,017**	**15,492**	**24,991**	**52,500**

Public Health allocation 2016/17	**Poole**	**Bmth**	**Dorset**	**Total**
	£000's	**£000's**	**£000's**	**£000's**
2016/17 Grant Allocation	6,057	8,296	12,889	27,242
Children's Commisioning Full Year	2,576	3,636	4,534	10,746
Public Health Grant In-year Reduction 2015/16	(455)	(626)	(938)	(2,019)
Total Grant Allocation 2015/16	**8,178**	**11,306**	**16,485**	**35,969**
Less Pooled Treatment Budget and DAAT Team costs	(1,449)	(3,098)	(170)	(4,717)
Public Health Increase 2014/15 back to Councils	(199)	(246)	(555)	(1,000)
Public Health Increase 2015/16 back to Councils	(100)	(125)	(275)	(500)
Joint Service Budget Partner Contributions	**6,430**	**7,837**	**15,485**	**29,752**
Public Health Grant Reduction 2016/17	(363)	(249)	(180)	(792)
Expected Budget 2016/17	**6,067**	**7,588**	**15,305**	**28,960**