Overview and Scrutiny Report

Transition of Public Health into the Local Authority

16 May 2013

North Tyneside Council

1. Executive Summary

1.1 The Public Health Transition Sub-group was established by the Adult Social Care, Health and Wellbeing Sub-committee to investigate the transfer of public health from North of Tyne Primary Care Trust to North Tyneside Council.

1.2 As part of their investigation, Members met with officers of the Council in order to gather evidence and the information needed to formulate recommendations.

1.3 The sub-group examined the public health grant for 2013/14, and gained assurance that this was adequate to put plans in place to deliver on our statutory responsibilities for public health and improve the health of the local population. However the Members were concerned, that as the Council continues to be under pressure to make savings further demands would be placed on the public health grant. The sub-group believe that the production of a medium to long term strategic plan for public health could prevent funding being vired into other areas.

1.4 In relation to the governance arrangements for public health, Members concluded that it would be beneficial to establish a member led committee or board which could provide additional assurance to the council and lead integration of public health functions across all portfolios. After considering a number of options the sub-group recommend the establishment of a Public Health Advisory Board.

1.5 Finally the sub-group discussed in detail the plans for future commissioning of public health improvement contracts and services. The Director of Public Health has developed a North Tyneside Health Improvement Commissioning Strategy and a draft Procurement Programme 2013-15 is due to be signed off by Cabinet on the 10th June 2013. Members felt it was important that the Council had an overarching public health policy statement or vision which would give direction to service specifications and the re-procurement of health services.

2. Recommendations

2.1 In accordance with Section 122 of the Local Government and Public Involvement in Health Act 2007, Cabinet are required to provide a response to the recommendations of the Overview and Scrutiny Committee within two months. In providing this response Cabinet are asked to state whether or not it accepts each recommendations and the reasons for this decision. Cabinet must also indicate what action, if any, it proposes to take.

R1: That Cabinet ask the Director of Public Health to give priority to producing a medium to long term strategic plan for public health.

R2: That Cabinet ask the Director of Public Health to ensure that Service Level Agreements are set up with any Council based service in receipt of public health grant monies.

R 3: That Cabinet ask the Director of Public Health to ensure that robust performance management processes are in place to monitor the key indicators, so that the maximum 'health premium' reward is achieved.

R4: That Cabinet agree to establish a Public Health Advisory Board as outlined in Option B (paragraph 6.3.10).

R5: That Cabinet agree a Council public health policy statement.

R6: That Cabinet approve, in principle, to the provision of commissioned health improvement services by North Tyneside Council, where this would achieve improved health outcomes, reduced inequalities and best value.

3. Context

3.1 In accordance with the Health and Social Care Act 2012 responsibility for public health was transferred from the Primary Care Trusts to local authorities on 1st April 2013. As such the local authority 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.

3.2 The local authority will have responsibility across the three domains of public health:-

- Leading investment for improving and protecting the health of the population and reducing heath in-equalities 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).

3.3 The local authority will also have a role in supporting, reviewing and challenging NHS commissioned immunisation programmes and national screen programmes.

3.4 Local authorities will be required to commission a range of public health services. Some public health services are identified by the Act as being 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 Health and Wellbeing Strategy. The mandatory and discretionary services are listed in Appendix A with this report.

3.5 From the 1st April 2013, the local authority will also have a responsibility to provide public health advice and information to the NHS Commissioners. The main focus in North Tyneside is on producing a Core Intelligence Offer for the

North Tyneside Clinical Commissioning Group (CCG) which will outline the type of support the local authority will provide to the CCG.

4. Background to the study

4.1 Overview and Scrutiny Committee at their meeting on the 1st October 2012 requested that a sub-group be established to investigate the transfer of the public health functions into the local authority. The main objective was to seek assurance that the transfer would be smooth and with adequate resources to create a high quality and locally accountable health system.

4.2 It was agreed at the outset that the study would focus on the following areas:-

- Public health grant 2013/14 and transfer of staff to the local authority.
- Governance arrangements and the operation model that the local authority has adopted for public health.
- Public health service contracts transferring into the local authority and the commissioning intentions for 2013/14.

4.3 A sub-group of the Adult Social Care, Health and Wellbeing Sub-committee was established to carry out the study. Members of the sub-committee included:

Councillor John O'Shea
Councillor Lesley Spillard (lead until 16 May 2013)
Councillor Alison Waggot-Fairley (lead from 16 May 2013)

5. Methodology

5.1 Members of the sub-group held a series of three meetings with Marietta Evans, Director of Public Health, Ian Atkinson, Business Manager for Public Health and Wendy Burke, acting Public Health Consultant between 15 January 2013 and 16 May 2013 to receive evidence in relation to the key areas reviewed.

6. Findings

6.1 <u>Public health grant</u>

6.1.1 The transfer of public health responsibilities will be funded through a public health grant from the Department of Health. These ring-fenced allocations for two years were released on the 10 January 2013.

6.1.2 North Tyneside Council's allocation for 2013/14 is £10,417,000 (£51 per head of population) and for 2014/15 is £10,870, 000 (£53 per head of population).

6.1.3 When the Department of Health released the public health grants, they also announced that the formula for public health funding will move towards a need-based approach over time, which means that North Tyneside will see moderate annual increases which should eventually bring it in line with other local authorities. This is evident in that cumulative growth between 2013/14

and 2014/15 for North Tyneside is 10.1% which is higher than all other local authorities Tyne and Wear where cumulative growth is 5.7%.

6.1.4 In terms of ring-fencing, the public health grant to the council is made under Section 31 of the Local Government Act 2003 and 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. The Chief Executive is formally accountable for all public health related spend and will need to evidence that the grant has been used to support public health activities. The day-to-day responsibility for management of the grant is delegated to the Director of Public Health.

6.1.5 Officers are confident that the public health grant allocation that North Tyneside will receive in 2013/14 and 2014/15 will be sufficient to put plans in place to deliver on our statutory responsibilities for public health and improve the health of the local population. They also welcome the Department of Health's decision to give local authorities two year budgets rather than the planned one year budget as this will ensure greater certainty of funding to enable the Council to make strategic decisions in commissioning public health services.

6.1.6 Table 1: Breakdown of service commitments for 2013/14:

Mandated Services	**£'s Committed in 2013/14**
Sexual Health	2,595,864
NHS Checks	500,000
National Child Measurement Programme	4,000
Sub-Total	**3,099,864**
Non-Mandated Services	
Drug Treatment	2,368,029
Alcohol Treatment	520,886
Smoking Cessation & Tobacco Control	349,927
Obesity - Adults and Children	293,492
Physical Activity and Nutrition	39,000
Children 5 - 19 Programme	1,074,149
Health Improvement	1,409,966
Sub-Total	**6,055,449**
Reconfiguration of Council Based Services	**897,833**
Central Recharges	**100,000**
Establishment (Salaries and On-Costs)	**793,154**
Total	**10,846,300**
Income	**-429,300**
Final Total	**10,417,000**

6.1.7 In relation to the amount of public health grant being used to reconfigure council based services, £897,833 is committed to this in 2013/14. The sub-group were concerned that as the Council continues to be under pressure to make savings, further demands would be placed on the public health grant. The sub-group felt that it was crucial that Service Level Agreements were in place with any services accessing the public health grant, to provide evidence that the grant was being used to fund public health activities and achieving public health outcomes. Members also viewed that without a clear strategic plan, funding could be vired into other areas.

R 1: That Cabinet ask the Director of Public Health to give priority to producing a medium to long term strategic plan for public health.

R2: That Cabinet ask the Director of Public Health to ensure that Service Level Agreements are set up with any Council based service in receipt of public health grant monies.

6.1.8 In 2015/16 a 'Health Premium' will be available to local authorities with the main aim being to incentivise health improvement. The criteria for this has not been determined but is likely to be based on performance against key indicators in the Public Health Outcomes Framework along side some local indicators. The 'Health Premium' will only be paid to local authorities who deliver appropriately their mandatory services.

R 3: That Cabinet ask the Director of Public Health to ensure that robust performance management processes are in place to monitor the key indicators, so that the maximum 'health premium' reward is achieved.

6.2 Staff structure

6.2.1 The Public Health Directorate consists of a team of 14 staff, including registered public health specialists, commissioners, analysts and business/administrative support staff. The team also commissions health improvement services based on local need. Eight public health staff transferred from the Primary Care Trust into the Council on the 1st April 2013, retaining their NHS terms and conditions. No immediate plans are in place to restructure.

6.2.2 There is a risk around a lack of skills and capacity to undertake the full range of public health responsibilities within the current public health staffing structure. To address this, the Director of Public Health is planning to recruit three additional specialist public health staff in 2013/14 to ensure that the local authority can meet the mandatory provision in relation to public health responsibilities.

6.3 Governance arrangements and the operating model for public health

6.3.1 Public Health will be a separate directorate within the Council with the Director of Public Health reporting directly to the Chief Executive.

6.3.2 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 on a whole systems approach to health improvement.

6.3.3 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 and health improvement responsibilities are distributed across the Council, while public health specialist advice and commissioning expertise is provided through a 'core team'.

6.3.4 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 Director of Public Health, which will be responsible for commissioning and where appropriate providing the mandatory public health services.

6.3.5 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.

6.3.6 To ensure cross sector engagement the Director of Public Health has convened a Health Improvement Commissioning Board which includes senior Council officers, Clinical Commissioning Group representation and other stakeholders. The Health Improvement Commissioning Board reports to the 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.

6.3.7 At its meeting on the 14th March 2013, the Council approved the establishment of the Health and Wellbeing Board in accordance with the requirements of the Health and Social Care Act 2012. At that time the Council agreed to appoint the Board on an interim basis and delay final determination of its membership, terms of reference and procedural rules pending consultation with relevant stakeholders and further consideration of recently published guidance. Subsequently at its meeting on the 16th May 2013, the Council approved the Health and Wellbeing Board's proposed Articles, Terms of Reference and Rules of Procedure.

6.3.8 Given the statutory responsibilities, mandatory services and ring-fenced budgets for public health, the sub-group felt that it was appropriate to consider a member led Public Health Committee or Advisory Board to provide additional assurance to the council and to lead integration of public health functions across all portfolios. Officers would attend the committee in an advisory capacity. It was also felt that Political leadership was fundamental for making transformational change. This view was supported by the Director of Public Health.

6.3.9 The sub-group sought advice from the Governance Services Manager on the options available for establishing a Public Health Committee. They were informed that public health is a function of the Executive, rather than Council, and currently falls within the portfolio of the Cabinet Member for Adult Social Care. Therefore, decision making on public health matters is the responsibility of the Cabinet and/or with effect from 1st April 2013, the Health and Wellbeing Board. It was also pointed out that it was important that the establishment of a Committee or Board as referred to above does not duplicate the statutory role and remit of health scrutiny, which is currently the responsibility of the Adult Social Care, Health and Wellbeing Sub-committee.

6.3.10 Accordingly, the following options for the establishment of such a Board/Committee are possible:

A. Establishment of a Committee of the Cabinet;
The Elected Mayor may appoint a Cabinet Committee, with executive decision making powers, and agree its terms of reference and its membership. However, membership would be restricted to Cabinet members. Officers would support such a Committee in an advisory capacity.

B. Establishment of an Advisory Board;
The Council could agree to set up an Advisory Board led by the Cabinet Member for Adult Social Care to provide a forum for elected Members and officers to discuss public health issues. Whilst such a Board would not have any decision making powers, it would act as a focal point to facilitate the integration of public health across the service areas of the Council. It could also play a key role in advising the decision makers, i.e. Health and Wellbeing Board, relevant Cabinet Members and Cabinet on public health matters.

C. Establishment of a sub-committee of the Health and Wellbeing Board;
Once established, the Health and Wellbeing Board can delegate its statutory functions to a sub committee or it can appoint a sub-committee to advise the Board with respect to any matter relating to the discharge of functions by the Board. In either case the membership of a sub-committee would comprise representatives from various agencies.

6.3.11 After considering the different options, the sub-group recommended Option B the establishment of an Advisory Board, as it would be best placed to facilitate

the integration of public health across Council policy and service areas and provide advice to the decision makers.

R4: That Cabinet agree to establish a Public Health Advisory Board as outlined in Option B.

6.4 Transition of Public Health Contracts 2013/14 and future commissioning

6.4.1 As part of the transition it has been essential to ensure safe and efficient transfer of public health commissioning responsibilities and contract arrangements to the local authority. Given that the existing contract arrangements between public health service providers and North Tyneside Primary Care Trust terminated on 31st March 2013, the Council invited current providers to enter into new contracts with the Council for one year to ensure continuity of provision pending re-commissioning. Standard Public Health Contracts and service specifications were issued to providers during February and March 2013. The extension will ensure continuity of provision, and such extensions have been undertaken in accordance with the Council's Contract Standing Orders. The Council will assume full responsibility for contract management including payment and performance monitoring.

6.4.2 The Director of Public Health has developed a North Tyneside Health Improvement Commissioning Strategy which describes the 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.

6.4.3 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 Procurement Strategy which was approved by Cabinet on 11th March 2013, 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. A draft Procurement Programme 2013-15 has also been produced and will go to Cabinet on the 10th June 2013 for approval.

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

6.4.5 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

6.4.6 It is anticipated that for 2013/14:

- Some public health service contracts 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 in the local authority.
- Some public health services will not be continued after 2013/14.

6.4.7 There are a number of issues in relation to historical health improvement contracts, the responsibility for which has been transferred to the Council. A number of the commissioned services are not fit for purpose and are not addressing or reducing health inequalities in the borough. During 2013-14 there will be in depth reviews and remodelling of specific services including; community health improvement, stop smoking services, drug and alcohol services, weight management services for children and adults, oral health promotion, breastfeeding and accident prevention. A number of these services will be re-procured in 2013-14. The following year 2014-15 sexual health services and school nursing services will be reviewed with a view to going out to the market. The aim with all the services will be to seek better targeting in relation to populations in greatest need, better value for money and more community involvement in delivery.

Key issues currently include;

- Cost of sexual health contract currently stands at £2.3m and is increasing year on year. Negotiations taking place during 2013-14 to move to block contact arrangement.
- Community Health Improvement Service at a cost of approximately £1m – not targeting provision, not value for money, difficult to measure outcomes.
- Poor provision for alcohol treatment with insufficient capacity and quality.
- Poor provision for oral health promotion – high rate of decayed, missing, filled teeth in 5 year olds.
- Outcomes in relation to childhood and adult weight management programmes variable and not of sufficient scale to have impact. Costly per head of population.

6.4.8 The sub-group thought that it was essential there was an overarching public health policy statement or vision, which would give direction to service developments, service specifications and re-procurement of public health services.

R5: That Cabinet agree a Council public health policy statement.

6.4.9 In relation to future commissioning of health improvement services the sub-group felt that the Council was in some instances, best placed to deliver sustainable frontline local services.

R6: That Cabinet approve, in principle, to the provision of commissioned health improvement services by North Tyneside Council, where this would achieve improved health outcomes, reduced inequalities and best value.

7. Background papers

- Written answers in response to queries raised by the sub-group
- Notes from meetings with the sub-group
- Cabinet report (14 January 2013) – Transfer of Public Health Functions from North Tyneside PCT to North Tyneside Council
- Council report (16 May 2013) Health and Wellbeing Governance
- Draft Public Health Contract Register 2013/14
- Department of Health – Public Health Grants to Local Authorities 2013-14 and 2014-15
- Briefing on options for establishment of a Board or Committee provided by Democratic Services

8. Acknowledgements

8.1 The sub-group would like to place on record their thanks to the following officers for the information, support and advice they have provided:

Marietta Evans, Director of Public Health
Ian Atkinson, Business Manager for Public Health
Wendy Burke, Acting Public Health Consultant
Sharon Ranadé, Scrutiny Advisor

9. Appendices

Appendix A – Mandatory and Discretionary Services