Agenda Item:

Insert Item No.

Joint Public Health Board

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

Date of Meeting	21 November 2016
Officer	Chief Financial Officer and Director of Public Health
Subject of Report	**Financial Report on Public Health Grant: November 2016**
Executive Summary	The revenue budget for Public Health Dorset in 2016/17 is £29.378M. This is based upon a Grant Allocation of £35.154M. This report contains an update on the outturn forecast for 2016/17 which currently stands at £1.529m underspent. The final outturn is likely to be lower given the delay in key projects coming on line, in particular Health Checks. It is suggested that the reserve and savings are considered as one and redistributed along previously agreed lines with oversight through the respective health & wellbeing boards. The details are in the recommendations section below.
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).
	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) Note the current and projected budget out-turn position; (ii) Note the value for money of public health spend in achieving national outcomes (iii) Agree that from the accumulated reserve and savings in 2016/17, totalling approximately £3.5m, the Board: • invest £0.4m in further expansion of the Livewell Dorset scheme to include expanding services for other age groups with an improved digital process for all potential service users. • invest £0.2m in improving analysis and modelling of patient flow and resource out of hospital care system to better understand the impact of any changes in the system. • invest £0.4m in developing services in localities, particularly around improving the engagement of patients and service users by training colleagues from the community and voluntary sector to better signpost people in need of care away from high cost acute services and statutory social care services. • Redistribute the remaining £2.5m to the three local authorities by the usual formula for their investment in early years' and health protection services. • Agree any further savings in 16/17 and 17/18 are redistributed based on discussion at the JPHB. • Agree that the respective Health & Wellbeing boards will provide oversight to ensure alignment with the respective health & wellbeing strategies.
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 – Public Health Grant & Budget 2016/17
Background Papers	CPMI – October 2016/17 and Public Health Agreement
Report Originator and Contact	Name: David Phillips, Director of Public Health Tel: 01305-225868 Email: d.phillips@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 At the last board meeting in September 2016 we discussed how, with the finalisation of many contracts, costs, and processes for the next couple of years it was possible to relook at how we might redistribute savings [reserve and 16/17 & 17/18]. We discussed a number of options but agreed we needed further discussion in particular with section 151 officers to ensure that any proposals supported common goals.

1.6 In the Board discussion we recognised the various factors and tensions that came into play, and while the importance of maintaining an effective spend in support of mandatory programmes was central, this needed, in several instances, to be seen in light of other local authority programmes, contributing to a common outcome.

1.7 We also looked ahead to the removal of the ring fence in April 2018 and the cessation of the public health grant in 2020. This paper expands the previous board discussions and in doing proposes some specific steps to deploy the public health grant to optimum benefit for the population.

2. Public Health Grant 2013-2020

2.1 At the last board meeting we discussed options as to the use of the savings and reserve and it was decided that this needed further discussion with a variety of people including the two section 151 officers. As part of the discussion with officers, it was felt that it is important to have some more understanding of the history and future of the grant. To that end we will look at:

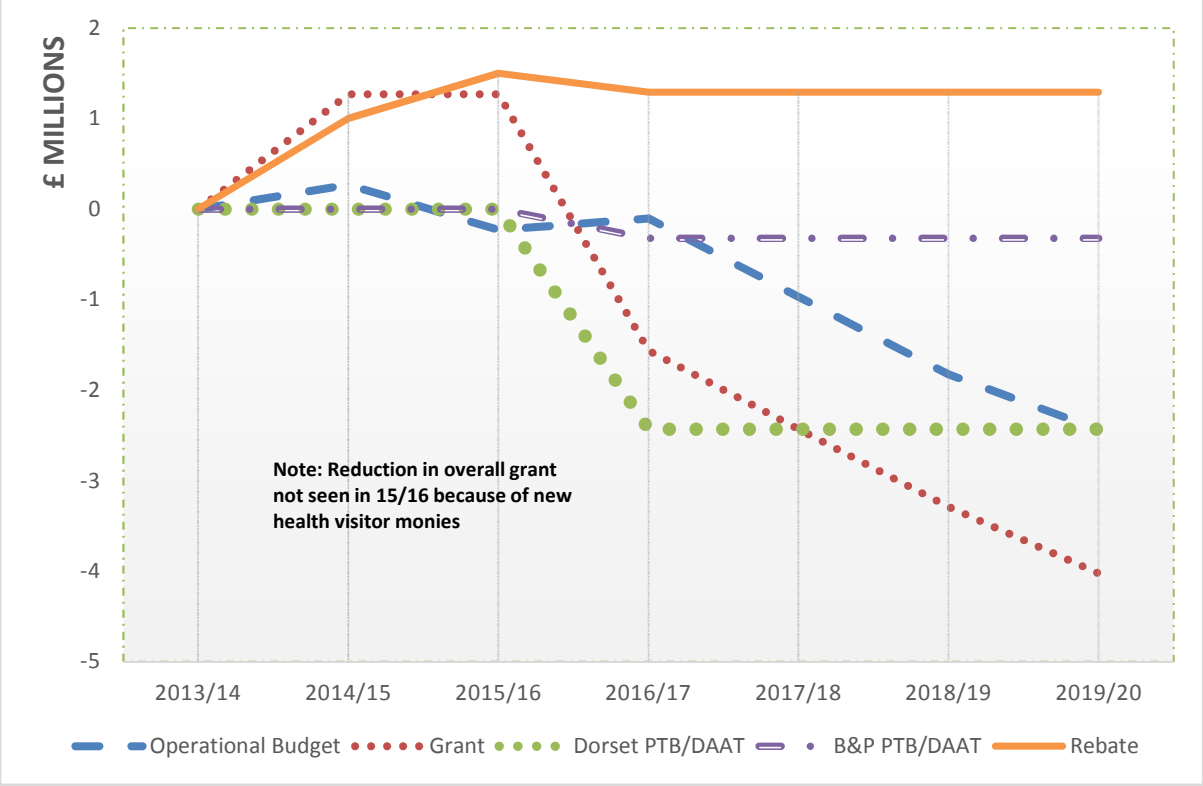
a. The history of the overall grant including future projection;

b. Changes in the grant's core elements;

c. The spend by authority on public health compared with other authorities and value for money considerations.

2.2 Table one describes the sums received and sums spent and savings made since 2013 projected to 2020 by major budgets lines. The changes in the grant in 2014/15 and 2015/1616 reflected the transfer of health visiting to local authorities. The overall grant rose for the first two years and is now on a steady decline equating to approximately 20% reduction in real terms by 2020

Table One: Public Health Grant 2013 – 2020 by Major Budget Lines

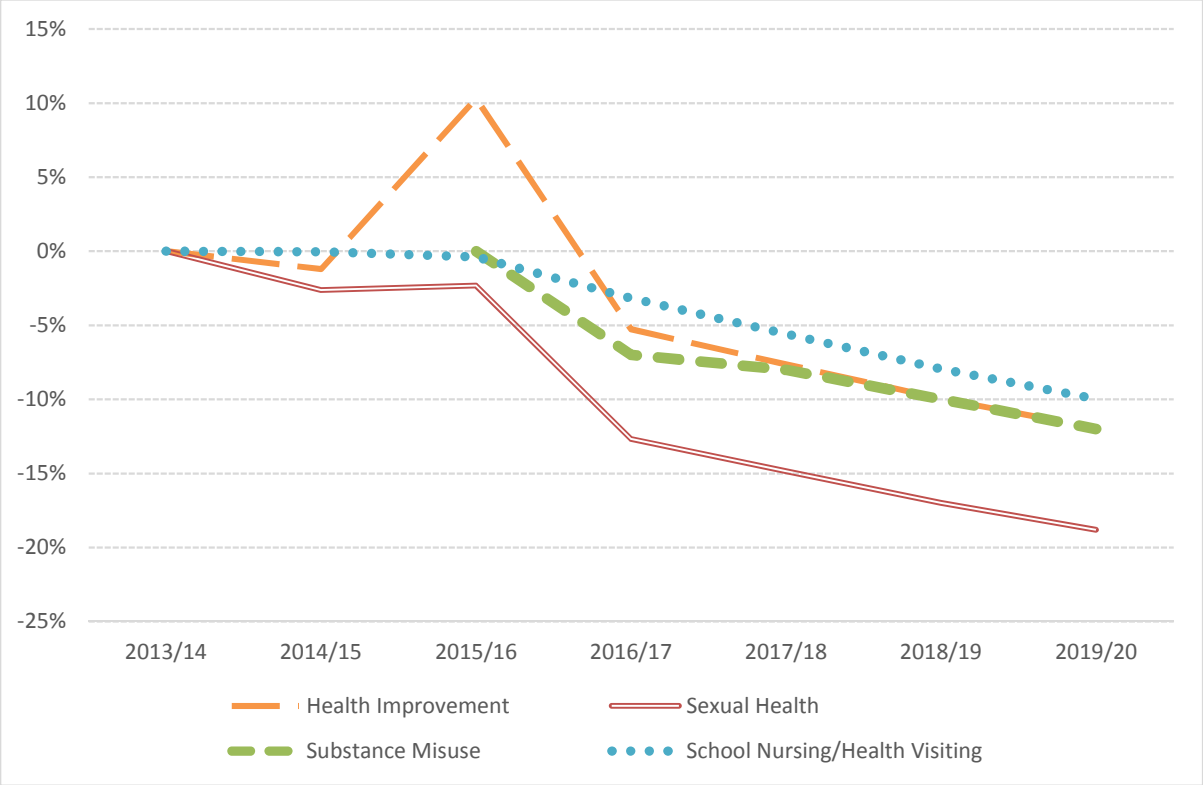


2.3 To date all the decline has been absorbed by reductions in the operating budget for mandatory services, retained (i.e. PTB/DAAT) and rebated monies have been left untouched.

2.4 These reductions in operating budgets have been made through a combination of both contract and efficiency/effectiveness measures. The pooling of the respective LA grants has been central to the ability to do this.

2.5 93% of the budget goes on front line services and of the remaining 7%, 4% goes on salaries for PHD staff and 3% on hosting charges for all three authorities. Table two shows a similar pattern for all the major programme areas, reflecting the reduction in grant in table one. The increase in health improvement reflected the investment from reserves in Livewell.

Table Two: Public Health Outturn by Major Programme Areas (% change from 2013)



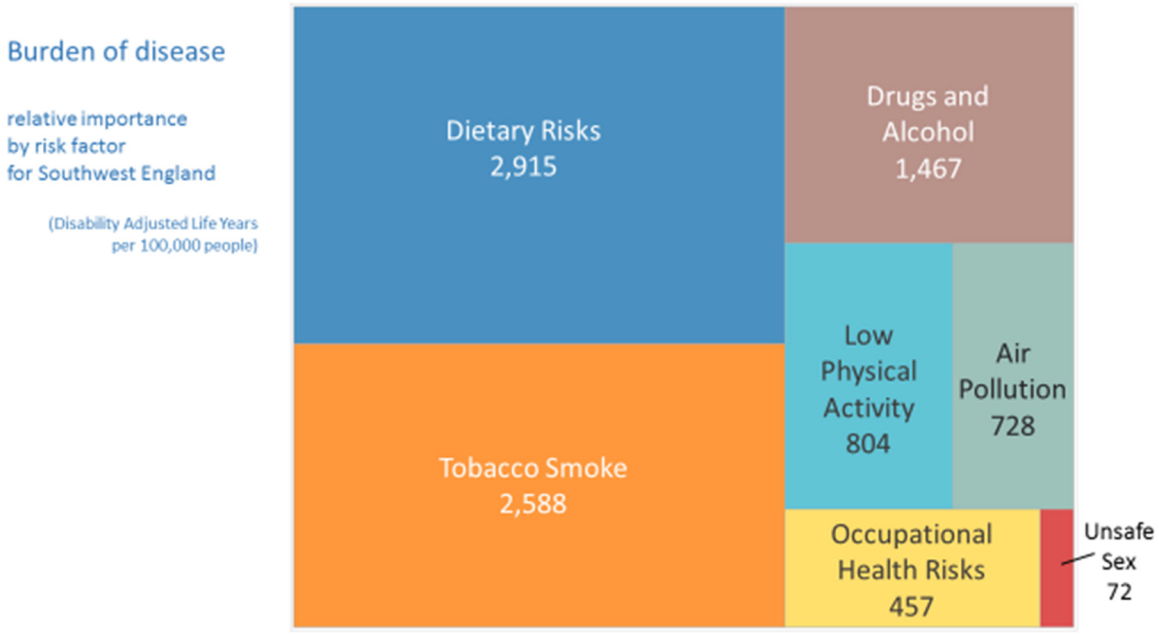
April 2018 - 2020

2.6 The ring fence will be removed in 2018 - we await the conditions around this. However it is highly unlikely that there will be removal of the statutory responsibilities in respect of both inequalities and mandatory programmes. As such it is unlikely that this will provide a significant opportunity for further savings or alternative reinvestment beyond those already flagged in other board papers.

2.7 More generally the public health grant is also projected to end in its current form in 2020/21. The current government position is that funding of local public health responsibilities will need to be out of business rates. It is the view of many that this will be a difficult positon to hold in the light of the future funding pressures on local government, and as such we need to look how we embed public/population health gain within broader plans and processes. This is already under way and we have many good examples at a local level, including the prevention at scale programme in the STP.

2.8 Figure one below illustrates how an understanding of the contribution of differing risks within a population to the burden of ill-health might inform a discussion of where to spend limited resources for population health gain as we go forward.

Figure One:

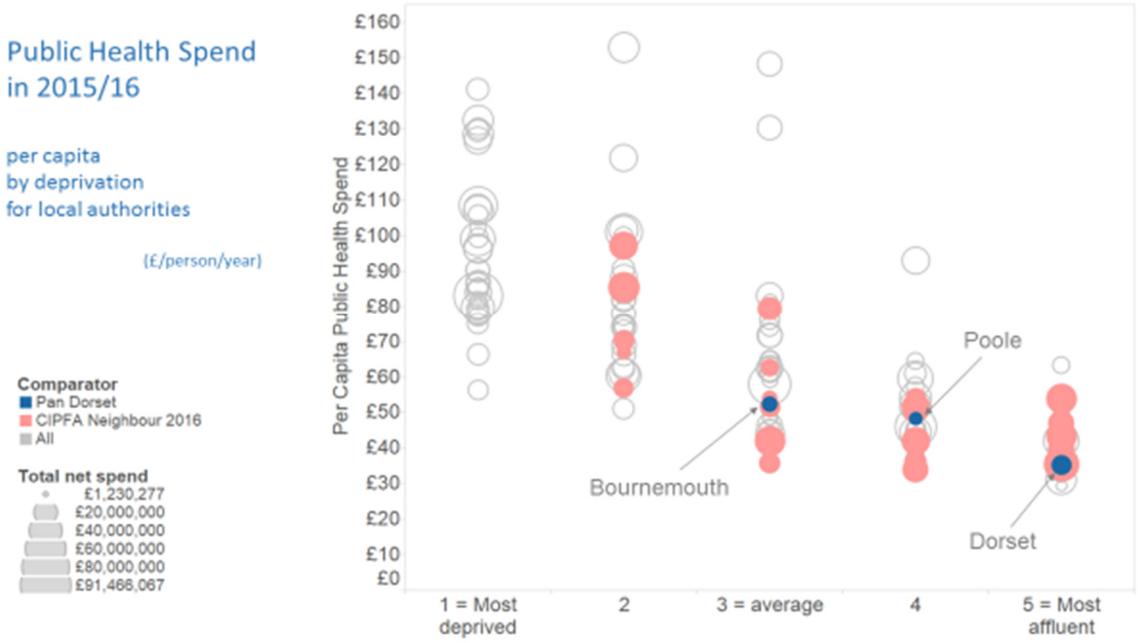


2.9 If we combine this information with an understanding of where we currently spend money and the relative return on investment on this spend, which is illustrated in figure two below, we can make better informed choices as to where to spend increasingly small budgets to best effect..

Figure Two:

Value for Money

Table Three: Per Capita Spend: LA v Deprivation v CIPFA neighbours



2.9 Table three shows that the per capita public health grant varies from £25/head to £155/head across England. Dorset is at £27/head, Poole at £43/head and Bournemouth at £50/head. These reflect historical spends inherited from the NHS. In relation to CIPFA neighbours the Dorset spend is in the bottom 5%, Poole top 40% and Bournemouth bottom 40%.

2.10 Tables four, five and six show the per capita spend per head on public health v outcomes by respective local authority by comparison with CIPFA neighbours and within authorities by comparison with other services.

2.11 It shows that all three authorities 'spend v outcome' for public health is positive being in the lower spend: better outcome quadrant and that in all instances it compares positively with the same ratio for other local authority services.

Table Four:

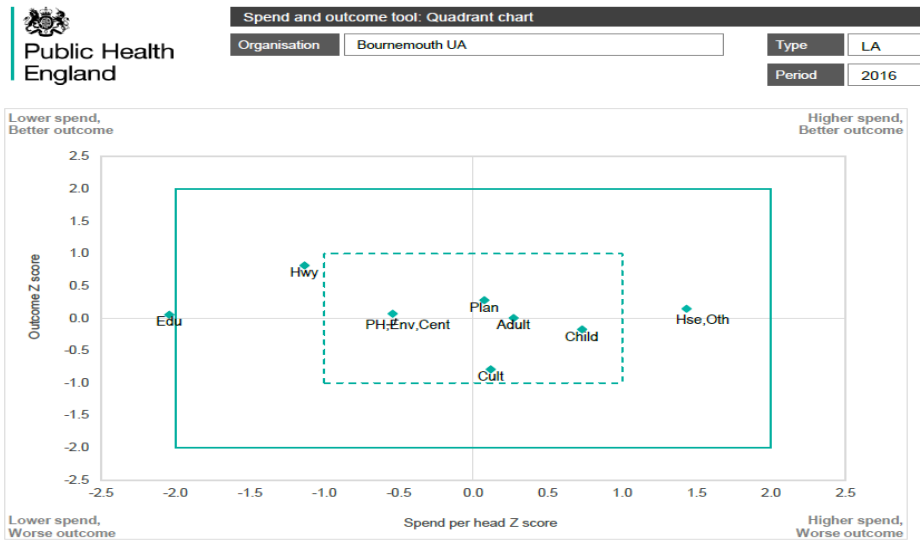
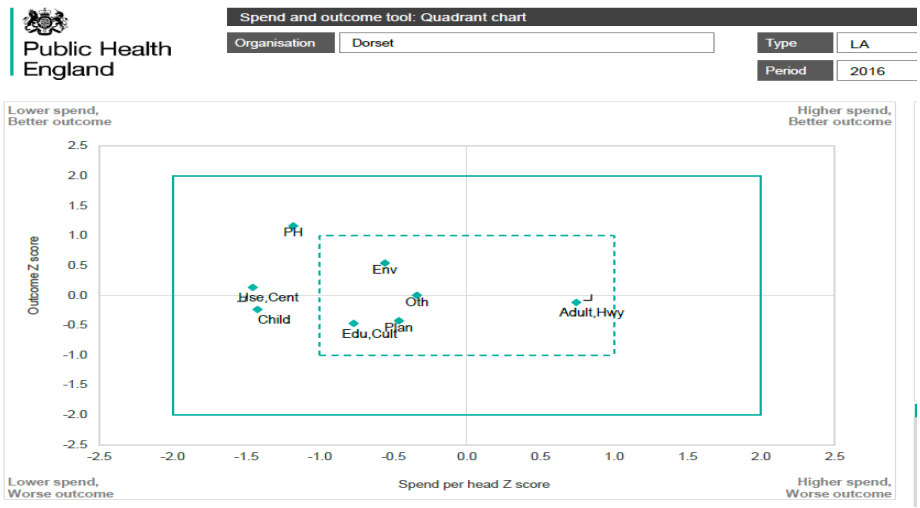


Table Five:

Table Six:



3. Use of Reserve and Savings

3.1 Subsequent to the last board meeting further discussions were held with key individuals in all three authorities and Public Health Dorset including the two Section 151 officers and it was agreed that savings for 16/17 and the reserve would be treated as a whole and allocated as follows:

a. £2.5m to be returned to the respective authorities by the agreed formula as per the decision made at the previous Board meetings, namely to support 'early years and health protection'.

Rationale: One of the criteria for spend of the public health grant requires investment in 'high value' activities and those with a clear link to existing public health outcomes. A sustainable and comprehensive early years programme is a good example as it is essential to not only addressing inequalities but also key to supporting a major element of the grant spend, i.e. health visiting and school nursing, and the transformation of such work.

The pressures in the early years area are such that if only mandatory (e.g. safeguarding functions or services to high risk populations) are provided and more comprehensive approaches to prevention are not funded, there will be a rapid erosion of outcomes in young children, which will feed into the need for high cost 'care' services.

b. £1.0m be retained by PHD to invest in support to three areas that are central underpinnings of all outcomes and priorities, these are:

- *Livewell:*
  It is proposed to invest approx. £400k in Livewell our established behaviour change service to develop the infrastructure to enable it to become a robust behaviour change platform for a larger cross section groups of people and organisations.

  Rationale:
  Effectively promoting behaviour change is recognised as central to managing demand in in a wide variety of services. The Livewell project has clearly demonstrated its effectiveness and has been recognised nationally. However, to date investment has been limited until we were clear that it was a cost effective model. We now have the information to expand the model.

- *Intelligence Capacity*:
  It is proposed to invest approx. £200k in intelligence capability primarily to better analyse/understand activity, costs and benefits at the interface between the health and social care system, including the impact of any changes in the system.

  Rationale:
  A far better understanding of the real costs and benefits of various current areas of focus, e.g. delayed transfer of care and courses of action is vital, especially going forward. This is of particular importance given the current focus of the STP on financial balance for the system.

- *Improving Capacity in Localities for Demand Management*

  In addition it is proposed to invest up to £400k to train and support Patient and Public Involvement Groups in primary care across the 13 Localities in Dorset to be able to develop their own networks of voluntary sector support over a two year period.

  Rationale:
  This will help with the development of integrated locality teams, particularly improving the engagement of patients and service users by training people from the community and voluntary sector who will be able to better signpost people in need of care. This has been shown to be effective in improving outcomes among people living with long term conditions. This links to existing local authority and voluntary networks.

  This also maintains independence and resilience of people in their own homes and reduces demand on formal services, particularly high cost acute services and statutory social care services

3.2 All three elements build on existing capability with the express intent of managing demand through the use of better intelligence, better behaviour change programmes and better community engagement. These criteria are established as being key to any transformation programme, such as the STP (Kings Fund 2015).

3.3 It was the view of all parties that this was not only consistent with the grant criteria but an efficient and equitable use of funds to support core outcomes within the public health outcomes framework and to support the more general statutory responsibility of authorities to reduce inequalities.

3.4 The total sum of £3.5m should also be overseen by the respective health and wellbeing boards to ensure alignment with the health and well-being, and related, strategies. It is proposed that any additional savings in 16/17 and 17/18 are divided up based on discussion at the Board. To maximise the savings it will be important to maintain pooling of the PH grant.

4. Public Health Grant: 2016/17 Forecast Outturn & Reserves

4.1 The Public Health Budget is forecast to be underspent by £1.529m at the end of 2016/17. This out-turn figure is a straight line extrapolation of existing spend patterns and is likely to be significantly lower as some costs have been delayed to the second half of the year due to delays in signing contracts in particular Health Checks. The update positon of the reserve is £2.35m. This will not affect the sums discussed for reallocation above. If the savings are less then the PHD investment will be scaled back appropriately. The budget details are in appendices one, two and three.

5. Conclusion

5.1 Public Health Dorset recognising the budget challenges both to the central public health grant and the wider local authority budgets has worked to ensure further savings. It is proposed that we redeploy all savings [including reserves] to build resilience in the overall services and systems that work together for population health gain.

5.2 We have specific proposals to redeploy £2.5m back to local authorities on the usual formula and invest £1.0m in core infrastructure for future joint working.

5.3 It should also be recognised that collectively we remain amongst the bottom 10% of funding per head of population of all local authorities. These further savings and data shown in the paper illustrate our continuing delivery of value for money.

Richard Bates
Chief Financial Officer
November 2016

Dr David Phillips
Director of Public Health

APPENDIX 1

Public Health Budget 2016/17 and Forecast Outturn

2016/17	Budget 2016-2017	Outturn 2016-2017	Underspend 2016/17
Public Health Function			
Clinical Treatment Services	£11,464,100	£11,010,650	£453,450
Early Intervention 0-19	£11,575,500	£11,314,594	£260,906
Health Improvement	£2,984,700	£2,462,546	£522,154
Health Protection	£145,000	£54,000	£91,000
Public Health Intelligence	£244,800	£264,772	-£19,972
Resilience and Inequalities	£175,000	£75,000	£100,000
Public Health Team	£2,786,300	£2,664,799	£121,501
Total	**£29,375,400**	**£27,846,361**	**£1,529,039**

APPENDIX TWO

Public Health Reserves at November 2016

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
Public Health Underspend 2014/15	564
Total	**2,350**

APPENDIX 3

Public Health Grant And Budget (by Local Authority) – 2016/17

	Poole	Bmth	Dorset	Total
	£000's	£000's	£000's	£000's
2016/17 Grant Allocation	7,991	11,051	16,112	35,154
Less Commisioning Costs	(30)	(30)	(30)	(90)
Less Pooled Treatment Budget and DAAT Team costs	(1,300)	(2,925)	(170)	(4,395)
Public Health Increase back to Councils	(299)	(371)	(621)	(1,291)
Joint Service Budget Partner Contributions	**6,362**	**7,725**	**15,291**	**29,378**
Budget 2016/17	**6,362**	**7,725**	**15,291**	**29,378**