North Tyneside Council
Report to Cabinet
Date: 14th January 2013

ITEM 7(c)

Title: Transfer of Public Health Functions from North Tyneside PCT to North Tyneside Council

Portfolio(s):	**Public Health and Adult Social Care**	**Cabinet Member(s):**	**Councillor L Miller**

Report from Directorate: **Public Health**

Report Author: **Marietta Evans Director of Public Health (Tel: 0191 6432880)**

Wards affected: **All**

PART 1

1.1 Purpose:

The purpose of the report is to advise Cabinet of the progress in relation to transferring public health functions from North Tyneside PCT to North Tyneside Council in line with the requirements of the Health and Social Care Act 2012.

The extent of the changes in the public health system is complex and far reaching. It is important that Cabinet is appraised of transition plans and governance arrangements so that it is assured that the change is being managed in line with national guidance and milestones.

1.2 Recommendation(s):

It is recommended that Cabinet

(1) Notes the process of transferring public health resources, workforce and responsibilities to the Council:

(2) Notes the governance arrangements and assurance mechanisms in place to manage the transition:

(3) Approves a Public Health Operating Model within the Council post April 2013:

(4) Notes the process for transferring public health contracts to the Council for 2013-14:

(5) Approves the principles for future commissioning of public health contracts and agrees to receive a further report detailing the commissioning intentions for 2013/14.

1.3 Forward Plan:

28 days' notice of this report has been given and it first appeared on the Forward Plan that was published on 12 December 2012.

1.4 Council Plan and Policy Framework

This report relates to the following themes in the [2012/13] Council Delivery Plan: Supporting people to be healthy and independent and protecting the vulnerable

1.5 Information:

1.5.1 Background

In March 2012, the Health and Social Care Act ("the Act) gained royal assent, which significantly changes the way in which public health in England is delivered. From 1st April 2013 local authorities will have a duty to improve and protect the health of the population in their area and will have responsibility for commissioning public health services.

1.5.2 Responsibilities

On 1st April 2013 pursuant to the Act the responsibility for public health services will transfer from North Tyneside PCT to North Tyneside Council. From this date local authorities will have responsibility across all three public health domains for:

- leading investment for improving and protecting the health of the population and reducing health inequalities using the ring-fenced grant
- ensuring plans are in place to protect the health of the population and ensuring an appropriate public health response to local incidents, outbreaks and emergencies
- providing public health expertise, advice and analysis to Clinical Commissioning Groups (CCGs)

The local authority will also have a role in:

- supporting, reviewing and challenging NHS commissioned immunisation programmes and national screening programmes

Local authorities will be required to commission a range of public health services. Some public health services are identified by the Act as mandatory, in order to ensure that service areas have greater uniformity of provision especially where they are legally required (such as health protection, and the provision of contraception). Others are described as discretionary services and the commissioning of such services will be guided by the Public Health Outcomes Framework, the local Joint Strategic Needs Assessment and the joint Health and Wellbeing Strategy. (See Appendix 1 for details of mandatory and discretionary functions).

The Council will also have a responsibility from 1 April 2013 to provide public health advice to NHS Commissioners. The main focus is on providing a Core Intelligence Offer for North Tyneside Clinical Commissioning Group (CCG).

1.5.3 Transition

A North Tyneside Public Health Transition Group, comprising senior officers and managers, is overseeing the transition of public health from the "sender" organisation to the "receiver" organisation, to ensure a smooth transfer of functions and resources. The Transition Group has six work streams and under the agreed terms of reference operates

as a Task Group of the Health Improvement Commissioning Board, chaired by the Director of Public Health which subsequently reports to the Shadow Health and Wellbeing Board via the Commissioning Executive.

The Group provides leadership and accountability for transition, and will manage any risks to the successful delivery of the Public Health Transition Plan (agreed by Cabinet in March 2012) and ensure that:

- The Council has a clear understanding of the contract transition process and the portfolio of contracts that will transfer to the Local Authority
- The Council has assurance that the risks associated with the transfer of staff, contracts and commissioning responsibilities are being managed effectively
- The Council has assurance that the grant allocation will cover the public health service contracts and staffing
- Statutory responsibilities for Public Health are transferred smoothly without disruption to services and ensuring performance is maintained
- All providers have a clear understanding of the contract transition arrangements and implications

1.5.4 Role of Director of Public Health

The role and responsibilities of the Director of Public Health (DPH) are defined by statutory guidance issued by the Department of Health in October 2012. In addition the DPH will be added to the list of statutory Chief Officers in accordance with the Local Government and Housing Act 1989. A DPH must be a trained public health specialist, qualified in public health practice and registered with an appropriate national professional body. It is clear that the legal responsibilities for the DPH translate into the DPH acting as 'the lead officer in a local authority for health and championing health across the whole of the authority's business'. The DPH will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. They will also be required to produce an annual report on the health of the local population and will be statutory members of the Health and Wellbeing Board.

The DPH will be the person elected members and senior officers will consult on a range of public health issues, including emergency preparedness to concerns around access to local health services. The DPH will work closely with the Strategic Director of Children, Young People and Learning, the Strategic Director of Community Services and colleagues in the NHS to integrate commissioning. The DPH will work with the new Police and Crime Commissioner to promote safer communities.

The formal accountability of the public health ring-fenced grant rests with the Chief Executive, but it is expected that day-to-day responsibility for management of the grant is delegated to the DPH.

In relation to health improvement the DPH will be responsible for identifying health needs and improving outcomes in the health of the population. In relation to health protection the DPH will be responsible for exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health. In addition a Lead DPH from a local authority in the Northumbria Local Resilience Forum (LRF) area will be identified to co-ordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area. The Lead Director of Public Health will co-chair a Local Health Resilience Partnership with a lead director appointed by the NHS Commissioning Board. The Lead DPH will have access to a health emergency planning resource.

In relation to screening and immunisation programmes, the DPH will advise on whether screening or immunisation programmes in North Tyneside are meeting the needs of the population and whether there is equitable access.

1.5.5 Staff

At present the Council has two employees who are recharged to the PCT for their work in public health commissioning of drug treatment services. On April 1st 2013 eight staff, including the Director of Public Health, will be transferred from the PCT to the Council. Two additional specialist public health staff will be recruited in 2013/14 to ensure that the Council can meet the mandatory provision in relation to public health responsibilities. The transfer discussions and consultation are underway and the PCT staff concerned have already been assigned to North Tyneside Council and relocated within Quadrant to facilitate the transition.

The public health service will include Public Health Specialists (qualified in public health practice and registered with appropriate national professional bodies), public health commissioning managers, and specialist health intelligence officers.

1.5.6 Public Health Operating Model

Public health provides a critical resource for the exercise of the Councils responsibilities. The new public health role for local authorities requires an understanding of public health issues across all council services and successful integration of the public health team in order for a local public health system to develop.

A clear vision for how the new public health system will work with and beyond the local authority is an essential starting point for designing an operating model. The vision for North Tyneside is:

- Reduced health inequalities, improved health outcomes and better integration of health and social care which will be achieved through more cost effective delivery of evidence based programmes.
- Public health integrated with every Council function so that Heads of Service and Service Managers take action to improve health.
- The public health delivery system includes all our statutory partners and contracted providers.

Following an assessment of the options for the public health operating model within the local authority, the preferred option is an 'integrated' model in which public health responsibilities are distributed across the Council, while public health specialist advice and commissioning expertise is provided through a 'core team'.

The 'North Tyneside Public Health Operating Model' will provide public health leadership through an Office of the Director of Public Health and integrated, evidence-based commissioning through the core team. The core public health team will include the specialist public health staff under the leadership of the DPH, which will be responsible for commissioning and where appropriate providing the mandatory public health services (i.e. the Core Offer).

Selected discretionary services will be jointly commissioned by the Public Health Team working with Commissioning Teams in Children Services and Adult Social Care, which will form an Extended Public Health Team**.**

To ensure cross sector engagement the DPH has convened a Health Improvement Commissioning Board which includes senior Council officers, CCG representation and other stakeholders. The Health Improvement Commissioning Board reports to the

shadow Health and Wellbeing Board via the Commissioning Executive. Two commissioning support groups have been established to support the work of this board, one for children's health improvement services which jointly accounts to the Director of Children's Services and the other for adult health improvement services which jointly accounts to the Director of Community Services.

1.5.7 Transition of public health contracts 2013-14

It is essential to ensure that public health commissioning responsibilities and contract arrangements are able to transition to the local authority in a safe and efficient manner. The majority of contracts will be transferred to North Tyneside Council from the PCT and extended for 2013-14. This extension is to ensure continuity of provision, and such extension to be undertaken in accordance with the Council's Contract Standing Orders. The Council will assume full responsibility for contract management including payment and performance monitoring.

Current providers, partners and other key stakeholders are being notified by the PCT of these changes to the commissioning arrangements for public health services. It will be for the Director of Public Health to develop the Council's commissioning intentions for 2013/14. This will be the subject of a separate report to Cabinet. Current providers will be notified of the Councils intentions in relation to commissioning future services. Soft market testing may be undertaken with the current provider and potential providers in order to formulate the specification. When the procurement of a new service is undertaken, the process will be compliant with the Council's Contract Standing Orders, and EU and UK public procurement legislation.

1.5.8 Health Improvement Commissioning Strategy 2013-14

The DPH has developed a North Tyneside Health Improvement Commissioning Strategy (as detailed in Appendix 2) which describes North Tyneside Council's public health commissioning responsibilities and outlines the health improvement commissioning intentions in the transition period and beyond. The Strategy also identifies the underpinning principles and process for reviewing current public health services and future health improvement requirements. Public health commissioning will be undertaken within the context of the Joint Strategic Needs Assessment, Health and Wellbeing Strategy priorities and North Tyneside Council's commissioning framework and process of procuring services, in order to ensure that the ring fenced public health grant is used effectively to secure the best health outcomes for the population of North Tyneside.

From Transition to Transformation

There is a need to move beyond the practical steps of transition with new and innovative models of delivery. There is an opportunity for a complete transformation of the delivery agenda, demonstrating the most effective and efficient use of the public health ring fenced grant and ensuring that there is no double funding of services.

The Health Improvement Commissioning Strategy 2013-14 outlines the five principles that will underpin the future commissioning of public health services.

Each public health contract will be reviewed in line with the five principles identified below:

- Evidence based
- Promote integration
- Outcome focussed
- Reduce health inequalities
- Value for money

The Strategy sets out the initial broad commissioning intentions. Final commissioning intentions will be reported to Cabinet after wider engagement with key stakeholders.

1.5.9 Finance

A public health ring fenced grant will be allocated to the local authority based on North Tyneside PCT's historic spend 2010/11 as provided to the Department of Health (DH) by the PCT. The DH estimates that in 2012/13 £8,500,000 will be spent on public health services that will become the responsibility of North Tyneside Council. The DH has made a commitment that the amount allocated to North Tyneside Council for 2013/14 will not fall below the 2012/13 spend estimate in real terms. Change values totalling £600,000 were proposed to DH in relation to PCT errors in calculating the 2010/11 North Tyneside spend. The DH has responded to the changes proposed jointly by North Tyneside PCT and North Tyneside Council to acknowledge that the errors will be taken into account.

The formula for public health funding will move towards a needs-based approach over time. This should see a modest increase in the allocation for North Tyneside but full details have not yet been agreed. A 'Health Premium' will also be available from 2015/16 to incentivise health improvement. The criteria have yet to be determined but it is likely to include performance against key indicators in the Public Health Outcomes Framework.

For the purposes of 2013/14 outline planning it is assumed the allocation will be £8,900,000. It is anticipated that the actual allocation for North Tyneside Council will be confirmed in January 2013.

The public health grant to North Tyneside Council will carry conditions about how it may be used. The grant can only be spent on activities whose main purpose is to improve the health and wellbeing of the local population, including protecting their health and reducing health inequalities. The duty to secure best value will also apply.

1.5.10 Health and Wellbeing Board

A shadow Health and Wellbeing Board was established in North Tyneside in November 2010 to enable North Tyneside Council to develop its role to meet new Government legislation on the future of health and social care services.

Health and Well Being Boards will have statutory responsibilities from April 2013 (Appendix 3). They will have the primary aim of promoting integration and partnership working between the NHS, social care, public health and other local services, to improve democratic accountability.

It is anticipated that regulations governing Health and Wellbeing Boards will be published by the Government in January 2013, and detailed terms of reference and procedure rules will be prepared once the regulations come into effect. The Council's Constitution will need to be amended to reflect these new arrangements.

1.6 Appendices:

Appendix1: Mandatory and discretionary public health services
Appendix 2: Health Improvement Commissioning Strategy 2013-14
Appendix 3: Health and Wellbeing Board

1.7 Contact officers:

Marietta Evans	Director of Public Health	0191 6432884
Wendy Burke	Specialty Registrar in Public Health	0191 6432104
Ian Atkinson	Public Health Business Manager	0191 6432882
Alison Campbell	Finance Business Manager	0191 6437038

1.8 Background information:

The following background papers/information have been used in the compilation of this report and are available:

1) Health and Social Care Act 2012. Health and Social Care Act 2012
2) Public Health in Local Government: The new public Health role of local authorities. Department of Health 2012 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf
3) Public Health Transition Plan presented to Cabinet in March 2012 by the Director of Public Health.
4) The new public health role of local authorities. Department of Health 2012. https://www.wp.dh.gov.uk/publications/files/2012/10/Public-health-role-of-local-authorities-factsheet.pdf
5) Directors of Public Health in Local Government: (i) Roles, responsibilities and context. Department of Health 2012. https://www.wp.dh.gov.uk/publications/files/2012/10/DsPH-in-local-government-i-roles-and-responsibilities.pdf

PART 2 – COMPLIANCE WITH PRINCIPLES OF DECISION MAKING

2.1 Finance and other resources

The transfer of public health responsibilities from 1 April 2013 will be funded through a grant from the Department of Health. The amount of grant allocated is not yet announced but should be known during January 2013. The grant is ring-fenced and must be used by the Council to fund public health expenditure to address health needs and improve health outcomes for the local population. There is an opportunity for a complete transformation of the delivery agenda, demonstrating the most effective and efficient use of the public health ring-fenced grant and ensuring that there is no double funding of services. There are implications in terms of the financial allocation to the Council for public health and whether this will be adequate to address health needs and improve health outcomes for the local population.

2.2 Legal

2.2.1 Employment
It is anticipated that the employment of eight staff referred to at paragraph 1.5.5 above will transfer to the Council from 1 April 2013 in a TUPE-like transfer by virtue of a staff transfer scheme created by the Secretary of State pursuant to his powers under the Health and Social Care Act 2012 (‘the Act”). Such employees, whether or not they also have any rights under TUPE, would have such rights as are granted to them by the staff transfer scheme.

Where TUPE applies to transferring staff, any liabilities owed by their employer to the employees would transfer to the Council. A staff transfer scheme might also allocate such liabilities to the Council, even if TUPE did not apply.

In relation to pensions, the Department of Health has confirmed that transferring employees will have the right to remain in their current scheme.

The Act defines the responsibility of, and the appointment process in respect of, Directors of Public Health. The legislation requires local authorities and the Secretary of State, 'acting jointly', to appoint Directors of Public Health under the new provisions. The Director of Public Health will be a statutory chief officer.

The Act defines the responsibilities of Directors of Public Health, which relate to health improvement, responses to public health emergencies, co-operating with public sector partners in assessment of violent or sexual offenders, the production of an annual report on the health of people in the borough and other public health functions specified by the Secretary of State.

The Act also requires the local authority to have regard to any guidance given by the Secretary of State in relation to the Director of Public Health, including any guidance as to appointment and termination of appointment, terms and conditions and management.

2.2.2 Arrangements for Health and Wellbeing Boards

Under the Act Health and Wellbeing Boards will be established as committees of the Council and detailed Regulations are expected in January which set out precise requirements and responsibilities. However the Act specifies that membership of Health and Wellbeing Boards must include the three statutory officers (Director of Public Health, Director of Children's Services and Director of Adults' Social Services) as well as at least one councillor and representatives of Local Healthwatch, Clinical Commissioning Group and others as desired. The new Regulations may disapply or modify the usual statutory requirements relating to Council committees in relation to Health and Wellbeing Boards for example to permit Directors of Public Health and Directors of Adults Social Services and Directors of Children's Services to be full members of Health and Wellbeing Boards as voting members, thereby introducing a new type of relationship between officers and elected Members.

Health and Wellbeing Boards are given a number of specific functions and powers. These include a duty to discharge the functions of Clinical Commissioning Groups and local authorities to prepare Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies. Clinical Commissioning Groups must consult with Health and Wellbeing Boards on whether their commissioning plans have adequately taken account of the latest Joint Health and Wellbeing strategy. Draft statutory guidance on Joint Strategic Needs Assessments, the development of Strategies and interface with commissioning has been published. The expectation is that under transitional arrangements strategies are developed to influence commissioning in 2013/14.

There is also a power for the local authority to delegate any of its powers to the Health and Wellbeing Board, except health scrutiny.

2.2.3 Contracts

With regard to existing contracts, PCTs are currently in the process of identifying the contracts to be transferred on 1 April 2013. It is anticipated that contracts transferred will either be extended for a further year, or alternatively a short term contract will be entered

into, to allow for continuity of services pending re-commissioning. However, the contracts will be assessed in accordance with the Health Improvement Commissioning Strategy appended. The Council is undertaking its own due diligence in order to properly understand the rights and liabilities embodied in those contracts prior to agreeing to the transfer of any contract. Any future commissioning must comply with Contract Standing Orders and the Public Procurement regulations.

2.2.4 Data Security
There may be a requirement for specific data security arrangements to be put in place, in particular in relation to the security of sensitive health information, which will be addressed in advance of the transfer of functions.

2.3 Consultation/community engagement

2.3.1 Internal Consultation
Member engagement has taken place over the past 12 months through Member briefing sessions, Members newsletter and the Adult Social Care, Health and Wellbeing Sub Committee.

2.3.2 External Consultation/Engagement
A range of stakeholder and public engagement has taken place via the Health and Wellbeing Board, LINk Members meetings, a Working with the Community and Voluntary Sector Event and Clinical Commissioning Group meetings.

2.4 Human rights

There are no human rights issues in relation to this report

2.5 Equalities and diversity

There are issues in relation to the commissioning and delivery of services. Our aim is to ensure that the difference in life expectancy between the most deprived and least deprived communities in the borough is reduced. This will be achieved by ensuring that services target those who are most vulnerable and at highest risk of developing disease.

2.6 Risk management

2.6.1. There are risks in relation to not delivering key targets associated with commissioned programmes. These risks will be managed by the Health Improvement Commissioning Board and will be minimised through robust contract management and outcomes measures specified in contracts.

2.6.2 There are clinical risk issues around the commission of clinical services and these will be managed through robust service specifications with clear standards and a system of reporting for serious untoward incidents.

2.7 Crime and disorder

There are implications in terms of the commissioning of drug and alcohol treatment services, which will contribute to a potential reduction in both acquisitive crime, antisocial behaviour and violent crime.

2.8 Environment and sustainability

There are implications in terms of the local authority responsibility for public health outcomes in relation to utilisation of outdoor space for exercise/health reasons and fraction of mortality attributable to particulate air pollution.

PART 3 - SIGN OFF

• Chief Executive	X
• Strategic Director(s)	X
• Mayor/Cabinet Member(s)	X
• Chief Finance Officer	X
• Monitoring Officer	X
• Strategic Manager, Policy and Partnerships	X

Appendix 1

Mandatory and Discretionary Public Health Services

The **mandatory services** include:

- Appropriate access to sexual health services (except abortion services, which will be commissioned by CCGs, and Sexual Assault Referral Centres (SARC), which will be commissioned by NHSCB)
- Duty to ensure there are plans in place to protect the health of the population
- Ensure NHS commissioners receive public health advice they need
- Deliver the National Child Measurement Programme
- Offer the NHS Health Check assessment

(The elements of the Healthy Child Programme (age 5-19) previously proposed as mandated is subject to further review and will not be mandated during 2013.)

The **discretionary services** include:

Prevention and Lifestyle services

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19
- 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
- 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

Health Protection

- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Local authority role in dealing with health protection incidents, outbreaks and emergencies
- Local initiatives that reduce public health impacts of environmental risks

Wider determinants of health

- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion

Appendix 2

North Tyneside Council

North Tyneside

Health Improvement

Commissioning Strategy

2013-2014

Drafted by:
Wendy Burke
Specialty Registrar in Public Health
December 2012

1. Background

1.1 In March 2012, the Health and Social Care Act gained royal assent, which changes the way in which public health in England is delivered. From the 1st April 2013 local authorities will have a duty to improve the health of the people in their area and will have responsibility for commissioning public health services.

1.2 On 1 April 2013 the responsibility for public health services transfers from North Tyneside PCT to North Tyneside Council and the local authority will have responsibilities across all three public health domains:

- leading investment for improving and protecting the health of the population and reduce health inequalities using the ring-fenced grant
- ensuring plans are in place to protect the health of the population and ensuring an appropriate public health response to local incidents, outbreaks and emergencies
- providing public health expertise, advice and analysis to Clinical Commissioning Groups (CCGs), Health and Wellbeing Board and the NHS Commissioning Board (NHS CB) (through a "core public health offer")

The local authority will also have a role in:

- supporting, reviewing and challenging NHS commissioned immunisation programmes and national screening programmes

1.3 NHS North of Tyne currently holds a number of public health contracts with non NHS organisations, Foundation Health Trusts and GP providers to provide a range of services including health improvement, smoking cessation, sexual health, NHS Health Checks, alcohol and substance misuse, and weight management**.**

1.4 There is need for North Tyneside Council, under the leadership of the Director of Public Health to review public health services to confirm need and ensure best value.

2. Aims of the strategy

2.1 The aims of this strategy are to:

- Describe the North Tyneside Council's public health commissioning responsibilities
- Identify the underpinning principles and process for reviewing current public health services and future health improvement requirements beyond the transition within the context of the JSNA, Health and Wellbeing Strategy and North Tyneside Council's commissioning framework and process of procuring of services
- Identify the health improvement commissioning intentions during and beyond the transition period
- Ensure that the ring fenced public health grant is used effectively and efficiently to commission services for the population of North Tyneside

2.2 Some public health services are identified by the Government as mandatory, in order to ensure that service areas have greater uniformity of provision especially where they are legally required (such as health protection, and the provision of contraception). Others are described as discretionary services and the commissioning of such services will be guided by the Public Health Outcomes Framework, the local Joint Strategic Needs Assessment and the joint Health and Wellbeing Strategy.

2.3 The **mandatory services** include:

- Appropriate access to sexual health services (except abortion services, which will be commissioned by CCGs, and Sexual Assault Referral Centres (SARC), which will be commissioned by NHSCB)
- Duty to ensure there are plans in place to protect the health of the population
- Ensure NHS commissioners receive public health advice they need
- Deliver the National Child Measurement Programme
- Offer the NHS Health Check assessment

(The elements of the Healthy Child Programme (age 5-19) previously proposed as mandated is subject to further review and will not be mandated during 2013.)

2.4 The **discretionary services** include:

Prevention and Lifestyle services

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19
- 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
- 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

Health Protection

- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Local authority role in dealing with health protection incidents, outbreaks and emergencies
- Local initiatives that reduce public health impacts of environmental risks

Wider determinants of health

- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion

2.5 The health premium will incentivise progress in population health outcomes and reductions in health inequalities as measured by indicators that:

- can be directly influenced by a local authority ;
- are not solely linked to services that are mandated through regulations;
- are amenable to cost effective interventions that can be delivered using the available budget;
- have health as one of their principal, but not necessarily direct, impacts
- benefit a significant proportion of the local population directly; or significantly reduce health inequalities; or reduce the spread of infection or risky behaviours in the wider population; or are linked to local authority interventions that contribute to a wider health-led programme.

2.6 There will be a delay in the first payments of the health premium until 2015-16, the third year of local authority responsibility for public health responsibilities. An incentive will not be paid to an individual authority if any of the mandatory services (as prescribed in regulations) are not being appropriately delivered.

3. The principles of commissioning

3.1 There is a need to move beyond the practical steps of transition with new and innovative models of delivery. There is general agreement that the move to local authorities should not be about the same programmes being offered from a different organisation, but a complete transformation of the delivery agenda, demonstrating the most effective and efficient use of the ring fenced grant and ensuring that there is no double funding of services.

3.2 The commissioning of mandatory and discretionary public health services in North Tyneside Council from 1st April 2013 will be underpinned by the following five principles:

Evidence based
Commissioning of public health services will be based upon information and intelligence of need, effectiveness and community voice. The JSNA provides an overarching assessment of the health and wellbeing needs of our population and is one of the major influences in establishing the priorities in Health and Wellbeing Strategy and directing future commissioning. The current JSNA and the Health and Wellbeing strategy highlight the areas where we need to focus action. There is a need to prioritise action and

- address those needs that cause the greatest burden of mortality and morbidity and where there has been no improvement or the situation is worsening
- target groups of people who are a greater risk or have greater needs
- target geographical areas of the borough where health is poorest.

Integration
The DPH and the public health team will work within an operating framework in North Tyneside Council which promotes integration in commissioning processes and also integrates a public health provider role within Council functions. Close working with clinical commissioning groups and NHS Commissioning Board will also be central to creating integrated public health services. Synergy with Clinical Commissioning Groups and close engagement within the NHS, are critical to the delivery of public health outcomes, in particular in reducing risks, and in primary and secondary prevention.

Outcome focussed
The focus of public health commissioning will be on outcomes. The Public Health Outcomes Framework sets out key indicators of public health from the wider determinants of health through to effectiveness in reducing premature mortality. North Tyneside Council will be held to account for performance against the indicators.

Reducing Health inequalities
The overall goals are to increase healthy life expectancy and reduce health inequalities. The focus will be upon raising the health of the poorest, fastest by redistributing and rebalancing public health resources to:

- areas of the borough suffering from the greatest deprivation
- support vulnerable groups
- areas in the borough where there are gaps in universal service provision
- develop preventative approaches across the life course rather than focussing on therapeutic or treatment approaches.

Simply working to narrow the health gap and focusing on the health needs of a small proportion of the population will not be enough to achieve the biggest impact on local populations. There is a need to tackle the social gradient in health and this will require a combination of both universal (population-wide) and targeted interventions that reflect the level of disadvantage or need (proportionate universalism).

Value for Money
The focus of public health commissioning will be upon cost efficient and effective use of the ring fenced public health grant. Under the Duty of Best Value, local authorities must consider overall value, including economic, environmental and social value seeking to maximise benefit of commissioning services.

4. Commissioning Intentions 2013/14

4.1 Each contract will be reviewed in line with the five principles identified above.

4.2 It is anticipated that for 2013/14:

- Some public health services will be transferred and extended
- Some public health services will be re-commissioned through the agreed procurement process within North Tyneside Council, stimulating the market and potentially offering a range of diverse service providers
- Some public health services will be re-provided within North Tyneside Council. Offering an integrated approach and utilising the capacity and expertise within the local authority
- Some public health services will not be continued in 2013/14.
- Resources will be released to allow investment in other discretionary areas

4.3 The DPH will be accountable for commissioning decisions taken through the North Tyneside Health Improvement Commissioning Board.

4.4 Specific commissioning intentions will be produced following a review of each public health contract. However, we have agreed some broad commissioning intentions:

4.5 Nutrition, Obesity and Physical Activity

4.5.1 Breast Feeding
We will commission a community based model in order to sustain breast feeding rates, through the network of Children Centres in North Tyneside and through peer support programmes.

4.5.2 Adult Weight Management
We will review the outcomes and value for money of the current Adult Weight Management programme.

4.5.3 Childhood Obesity
We will review the outcomes and value for money of Healthy4Life childhood weight management programme and move to a programme supplied by a single provider that is integrated with Healthy Schools, School Nursing, NCMP and Leisure Services.

4.6 Drugs and Alcohol

4.6.1 New integrated drug and alcohol service
We will design and develop a new integrated drug and alcohol treatment service in 2013, which will come into existence from 1st April 2014. There will be a joined up partnership for commissioning, performance and service development.

4.6.2 Alcohol Care and Treatment Service
We will fully implement an alcohol support service with the aim of targeting and reducing multiple admissions to hospital due to alcohol.

4.6.3 Balance
We will review the contract for Balance: the North East Office for Alcohol, but we do not anticipate renewing the contract in 2014/15.

4.7 Tobacco

4.7.1 Stop Smoking Services
We will ensure that intermediate Stop Smoking Services are accessible in deprived areas of the borough and to those groups of people in routine and manual occupational groups.

4.7.2 Tobacco Control
We will focus investment on preventing children and young people smoking and illegal tobacco sales. We will review the contract for Fresh: Smoke Free North East, but we do not anticipate renewing the contract in 2014/15.

4.8 Dental Public Health

4.8.1 Oral Health Promotion
We will review the outcomes and value for money of the Oral Health Promotion service provided by Northumbria Healthcare Foundation Trust.

4.8.2 Fluoridation
We will champion full fluoridation of areas in North Tyneside that have partial fluoridation.

4.9 Children 5-19 years

4.9.1 School Nursing
We will seek to realign the service in response to Department of Health's call to action for School Nursing, commissioning a service that is "visible, accessible and confidential, which delivers universal public health and ensures that there is early help and advice available to young people at the times when they need it". This will include the provision of the mandated service - the National Child Measurement Programme and also the Healthy Child programme 5-19.

4.9.2 Healthy School
We will seek to secure a local Healthy Schools programme that is fully integrated with the School Nursing Service, in order to prevent duplication.

4.9.3 Accident Prevention
We will commission a community based accident prevention service that ensures access for Health Visitors and Children's Centre staff.

4.10 NHS Health Checks

This is a mandatory service. We will commission Health Checks so that they offer universal provision to the eligible population but specifically target those groups at highest risk of cardiovascular disease. We will extend the number of providers to increase the uptake in areas of greatest need.

4.11 Health Improvement

4.11.1 Community Health Development Unit and Healthy Living Centres
We will undertake a whole system review of health improvement services and explore closer integration with existing Council services.

4.11.2 Social Prescribing
Following the outcome evaluation of the Social Prescribing pilot we will look to establish a social prescribing model in areas of the borough with greatest need.

4.12 Sexual Health

This is a mandatory service. We will seek closer integration of local sexual health services and efficiency savings:

- integrating the Chlamydia Screening programme into the Sexual Health services
- developing synergy between the successful approach to teenage pregnancy with the Councils Youth Service, School Nursing Service and the emerging Family Nurse Partnership programme
- we will work with the current provider to identify efficiency savings.

4.13 Improving health through council services and other organisations

- We will maximise opportunities to innovate, prime and support initiatives initially within children's services and adult social care that focus on delivering the outcomes in the PH outcomes framework.

- We will work with a range of organisations including community groups to maximise opportunities to improve health in the borough.

- We will work with the CCG to influence their commissioning plans in securing more investment in preventative approaches.

Appendix 3

Health and Wellbeing Board Update

A shadow Health and Wellbeing Board was established in North Tyneside in November 2010 to enable North Tyneside Council to develop its role to meet new Government legislation on the future of health and social care services.

Health and Well Being Boards will have statutory responsibilities from April 2013. They will have the primary aim of promoting integration and partnership working between the NHS, social care, public health and other local services, to improve democratic accountability. They will focus on four main functions including:

- assessing the needs of the local population and leading the statutory joint strategic needs assessment (JSNA);

- developing a high-level joint health and wellbeing strategy (JHWS), based upon the findings of the JSNA

- promoting integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health; and

- supporting joint commissioning and pooled budget arrangements, where all parties agree this makes sense.

The Health and Social Care Act 2012 clearly states that the Health and Wellbeing Board will be a committee of the Local Authority. It is expected that this duty will come into effect in April 2013.

This means that the Board will be treated as if it were appointed by the Council. However, any legislation that normally applies to such committees may be disapplied or modified by regulations.

It is anticipated that regulations governing Health and Wellbeing Boards will be published by the Government in January 2013, and detailed terms of reference and procedure rules will be prepared once the regulations come into effect. The Council's Constitution will need to be amended to reflect these new arrangements.

The membership of Health and Wellbeing Boards specified by the Health and Social Care Act 2012 is as follows:

- At least 1 Councillor of the Local Authority nominated by the Elected Mayor (The Elected Mayor may, instead of or in addition to making such nomination , be a member of the Board)
- The Director of Adult Social Care for the Local Authority
- The Director of Children's Services for the Local Authority
- The Director of Public Health for the Local Authority
- A representative of the Local Healthwatch organisation for the area of the Local Authority
- A representative of each relevant clinical commissioning group
- Such other persons or representatives of other persons as the Local Authority thinks appropriate