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Public Health Working Group
Supplementary Agenda

Tuesday, 13 January 2015
7.00 pm, Committee Room 4 - Civic Suite
Lewisham Town Hall
London SE6 4RU

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This meeting is an open meeting and all items on the agenda may be audio recorded and/or filmed.

Part 1

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This report has not been available for 5 clear working days before the meeting and the Chair is asked to accept it as an urgent item. The report was not available for despatch earlier due to it requiring additional input prior to publication. The report cannot wait until the next meeting due to the Council's savings programme timeframes.

Overview and Scrutiny

Public Health Working Group

January 2015

Membership of the Public Health Working Group

Councillor Stella Jeffrey (Chair)

Councillor Ami Ibitson

Councillor David Michael

Councillor John Muldoon

Councillor Jacq Paschoud

Councillor J J Walsh

Councillor Alan Hall (ex-officio)

Councillor Gareth Siddorn (ex-officio)

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Chair's Introduction

To be inserted.

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Councillor Stella Jeffrey
Chair of the Public Health Working Group

Executive summary

To be inserted.

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Recommendations

The Committee would like to make the following recommendations:

To be inserted.

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Purpose and structure of review

1. As part of the Council's 2015/16 Revenue Budget Savings, two savings proposals relating to public health were put forward. These were considered by the Overview and Scrutiny Committee on 29 September 2014 and each of the Select Committees in October and early November, before being submitted to Mayor and Cabinet on 12 November 2014. The Mayor then authorised officers to carry out the required public/stakeholder/ staff consultation in relation to the proposals.

2. The Overview & Scrutiny Business Panel requested that a working group on public health be established, as the public health changes being proposed might have an impact across the whole council and the panel wanted the group to consider, in particular, whether any alternative application of public health funding would fulfil public health outcomes.

3. At its meeting on 26 November 2014, Council agreed to set up a time limited Public Health Working Group to operate until the end of February 2015 to consider the proposals to change public health services being proposed as part of the Council's budget process for 2015/16.

Terms of Reference

4. It is acknowledged that the Healthier Communities Select Committee has the statutory responsibility under the Health & Social Care Act 2012 in relation to significant changes in provision by relevant health bodies (including the Council itself in relation to public health services). It is also acknowledged that it is the Healthier Communities Select Committee which has the duty to review and scrutinise health service matters by virtue of regulations made under Section 244 NHS Act 2006. The establishment of the Public Health Working Group was not intended to detract from the statutory or other remit of the Healthier Communities Select Committee in any way. Rather it was intended to make a contribution to the Council's debate about the future of public health services in Lewisham.

5. The terms of reference agreed for the working group were:

   "Without prejudice to the remit of the Healthier Communities Select Committee, to consider any proposals to change public health services being proposed as part of the Council's budget process for 2015/16. To make any comments it considers appropriate about those proposals to the Council's Public Accounts Committee (PAC) prior to any submissions PAC may decide to make to the Mayor in February 2015 in relation to budget proposals for 2015/16. The Working Group will consist of 6 members (7 if the councillor
   outside the majority party wishes to sit on the Group) and will cease to exist at the end of February 2015".

Scope

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6. The working group had two formal meetings to consider the following:

First meeting (**15 December 2014**)

(1) Receiving a written report providing information on:
   The context:
   (i) The Council's public health responsibilities
   (ii) The nature of the ring-fenced budget
   (iii) How public health is structured at Lewisham in terms of staffing (structure and reporting lines) and governance (the role of the Healthier Communities Select Committee, the Health and Wellbeing Board etc.) and how this compares to other local authorities.
   The proposals:
   (i) The savings being proposed (including any alternative services that exist/will be put in place to replace reduced or stopped services)
   (ii) Options for redirecting the savings made to other activities with a public health outcome.

(2) Questioning officers on the written report.

Second meeting (**13 January 2015**)
To consider and agree a final report presenting all the evidence taken and to agree recommendations for submission to the Public Accounts Select Committee on 5 February 2015 (and on to Mayor & Cabinet on 11 February 2015).

7. Informal work took place between the two formal meetings to ensure that the working group collated all the evidence it needed for this report. The working group also received the results of the consultation with Lewisham Clinical Commissioning Group on the savings proposals.

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The context

The Council's public health responsibilities

8. The 2012 Health and Social Care Act provided the legal basis for the transfer of public health functions from the NHS to local authorities. On 1 April 2013 the Council assumed responsibility for the provision of most public health functions, with the remaining functions provided by Public Health England and NHS England.

9. The Health and Social Care Act 2012 places a duty on local authorities and their partner clinical commissioning groups to prepare and publish joint health and wellbeing strategies to meet needs identified in their joint strategic needs assessments (JSNAs).

10. In line with the Health and Social Care Act, the Council has three overarching responsibilities in relation to public health[1]:

    1) To deliver its statutory duties to take such steps as it considers appropriate for improving the health of people in its area, and to plan for and respond to emergencies involving a risk to public health.
    2) To deliver the key public health outcomes in the National Public Health Outcomes Framework.
    3) To deliver a Joint Strategic Needs Assessment (providing officers and elected members with appropriate advice, based on a rigorous appreciation of patterns of local health need, what works and potential for improving health) and a Health & Wellbeing Strategy for the borough.

11. These overarching functions encompass the three domains of public health: service improvement; health protection; and health improvement.

12. The Council is mandated to provide public health commissioning advice based on quality population-level analysis of health data and needs assessment at no cost to the Lewisham Clinical Commissioning Group. Official Department of Health guidance on the proportion of time and resource spent by Local Authorities on public health commissioning advice for the CCG is around 40% of the specialist public health function.

13. The key elements of public health advice and support to clinical commissioners includes: assessing needs and strategic planning; reviewing service provision; deciding priorities; service re-design and planning; managing performance; supporting patient choice and seeking public and patient views; and maintaining workforce expertise.

[1] Public Health in Local Government**:** The new public health role of local authorities, DH *2012*

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Health protection

14. The Council, and the Director of Public Health (DPH) acting on its behalf, has a mandatory duty to protect the health of the population, both in terms of helping to prevent threats arising and in ensuring appropriate responses when things go wrong. The Council needs to have available the appropriate specialist health protection skills to carry out these functions.

15. The Council, through the DPH, has a duty to ensure plans are in place to protect the population including screening and immunisation. It provides assurance and challenge regarding the plans of NHS England, Public Health England and providers. The DPH needs to assure the council that the combined plans of all these organisations, when delivered in Lewisham, will deliver effective screening and immunisation programmes to the population. There are a large number of screening and immunisation programmes including: cervical, bowel and breast cancer screening; ante natal and neo-natal screening; abdominal aortic aneurysm screening; routine immunisation of children and influenza immunization; and diabetic retinopathy screening.

Health Improvement

16. The Council has specific responsibilities, supported by its ring fenced public health grant (see next section), for commissioning public health services and initiatives[2]. Some of these functions are mandatory and the Council is obliged to deliver the defined function, others are discretionary and the Council can determine the level of provision, guided by the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy[2]. These responsibilities are:.

    Mandatory commissioning responsibilities:

    - National Child Measurement Programme
    - NHS Health Check assessments
    - Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)

    Locally determined commissioning responsibilities:

    - Tobacco control and smoking cessation services
    - Alcohol and drug misuse services
    - Public health services for children and young people aged 5-19 (in longer term all public health services for children and young people)
    - 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

[2] Public Health in Local Government: Commissioning responsibilities, DH 2012

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- Dental public health services
- Accident injury prevention
- Local initiatives on workplace health
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Population level interventions to reduce and prevent birth defects
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Local authority role in dealing with health protection incidents, outbreaks and emergencies
- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion
- Local initiatives that reduce public health impacts of environmental risks

17. Information on the impact of the Council's public health activity since responsibility moved to the local authority in April 2013 can be found at **Appendix A**.

The Public Health Budget

18. The public health budget is ring fenced until at least the end of 2015/2016. The Council is required to file annual accounts to Public Health England on how the Council's public health allocation is spent against pre-determined spending categories linked to public health outcomes and mandatory functions. A copy of the latest statement was provided to the working group following its meeting on 15 December 2014.

19. The following chart itemises budget allocations against each programme area:

Function		**2014/15 Budget Allocation £**	**Spend Commitments 2014/15* £**
Sexual Health	Sexual Health Services: STI Testing & Treatment	2,753,834	2,728,834
	Sexual Health Services: Contraception	3,902,467	3,933,027
	Sexual Health Services: Advice, Prevention & Promotion (including HIV prevention)	480,500	480,500
NHS Health Check Programme	NHS Health Check Programme	558,200	522,057
Health Protection	Health Protection	288,586	259,769
National Child Measurement Programme	School Nursing	1,600,000	1,600,000
Public Health	Public Health Advice to CCG	543,500	490,900

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Advice			
Promoting Healthy Weight & Obesity	Obesity: Adults	297,100	241,100
	Obesity: Children	504,100	490,275
Physical Activity	Physical Activity: Adults	370,000	355,000
	Physical Activity: Children	70,000	20,000
Substance Misuse	DAAT-Adults Substance Misuse Service	3,580,700	3,580,700
	DAAT-Alcohol Service	419000	419,000
	DAAT-Young Persons Substance Misuse	232,000	232,000
	DAAT-Drug Intervention Programme	369,000	369,000
	DAAT-Adult Rehab Placements	300,000	300,000
Smoking and Tobacco	Stop Smoking Service	706,811	670,711
	Smoking and Tobacco: Wider Tobacco Control, including prevention of uptake, tackling illegal sales and smoke free homes	226,000	116,000
Children 5-19 Public Health Programmes	Children 5-19 PH Programmes	150,700	120,878
Other Public Health Services	Other Public Health Services: Administration £104,200, Prescribing Costs £718,000,	822,200	822,200
	Other Public Health Services - Reducing Health Inequalities & Addressing Wider Determinants of Health: Area Based Initiatives - £90,000, Library Services - £15,375, Lewisham Refugee & Migrant Network - £21,500, Federation of Refugees from Vietnam in Lewisham - £29,000, Community Health Improvement Service - £1,065,941, North Lewisham Plan - £99,000; Warm Homes - £75,000; Health Assessments for Housing Eligibility - £28,000 Money Advice (Citizens Advice Bureau) - £148,000	1,571,816	1,559,816
		20,053,514	19,311,767

*The expenditure is less than the budget due to efficiency savings being implemented in some areas within year 2014/15.

Public Health at Lewisham

20. The current staffing structure of the Council's public health department, including vacant posts, is shown in Appendix B. The total staff employed currently is 28, equating to 24.4 whole time equivalents. The total staff budget is £1.475m, but because of staff vacancies and secondments forecast expenditure for 2014/15 is £1,300,278. At its meeting on 15 December 2014, the working group considered the structure chart for the public health department, noting that the DPH worked for 2.5 days a week and line managed 13 people, something that would change post a restructure effective from April 2015. A restructure was thought necessary as it was clear that the role of the public health workforce within local government was continuing to evolve as councils' understanding of their new responsibilities matured and as they become more adept at incorporating public health into the full range of their activities and commissioned services. Therefore the current staffing arrangement and functional responsibilities would be reviewed as part of a wider review of council arrangements.

21. In line with most other London boroughs, the DPH at Lewisham is line managed by the Executive Director for Community Services. He also has a 'dotted line' to the Chief Executive and Mayor in view of his advisory responsibilities. The reporting arrangements for public health in Lewisham reflect the most common arrangement across London boroughs. This in turn reflects the London-wide integration programme which is bringing synergies between acute health providers, community and primary care based services, adult social care and public health. It is usually the equivalent of the Community Services Directorate which carries the local authority role for liaison with health. However, nationally some local authorities have adopted alternative models, with the DPH reporting directly to the Chief Executive, or the DPH role being combined with other council responsibilities such as environmental health (e.g. Halton Borough Council), housing, and joint commissioning of health and social care services (e.g. West Sussex County Council).

22. In relation to the role that public health specialists play in discharging a council's public health responsibilities, a few London councils have moved towards a model in which public health professionals provide an 'expert-led' advisory service with public health commissioning undertaken elsewhere (e.g. Lambeth and Newham). However, the majority have maintained or are increasing the commissioning remit of their public health specialist workforce. In Lewisham public health strategic commissioning is discharged by the appropriate commissioning unit, but overseen by the public health service.

23. The DPH manages the public health department and has budget management responsibilities for the ring fenced grant with the exception of the drugs and alcohol budget, which is managed by the head of crime reduction and supporting people. The current DPH works for 2.5 days a week as he is seconded half time to King's College London Department of Primary Care and Public Health Sciences and to the School of Medical Education.

24. In addition to the DPH (0.5 WTE[3]), there are 3.3 WTE Consultants in Public Health[4] in the Public Health Division Senior Management Team. The Faculty of Public Health

[3] Whole Time Equivalent.

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previously recommended an average consultant in public health complement of 4.3 WTE for a population of 270,000, with greater capacity for populations with greater health need such as Lewisham's.

25. The Consultants in Public Health have responsibility for key portfolios including Children and Young People, Sexual Health, Health Protection, Tobacco Control, Mental Health, Cardiovascular Disease, Cancer and Health Intelligence. They have also been given a lead responsibility for liaising with the four Council Directorates (Resources and Regeneration, Customer Services, Children and Young People and Community Services), and for providing public health advice to the Lewisham Clinical Commissioning Group (CCG). The working group observed that a number of senior public health officers did not have line management responsibilities but were specialists managing specialist programmes of work.

Recommendation X:

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[4] To assure themselves of the continuing competence of their Consultants in Public Health, local authorities should ensure that they are registered with the GMC or the UK Public Health Register; undertake a continuing professional development programme that meets the requirements of the Faculty of Public Health; maintain a programme of personal professional development to ensure competence in professional delivery; undertake appropriate annual professional appraisal in order to ensure revalidation and fitness to practise.

Findings

The Savings Proposals:

26. Lewisham Council has to make savings of £85m over the next 3 years. The public health budget is ring fenced until at least the end of 2015/2016. Where savings have been identified from the current ring fenced public health budget these will be used to support public health outcomes in other areas of the Council. The working group was informed that the guiding principle for the re-investment would be to support areas where reductions in council spend would have an adverse impact on public health outcomes.

27. The approach to identifying savings has been:

    1) To identify any duplication with aspects of other council roles which can therefore be combined or streamlined.

    2) To identify any service which should more appropriately be carried out by other health partners.

    3) To stop providing service level agreements or incentive payments to individual GP practices and develop those services more efficiently and equitably across the four GP neighbourhood clusters where appropriate.

    4) To gain greater efficiency through contract pricing where applicable.

    5) To integrate public health grants to the voluntary sector into the Council's mainstream grant aid programme.

28. The working group was informed that the Public Health programmes which transferred to Lewisham Council in April 2013 had all been reviewed. The review identified an initial £1.5M of savings which could be delivered largely through efficiencies and using the uplift applied to the public health budget in 2014/15. A further disinvestment of £1.15M was also identified, although it was acknowledged that this was likely to have some negative impact unless the service delivery models were re-configured; subsequent savings identified in provider overheads and on costs; and there was a commitment from schools to both engage in health improvement programmes and contribute financially.

29. At its meeting held on 15 December 2014, the working group was informed by the Executive Director for Community Services that the first set of proposals (£1.5m) would have a minimal impact on outcomes; and whilst the second set of proposals (£1.15m) might have a more significant impact, this would be mitigated by a reconfiguration of services at a neighbourhood level, in alignment with the development of integrated services.

30. The programmes where savings are proposed include the following:

    - Dental Public Health

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- Health Inequalities
- Mental Health (adults and children)
- Health Protection
- Maternal and Child Health
- NHS Health Checks
- Obesity/Physical Activity
- Sexual Health
- Smoking and Tobacco Control
- Training and Education.

31. The savings proposals are presented in the table below. The working group noted that the Council, as the commissioner of these services, would work closely with the provider of services on planned service re-configuration, in order to mitigate the impact of any service changes, maximise the efficiency and effectiveness in service delivery and to optimise value for money.

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Table 1 – Savings Public Health Savings Proposals

Public Health Programme Area	Total Budget	Total Saving	Proposals	Service re-design where applicable	Risk & Mitigation
Sexual Health	£7,158,727	£321,600	1. Re-negotiation of costs for sexually transmitted infection testing with LGT in 2015/16, including application of a standard 1.5% deflator to the contract value as an efficiency saving, and inclusion of laboratory costs in the overall contract (£275.6k). 2. Reduce sex and relationships (SRE) funding and develop a health improvement package that schools can purchase that includes SRE co-ordinated and supported by school nursing (£20k) 3. Remove incentive funding for chlamydia and gonorrhoea screening in GP practices (£26k)	In the short to medium term the development of a neighbourhood model of sexual health provision will lead to improved services. In the longer term a London wide sexual health transformation programme is being developed in partnership with 20 boroughs, which is expected to deliver greater benefit at reduced costs.	The risk would be that LGT cannot deliver the same level of service within reduced funding, and GPs disengage with sexual health. Mitigation includes work with primary care to deliver sexual health services in pharmacy & GP practices, and free training given to GPs and practice nurses. The risk is that SRE is not delivered in schools. Mitigation includes developing a health improvement package that schools can purchase that includes SRE, and work with school nursing to support schools to provide quality SRE.
NHS Health checks	£551,300	£157,800	1. Removing Health checks facilitator post 2. Pre- diabetes intervention will not be rolled out 3. Reduced budget for blood tests due to lower take up for health checks than previously assumed 4. Reducing GP advisor time to the programme 5. Reduction in funding available to support IT infrastructure for NHS health checks	An essential component of the NHS Healthchecks programme is delivered through the Community Health Improvement Service. See proposed re-commissioning and service re-design under 'health inequalities'	Missed opportunity to prevent diabetes and for early diagnosis of diabetes. IT system not able to deliver requirements of the programme. Future plans to align commissioning of NHS Health Checks with Neighbourhoods will help to optimise the efficiency and

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				below.	effectiveness of resources and may identify more people at risk earlier.
Health Protection	£35,300	£12,500	Stop sending the recall letter for childhood immunisations (as this is already done via GPs)		Minimal as impact of letter on uptake appears to be low. Uptake of childhood immunisations continues to be monitored.
Public Health Advice to CCG	£79,200	£19,200	Decommissioning diabetes and cancer GP champion posts.		These posts will be commissioned by the CCG in future.
Obesity/ physical activity	£650,000	£173,400	1. Decommission Hoops4health (£27,400) 2. Changing delivery of Let's Get Moving GP & Community physical activity training (£5,000) 3. Decommissioning Physical Activity in Primary Schools (£50,000) 4. Reduce funding for community development nutritionist (£30k) 5. Remove funding for obesity/ healthy eating resources (£10K) 6. Withdraw of funding for clinical support to Downham Nutritional Project (£9k) 7. Efficiency savings from child weight management programmes. (£12k) 8. Reduce physical activity for health checks programme (£20k)		There is a risk of reduction of physical activity in schools. Mitigation includes Schools being encouraged to use their physical activity premium to continue programmes selected from a recommended menu of evidence based activities. The risk is a reduction in support to voluntary sector healthy eating and nutrition programmes. Mitigation includes organisations being encouraged to build delivery into their mainstream funding programme.
Dental public health	£64,500	£44,500	Release funding from dental public health programmes	Dental public health services commissioned by NHS England	Sufficient resource retained to assure dental infection control function.

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Mental Health	£93,400	£59,200	1. Withdraw funding for clinical input to Sydenham Gardens. 2. Reduce funding available for mental health promotion and wellbeing initiatives (including training).		The risk is that Sydenham Gardens is unable to sustain clinical input from grant funding, but it is agreed to direct them to alternative funding sources. The risk is a reduction in mental health awareness training across the borough. Mitigation includes pooling resources with neighbouring boroughs for delivery of training and work closely with voluntary sector and SLAM to deliver mental health awareness training and campaigns.
Health Improvement Training	£88,000	£58,000	1. Decommission Health Promotion library service. 2. Limit health improvement training offer to those areas which support mandatory public health services.		The risk is reduced capacity to develop a workforce across partner organisations which contributes to public health outcomes. Mitigation includes working with CEL to develop new models of delivery for essential public health training.
Health inequalities	£1,460,019	£581,500	1. Reconfiguring LRMN Health Access services to deliver efficiencies (£21,500) 2. Remove separate public health funding stream to VAL (£28,000) 3. Decommissioning FORVIL Vietnamese Health Project (£29,000)	It is proposed to integrate a number of community based health improvement programmes, including those funded by the GLA (e.g. Bellingham	The risk is reduced capacity across the system to tackle health inequalities, and a reduction in service for the most vulnerable. Mitigation includes working with the Adult integrated Care Programme

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			4. Reducing funding for Area Based Programmes (£40,000) 5. Decommissioning CAB Money Advice in 12 GP surgeries (£148,000) 6. Reduce the contract value for community health improvement service with LGT by limiting service to support mandatory Public health programmes such as NHS Health Checks only and reduce other health inequalities activity. (£270k) 7. Further reduce funding for area based public health initiatives which are focused on geographical areas of poor health with in the borough. (£20k) 8. Reduce funding for 'warm homes' (£25K)	Well London) with the health and social care activities currently being developed in these neighbourhoods by the Community Connections team, District Nurses, Community Health Improvement Service, Social Workers and GPs. There is also a plan to develop a stronger partnership working with Registered Social Landlords as well as any local regeneration projects in each of these neighbourhoods.	to deliver a neighbourhood model for health inequalities work, and develop local capacity. It is anticipated that basing these services directly in the community and with greater integration will accommodate the funding reduction. Voluntary organisations will have an opportunity to continue some of this work in a different way through the grant aid programme.
smoking and tobacco control	£860,300	£348,500	1. Reduce contract value for stop smoking service at LGT by £250k (30%) 2. Stop most schools and young people's tobacco awareness programmes 3. Decommission work to stop illegal sales	There are proposals to re-configure the stop smoking service as part of the neighbourhood developments described under 'health inequalities' above.	There is a risk of a reduction in number of people able to access stop smoking support and an increase in young people starting smoking if services are not – reconfigured appropriately. Mitigation includes optimising efficiencies in the delivery of the SSS and reducing the length of time smokers are supported from 12 to 6 weeks to release capacity. Schools will be able to fund some of the peer education non-smoking programmes as part of the menu of

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					programmes. The restructuring of enforcement services is likely to allow tackling illegal sales of tobacco in a more integrated way with the same outcomes and prevent young people having access to illegal tobacco.
Maternal and child health	£187,677	£68,400	1. Reducing sessional funding commitment for Designated Consultant for Child Death Review 2. Reduce capacity for child death review process by reducing sessional commitment of child death liaison nurse. 3. Removal of budget for school nursing input into TNG 4. Reduce capacity/funding for breast feeding peer support programme & breast feeding cafes.		There may be less opportunity to learn from and improve services for families which have been bereaved, but this is not the purpose of the panel and there will be no impact on prevention of child deaths. The school nursing service received grant funding of £250k in 2014/15 which has not been reduced, and the service will be able to accommodate input into TNG. There is a risk that women will be less well supported to breast feed and Lewisham may not achieve UNICEF/WHO Baby Friendly status in 2015. Mitigation will include re-negotiating support through the maternity services contract, although this may not be achievable in time for 2015 contracts. Baby café licences may be re-negotiated.

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Department efficiencies		£262,200	To be identified through a staff restructure in 2015. At this point public health staff terms and conditions and pay scales are to be harmonised with council staff terms and conditions and pay scales.		
2014/2015 Uplift (uncommitted)		£547,000			
TOTAL	**£14,995,000**	**£2,653,800**			

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Mitigation

32. One of the aims of the working group in relation to the savings being proposed, was to consider any alternative services that existed or would be put in place to replace reduced or stopped services. The working group considered the table above and the column listing the risks and mitigation associated with each element of the savings proposals. In response to questions from Members of the group, the following points were noted:

- Savings proposals relating to breastfeeding services had the potential to affect the achievement of UNICEF/WHO baby friendly status in 2015, so steps would be taken to ensure the renegotiation of contracts relating to breastfeeding cafes would not jeopardise the Council's chances of achieving the status.

- The new neighbourhood model was largely in place in terms of management infrastructure, although geographic co-location was still to be achieved. Further integration was also required in terms of integrating more services and extending networks (with mental health, the voluntary and community sector, pharmacies etc.). However, the Community Connections programme was now firmly established in the neighbourhoods.

- South East London had chosen to retain infection control nurses rather than devolve the relevant budgets to NHS England and this had given the boroughs an advantage in terms of ensuring adequate health protection activity.

- In terms of work with specific communities, such communities would now only receive specific targeted interventions if there was clinical need (e.g. if a particular illness was prevalent in a certain community); and that in terms of access to services, a broader picture would be considered and efforts made to ensure everyone had access to services.

Recommendation X:

33. The working group was reassured to hear that the impact of a cut in funding of 50% to the national HIV prevention programme in England would not be that significant in Lewisham as the borough had never relied on the national programme but had done a lot of locally based work. However, it was accepted that late diagnosis was an issue in the borough and officers were working with Lewisham CCG to address this within the existing budget. A further area for improvement was the local sexual health clinics. Financing improvement was difficult because central Genito-Urinary Medicine (GUM) services (that were more expensive than local services) were taking a lot of

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the available budget by re-charging the borough for working with Lewisham patients. However, officers were trying to drive down costs, working at a London level.

34. Rachel Braverman, the Co-Chief Executive of Lewisham Citizens Advice Bureau addressed the working group at its meeting on 15 December 2014. She made the point that advisory services had a huge impact and were income-generating and that, in short, cuts here would not deliver required savings. She also spoke of the links between debt and mental health and how good debt advice would reduce health expenditure. The Executive Director for Community Services made the following points in response:

- The importance of the advice sector was recognised, the borough funded the advice sector very heavily and the main grants programme had a specific strand relating to advice and information.
- Lewisham Citizens Advice Bureau was providing advice in 12 GP surgeries and the intention was to provide access to advice for vulnerable people, via referrals, at every surgery via the neighbourhood model.
- A health and social care information and advice website was being developed to ensure compliance with the Care Act and it was expected that the voluntary and community sector would contribute content to this.
- Library staff would be providing non-specialist advice from next year.
- Specialist debt advice would be commissioned.

35. The working group considered whether a one off transitional fund might help advice organisations manage the reduction in funding and identify alternative sources of funding.

Recommendation X:

Measuring impact

36. The working group was keen to consider how the impact of services could be measured to help it assess the impact of the cuts and the impact that alternative service provision might have. The DPH outlined the difficulties in quantifying benefits and reported that academic research indicated that the most sensible way of measuring the success of services was probably to list the different types of benefits they brought in words (and numbers where possible), compare these to the costs and make a value judgement. It was noted that in the case of the savings proposals that had been put forward, officers had made a value judgement about the benefits provided by the services under consideration for savings, versus their costs. It was accepted

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that, ideally, the options for spending the money saved would be considered at the same time but it was noted that this would not be done until the summer of 2015. However, the assumption was that the new areas of spend would produce the same level, or increased, public health benefits and there was every indication that using the money to reduce the level of required cuts next year would produce increased public health benefits.

Reinvesting savings

37. One of the aims of the working group was to consider options for redirecting the savings that would result from the proposals to other activities with a public health outcome. However, as specific options would not be considered until the summer of 2015, scrutiny of the options for spending any savings made could not yet take place. The working group noted that the savings resulting from the proposals would be put towards next years' savings requirement and used to maintain activity in areas where cuts were proposed, where the activity had a positive public health outcome. It was further noted that, in addition to using the funding to mitigate 2016/17 savings proposals, the savings could be used, if appropriate, to assist with any 2015/16 savings proposals that were not delivered. However, any re-allocation in other areas of council spend must have an equal or greater public health impact.

38. The working group considered which areas of council spend might benefit from the re-allocation and the following areas were mentioned: Supporting People; housing and environmental services. The DPH commented that scrutiny could assist in the prioritisation process and in helping him come to an assessment about the cost effectiveness of budget spend for the annual submission to Public Health England.

Recommendation X:

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Appendices

Appendix A: The impact of public health activity
Appendix B: Current Public Health Structure Chart

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Appendix A: The impact of public health activity

1. A dynamic Joint Strategic Needs Assessment (JSNA), supported by a Public Health data portal, has been developed and is accessible online (www.lewishmjsna.org.uk). The Health and Well Being Board is established and a ten year Health and Well Being Strategy has been developed.

2. The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in Shaping our Future – Lewisham's Sustainable Community Strategy, and in Lewisham's Health and Wellbeing Strategy. Lewisham's Health and Wellbeing Strategy was published in 2013.

3. Using the JSNA evidence and focusing on improving health, care and efficiency, the Health and Well Being Strategy was informed by the following considerations:

    1) Analysis of those areas which collectively are able to make the biggest difference to health and wellbeing at all levels of our health and social care system, from empowering people to make healthy choices to prevent ill health, through early intervention to prevent deterioration in health and wellbeing, to targeted care and support, right through to complex care for people with long term health problems;

    2) listening to the voice of Lewisham people and local communities, the voluntary and community sector, about the issues that affect their health and wellbeing;

    3) Analysis and prioritisation of those areas and actions that will enable transformative system level change and integration across social care, primary and community care, and hospital care;

    4) Identification of those areas where early action now, for example by addressing the 'causes of the causes' of ill health and inequalities, particularly in the early years, or intervening to prevent dependency, will improve quality and length of life in the future, and reduce the need for additional health and social care interventions later on.

4. Contributing to the objectives of Lewisham's Sustainable Community Strategy to reduce inequality and informed by the Marmot Review[5], the strategy has identified nine priority areas for action over the next ten years.

    - Achieving a Healthy Weight
    - Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
    - Improving Immunisation Uptake

[5] Marmot et al, Fair Society, Fair Lives, Strategic Review of health Inequalities, 2010

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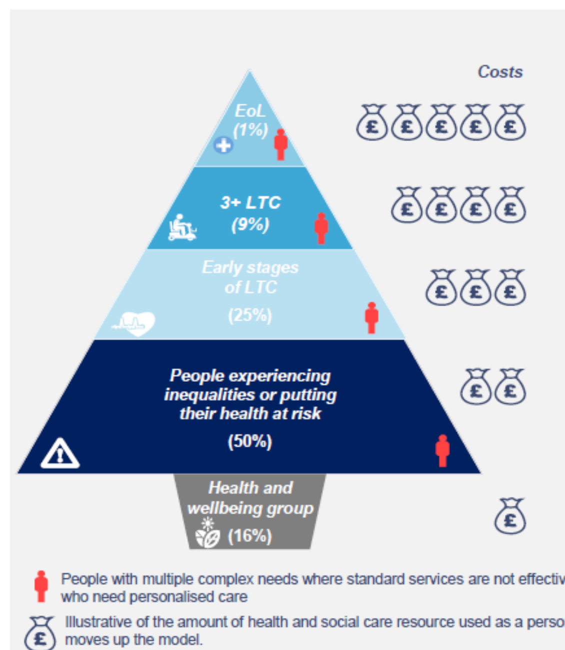
- Reducing Alcohol Harm
- Preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
- Improving mental health and wellbeing
- Improving sexual health
- Delaying and reducing the need for long term care and support
- Reducing the number of emergency admissions for people with long term conditions

5. The diagram below illustrates the scale of the health improvement challenge. It is estimated that in South East London, only around 16% of the population are not adversely affected by inequalities and do not put their health at significant risk. This emphasizes the need to ensure that all organizations and partners across the borough take a holistic approach to promoting the health and wellbeing of their residents, clients, patients and their own staff, so that 'every contact counts'.



6. In order to maximise the impact of public health in making every contact count and supporting the delivery of the health and wellbeing strategy priorities, effort and resources have been focused on delivering those public health functions which are mandatory or that have been identified as a priority in the strategy.

7. The following section describes the programmes, performance and challenges in relation to these key public health functions:

- National Child Measurement Programme
- NHS Health Checks assessments
- Comprehensive sexual health 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
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Public mental health services
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- Local authority role in dealing with health protection incidents, outbreaks and emergencies
- Public health advice and support to clinical commissioners

National Child Measurement Programme

8. The school nursing team of Lewisham and Greenwich NHS Trust (LGT) is commissioned to deliver the National Child Measurement Programme (NCMP). The National Child Measurement programme involves the annual height and weight measurement of all children in reception year and Year 6 in schools. The School Nursing Service has recently been expanded to enable it to increase its focus on health improvement including promoting healthy weight.

9. In 2012/13 over 6,000 children were measured (3,565 in Reception and 2,442 in Year 6). The participation rate in Lewisham of 92% (national target 85%) means that robust data are collected.

10. In Lewisham childhood obesity rates remain significantly higher than the England rate. In 2012/13 Lewisham remains in the top quintile of Local Authority obesity prevalence rates for Year 6. Reception year performance has improved and Lewisham is now in the second quintile. In 2012/13, 10.7% of Reception children were at risk of obesity and this rose to 23.3% in Year 6. The target set for the school year 2012/13 for obesity in Reception (12.2%) and Year 6 (24%) was achieved.

11. There is a small increase in obesity rates in both reception year and Year 6. This is similar to the national picture that shows that the proportion of children who were either overweight and obese or obese was higher for both Reception and Year 6 in 2013/14 compared to the previous year.

12. By deprivation: Results for Lewisham show obesity levels similar or lower to those seen in the most deprived decile. (The obesity prevalence among reception year children attending schools in areas in the most

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deprived decile was 12.0% compared with 6.6% among those attending schools in areas in the least deprived decile and 24.7% compared to 13.1% in Year 6.)

13. The most significant challenges are to support families with young children and pregnant mothers to reduce their dietary intake of sugars, energy rich and processed foods in order to achieve a healthy weight for babies and children that will persist through the life course. This is especially challenging in the face of an obesogenic environment that normalises and encourages excessive consumption.

NHS Health Check assessments

14. This service aims to improve health outcomes and quality of life amongst Lewisham residents by identifying individuals at an earlier stage of vascular change, and to provide opportunities to empower them to substantially reduce their risk of cardiovascular morbidity or mortality. A NHS Health Check is offered to 20% of the eligible population every year as part of a 5 year rolling programme with an uptake level of 50-75%.

15. The 30 minute risk assessment involves a series of simple questions about lifestyle (smoking, alcohol, diet and physical activity) and family history, measuring blood pressure and cholesterol and recording weight, height and waist measurements in order to assess someone's risk of developing cardiovascular disease. This large programme is co-ordinated and commissioned by LBL Public Health and provided by GPs, pharmacists and an outreach team, currently based with the Community Health Improvement Service, within Lewisham and Greenwich Health Trust.

16. A new Lifestyle Referral Hub service has been launched offering a "one-stop shop" for people who have received a NHS Health Check, have been identified as at high risk, and are referred to local lifestyle services.

17. The London Borough of Lewisham NHS Health Check team won "Team of the Year" at the Heart UK national awards in November 2014.

Performance:

	2013/14	April- Sep 2014/15
Number of health checks offered	18,543 people	9,271 people
% eligible population	27%	N/A
Number of health checks received	7,075	3,128
% uptake	38%	N/A

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% identified with high or very high risk	8%	7%

18. Referrals to lifestyle services have steadily increased as a result of the establishment of the Lifestyle Hub, apart from smokers to the Stop smoking Service.

Referrals	2013/14	April – Sept 2014/15
Referral to Stop Smoking Service	302	109
Weight Management services	539	347
Alcohol Services	27	23
Physical Activity	678	449

19. The most significant challenge is to increase the proportion of those people identified as having a high (>20%) risk of a cardiovascular event in the next ten years who are successfully referred for treatment or public health intervention and whose risk is reduced. A recent audit showed that only 11% of those identified by the health checks programme as at high risk had received any further GP follow up. A further audit of community outreach Healthchecks found 21% of people were at very high risk of Diabetes.

Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)

20. Lewisham experiences very high levels of abortion, teenage pregnancy, HIV infection and chlamydia and gonorrhoea infection. Sexual health is worse in young people, men who have sex with men and in some BME groups.

21. Lewisham Council entered into a partnership agreement with Lambeth and Southwark Councils in April 2013 to oversee the commissioning of sexual health services across the 3 boroughs. This commissioning function is provided by Lambeth.

22. Sexual health services are delivered through specialist genito-urinary clinics (GUM), community contraception and sexual health clinics (provided by Lewisham and Greenwich NHS Trust), GPs, pharmacists, voluntary sector organisations and an online laboratory service.

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23. In 2014 a new Lambeth, Southwark and Lewisham Sexual Health strategy (see appendix 2) was developed, following extensive stakeholder consultation and an updated public health needs assessment.

24. Lewisham had an increase in the teenage pregnancy in 2012 compared to the previous year. This was the worst rate in London and made it one of the few boroughs nationally not to see a sustained decrease in rates. Chlamydia screening rates have remained high (4th highest detection rate in London). Late diagnosis of HIV remains a problem in Lewisham with 47% of all diagnoses made "late" as defined in the public health outcomes indicators. Lewisham has the 3rd highest rate of repeat abortion in under 25 year olds in London with 36.9% of all abortions in this age group being repeats.

25. Lewisham services see around 30,000 people a year, and a further 8,000 patients choose to access services outside of the borough. Demand for sexual health services has been increasing across London, with many clinics often having to close early to manage demand for services.

26. Lewisham's growing "young" population will further increase the demand for sexual health services. Currently around 44% of diagnosed STIs are in the under 25s. A critical challenge for the future will be to better support individuals to self manage their sexual health through prevention of poor sexual health and improving access to services by delivering care in alternative settings such as pharmacies, GP practices and online screening and using longer acting contraception methods which require fewer visits to clinics. There is also a challenge to meet the needs of those who may have difficulty accessing services due to cultural or language barriers, a lack of awareness about sexual health more broadly and available services. These are addressed in the LSL Sexual Strategy and will form the basis of the implementation plan and future commissioning intentions.

<u>Tobacco control and smoking cessation services</u>

27. Key elements of the Lewisham Smokefree Future Delivery plan are:

- Preventing the uptake of smoking among young people through a peer education programme in schools with pupils from Year 8 and a targeted approach to reducing the supply of illegal and illicit tobacco.

- Motivating and assisting smokers to quit through commissioning a Stop Smoking Service (people trying to stop smoking are 4 times more likely to succeed with treatment which combines behavioural support and medication than if they 'go it alone'). This service currently costs £670,000, includes: targeting smokers most at risk from smoking for intensive and specialist support to stop (including one-to one and group support) ; recruiting smokers proactively into

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the service; managing service level agreements with GP practices and pharmacies to provide services in primary care; training all stop smoking advisors to provide evidence-based interventions.

- Promoting smoke free environments, including homes and cars.

28. A dedicated enforcement post, with the support of a sniffer dog, has enabled increased focus on illegal and underage sales and large quantities of illegal tobacco seized, including the biggest UK local authority seizure.

29. More than 2000 young people aged 12 to 13 were reached through a Tobacco Control Peer Education Programme to prevent the uptake of smoking by young people and 61 pupils (selected by their peers) trained as peer educators.

30. The number of smoking quitters (1712) in 2013/14 was lower than previous years and not meeting the target of 1800, but the rate per 100,000 is higher than London and England. 461 smokers quit with the Stop Smoking Service from April to September 2014.

31. The Stop Smoking Service is very successful in reaching heavily addicted smokers such as pregnant women and people with mental health problems, with an increasing number of smokers quitting from more deprived wards.

32. A key achievement has been embedding very brief smoking interventions and the automatic referral of smokers to the Stop Smoking Service in all Lewisham Hospital services.

33. The biggest challenge is to ensure that, as part of the integration of health and social care and the transformation of community based care through the development of new neighbourhood teams, supporting people to quit smoking becomes everybody's business as part of 'Every Contact Counts'.

Alcohol and drug misuse services

34. The council commissions a large integrated service which delivers interventions for adults aged 18 and over. It provides support, treatment and rehabilitation programmes that promote recovery and encourage individuals to maintain their recovery through engagement in positive activities such as employment and training.

35. The service provides: prescriptions for substitute medications such as Methadone; community alcohol detoxification; and manages the interface with all health services including GPs, hospitals, and pharmacies, and with the Criminal Justice System; interventions for young people aged 10-21, with much of the work carried out in satellite

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sites around the borough including schools, colleges, youth centres, housing providers and clients' homes.

36. The Director of Public Health has recently become a Responsible Authority for health, to help the licensing authority exercise its functions regarding licensing policy.

37. Lewisham's Drug and Alcohol services performed well in 2013/14 and continue to do so this year. A benchmarking exercise for the first three quarters of 2013/14 showed the services out performed comparator boroughs. Lewisham had the highest percentage of successful completions across all drug types. Successful completion means that clients have left treatment free from their drug(s) of dependency and have no requirement for any substitute prescribing. This is the main PHE performance indicator for treatment services. These results have been achieved despite lower investment per head.

38. Following the benchmarking period the services have continued to perform well with the latest performance figures showing that Lewisham continues to see growth in opiate users who successfully complete treatment and do not represent (9.9%) ahead of the national average (7.7%). Rates for non-opiate users have fallen slightly (47.8%), but remain ahead of national average (38.4%) and within top quartile.

39. There has been a rise in the number of dependent drinkers successfully completing treatment since 2013/14 (40.8%), ahead of the national average (39.53%).

40. More than 250 front line workers from a were trained to deliver identification and brief advice on alcohol and 8,152 people have been screened for alcohol risk through the health check programme, with 1,032 identified with excess alcohol intake.

41. Despite a generally positive picture drug and alcohol services continue to face challenges. An in-depth services review in 2014 highlighted a number of groups that do not access/benefit from services as well as others. These include individuals who:

- have an alcohol problem
- have a long term opiate addiction
- do not wish to enter a large treatment service and would prefer to access service in primary care or other community settings
- are under 25
- are in contact the criminal justice system

42. It is also expected that demand for alcohol services will rise over the coming years as awareness regarding the harms caused by drinking increases and there is likely to be a need for greater focus of so called 'legal highs' that are increasingly used by young people.

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43. The implementation of a new model of provision as part of a re-commissioning exercise will require careful management if the anticipated improvements in performance are to be achieved.

Public health services for children and young people aged 5-19

44. The Promoting Healthy Weight in Children and Families strategy encompasses prevention and treatment of overweight and obesity for children and families based on the triangle of need. To deliver the strategy there are two action plans:

- Universal Action Plans (promotion of healthy weight for all children) which are multi-component, involve partnership working and takes a life-course approach.

- A Delivery Plan for the local obesity care pathway for children and young people (targeted and specialist services).

45. The London Borough of Lewisham and its partners were successful in bidding for £500,000 from the Big Lottery Fund to improve emotional wellbeing and increase resilience in 10-14 year olds as part of the Head Start programme.

46. The existing School Aged Nursing Service (SANS) in Lewisham is well-established, fully recruited and has a high level of advanced skills; many of the nurses are qualified Public Health Practitioners and hold additional qualifications in sexual and reproductive health allowing them to deliver on the following priorities:

- Developing school based Healthy Child teams
- Developing early intervention support for emotional health and well-being.
- Support for children and young people with increased vulnerability around healthy lifestyle and ensuring access to health checks immunisations etc.
- Increasing access to support (in school)
- Increasing access to support (out of school)

47. Performance in tackling childhood obesity is described elsewhere (see National Child Measurement Programme above and Interventions to tackle obesity such as community lifestyle and weight management services below).

48. Lewisham SANS has faced significant challenges since April 2013, particularly in relation to an increasing workload relating to Safeguarding and because of the introduction of a major new immunisation programme in schools.

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49. The biggest challenge in addressing the public health needs of this age group is to develop a more holistic 'menu', of quality assured and evidence based public health interventions across a range of health issues including sex and relationships, healthy weight, physical activity, smoking and mental health that can be commissioned on behalf of schools and purchased by schools.

Interventions to tackle obesity such as community lifestyle and weight management services

50. An improved range of weight management programmes and support is now available for both children and adults. These include Weight Watchers, Shape-Up and dietetic support for adults and New Mum New You, Mend and Boost programmes for families. All services are accessible in a variety of venues across the borough.

51. Since the services have become fully operational 840 families have accessed the services. Nearly 300 families have completed the programmes, with positive outcomes on weight, physical activity and dietary behaviours. All services continue to offer on-going support for families for 12 months to help sustain lifestyle changes.

52. In 2013 there were over 1800 referrals to the adult weight management services with the majority of those completing the programmes achieving a weight loss, with 50% achieving at least a 5% weight loss.

53. The same challenges described under the National Child Measurement Programme above - namely to reduce their dietary intake of sugars, energy rich and processed foods in the face of an obesogenic environment that normalises and encourages excessive consumption - applies equally to all adults.

Locally-led nutrition initiatives

54. Increasing breastfeeding rates and the proportion exclusively breastfeeding at 6-8 weeks is a key priority for Lewisham, working towards achieving UNICEF Baby Friendly accreditation.

55. Universal Vitamin D provision for women and infants was launched in partnership with the Clinical Commissioning Group in November 2013 to help prevent the growing number of cases of vitamin D deficiency and rickets in children. The scheme enables all pregnant and postnatal women (for 12 months) and children under 4 to be eligible for Healthy Start vitamins. The vitamins are now easily accessible with over 60 distribution points including 46 community pharmacies, health centres and children’s centres.

56. Since November 2013, a borough-wide cooking & eating programme, *Easy Quick & Tasty* (a 5 week cookery club) has been successfully running at different venues across Lewisham (total of 22 cookery clubs

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to date), providing healthy eating recipes and knowledge when cooking on a budget for targeted families / individuals on low income and /or with poor cooking skills.

57. Lewisham recently adopted a Planning Policy on hot food take-away shops to prevent the establishment of new hot food takeaway shops, as part of the Development Management Local Plan. Lewisham is one of the local authorities with the most hot food take-aways per head of population (13th).

58. The stage two UNICEF Baby Friendly community award was achieved in February 2014 and the maternity award in August 2014. Both services are working towards the stage 3 assessment, planned for July 2015, achieving this will result in full accreditation.

59. Since the launch of the vitamin D scheme, over 6,700 bottles of women's tablets and nearly 11,500 bottles of children's drops have been issued. The scheme is reaching 20-30% of eligible women and 50% of infants.

60. The *Easy, Quick & Tasty* initiative has had a high response with over 80% beneficiaries completing the courses and with over 200 individuals taking part. Post course evaluation shows that 77% of participants have reported other changes to their lifestyle apart from diet as a result of coming to cookery clubs. Some participants have successfully completed accredited training and some are now employed in delivering some of the Easy Quick & Tasty cookery clubs.

61. The Planning Inspector, at a recent examination of the Lewisham Development Local Plan, found the policy 'sound'. The GLA wish to include this as a Case Study in their forthcoming Social Infrastructure Supplementary Planning Guidance for the London Plan.

62. The most significant challenges are in finding ways to deliver locally-led nutrition initiatives such as the baby friendly and the community cooking programmes to scale, so that they achieve a population level impact. The new planning policy will not reduce the number of existing unhealthy fast food take aways, and the challenge will be to encourage these existing outlets to adopt healthier catering commitments, and to encourage new, healthier retailers to enter the market.

<u>Increasing levels of physical activity in the local population</u>

63. Public Health commissions specific programmes to promote the increase of physical activity including: The Get Moving physical activity programme, part of the NHS Health Check, which provides free and discounted exercise sessions to people who are identified as inactive at their NHS Health Check; A Healthy Walks programme; a Let's Get Moving Physical Activity Pathway training programme; and a road safety/cycling training programme.

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64. The Council also provides free swimming to all residents under 16 and over 60 years of age.

65. Four hundred and twenty people attended the Get Moving activity sessions between October 2013 – March 2014. From April – November 2014 there have been two Get Moving programmes and 274 participants have attended the activity sessions so date.

66. In 2013/14 the total numbers of those aged under 16 who accessed free swimming was 9,487. They made a total of 28,930 visits, an average of three visits per user per year. For the same period there were 2,293 people aged 60 and over who access free swimming. They made a total of 26,068 visits, an average of 11 visits per user per year.

67. In 2013 – 14 2,434 adults participated in regular walks (on average one walk per week). There were 237 new walkers recorded and 87% of those subsequently reported doing more physical activity.

68. In 2013 -14, 152 primary care staff were trained to deliver physical activity brief advice. From April – November 2014 225 staff received the motivational training. This included primary care staff and community groups in North Lewisham and Well London Bellingham.

69. The road safety/cycling training programme is being delivered to 40 schools and has booked 1877 primary school age children in years 5 and 6 to attend the training.

70. The challenge is to increase awareness of the benefits of physical activity and the independent risks of inactivity and the need to address this through incorporating increased physical activity in the daily routine. Promoting physical activity will also need to become everybody's business as part of every contact counts.

<u>Local initiatives to reduce excess deaths as a result of seasonal mortality</u>

71. Lewisham's Warm Homes Healthy People (WHHP) project is now in its 3rd year and continues to provide help to residents vulnerable to the effects of living in cold housing. In 2013/14 & 14/15 has been funded by Public Health, led by the Council's Sustainable Resources Group and delivered in partnership with a range of public, private and community sector organisations. The main focus of the project was to alleviate the negative impacts of cold weather, reduce hospital admissions and help the most vulnerable people in our borough stay warm and well and feel more comfortable in their homes over the coldest months of the year.

72. In 2013/14 495 Warm Homes referrals were received from 30 different organisations working with residents likely to be vulnerable to fuel poverty and cold weather. 437 vulnerable households received a home visit and winter warm pack. 4300 free measures were provided to

vulnerable households to keep warm and save money on their fuel bills. There were 710 onward referrals to other relevant related services. 89 vulnerable households received advice on switching energy tariff identifying savings of up to £17,800 a year1 (combined total). 199 referrals were made to the Warm Homes Discount which represents £25,870 a year benefit for Lewisham residents. 16 vulnerable households received heating improvements and/or insulation, bringing in £10,500 external funding and training was provided for 160 front line professionals on fuel poverty and health awareness.

73. A key challenge will be in implementing 'Every Contact Counts' systematically across the whole system to ensure that front line workers identify people at risk and ensure they are referred to the Warm Homes service.

Public mental health services

74. Public Mental Health is defined by the Chief Medical Officer as describing the 3 overlapping areas of mental health promotion, mental illness prevention and treatment and rehabilitation.

75. The Public Mental Health budget is very small, and generally has funded mental health awareness training and courses for front line workers in any public facing public or voluntary sector organisation to support them to manage clients who present with symptoms of mental illness (Mental Health First Aid).

76. Historically this budget has also funded projects and voluntary sector organisations with mental health outcomes. Most recently, some of this funding has been used to provide match funding for the Big Lottery "HeadStart" programme which is designed to improve resilience and emotional wellbeing in 10-14 year olds.

77. The main public health outcome measure of public mental health is self reported wellbeing. Lewisham ranks 31 of 33 London Boroughs for self reported wellbeing. The proportion of people with a low satisfaction with their life score increased from 7.2% to 8.7% between 2011/12 and 2012/13. When compared to other boroughs with a similar level of deprivation overall Lewisham has a worse outcome for this indicator.

78. Demand for mental illness services is high. Supporting people with mental illness to recover and access employment and secure housing is an important part of recovery but challenging in the current economic climate. The welfare reforms implemented as part of the austerity measures in response to the economic crisis are thought to have had a detrimental effect on mental health.

79. Lewisham has got through to the second stage of the Big Lottery's HeadStart programme. It is anticipated that this programme will build

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resilience in this population, but continuation and expansion of this will be dependent on being successful in the final stage of the process in 2015.

Behavioural and lifestyle campaigns to prevent cancer and long-term conditions

80. Public health has provided leadership and match funding to the Bellingham Well London Programme Phase 2, funded by the Big Lottery. It has effectively involved the community and enabled the delivery of lifestyle activities aimed at promoting healthy eating, physical activity and mental wellbeing.

81. The North Lewisham Health Improvement Programme (NLHIP) is a five-year plan that developed as part of the Health Inequalities Strategy for Lewisham, covering New Cross and Evelyn wards in the north of the Borough. The scope of the programme is wide-ranging and includes many inter-related projects and initiatives, such as community health projects; primary care interventions; health promotion initiatives; participatory budgeting and small grants to community groups; social marketing; needs assessments and health impact assessments.

82. The public health department delivers and commissions a programme of health improvement training to enhance the skills of those in Lewisham who have health promotion roles, whether paid or unpaid. The programme delivers across a range of topics selected to support delivery of the Health & Wellbeing Strategy.

83. Approximately 3,160 people participated in Bellingham Well London healthy lifestyle activities from April 2013 to April 2014. An external evaluation shows a 16% increase in respondents reporting that they do enough physical activity to keep fit, 13% reporting they feel very or quite happy with life in general, 14% increase in those that feel their eating habits are very or quite healthy. Bellingham has been cited by University of East London as one of the Well London areas that has demonstrated outstanding performance and has currently been named as one of three candidate areas for Phase 3 Well London scheduled to start in mid-2015.

84. The North Lewisham Health Improvement Programme has funded 53 community groups and 656 people accessed community health activities organised as a result of the Participatory Funding. 330 reported improved mental wellbeing, 129 reported eating more than 3 portions of fruit a day following attendance of healthy eating promotion activities compared with 175 participants reported eating less than 3 portions of fruit a day at the start and 219 participants reported that they had increased their levels of physical activity. In addition over 40 volunteers have been engaged. More than 400 people recently attended a community awareness event at Deptford Lounge including community lifestyle activities.

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85. 407 front line workers across partner organisations have attended health improvement training courses since October 2013.

86. The main challenge is to ensure that these campaigns are successfully embedded within the new emerging neighbourhood teams and re-commissioning of the voluntary sector aligned to health and social care integration.

Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes

87. Over the past two years, the public health team has worked with the CCG, Lewisham & Greenwich Healthcare NHS Trust, NHS England, PHE and with local general practitioners, to increase the uptake of childhood and flu immunisations in Lewisham, and to maximise the uptake of the national cancer screening programmes for example for breast, cervical and bowel cancer screening. The public health team has also worked closely with the school nursing service to encourage schools to support the Human Papilloma Virus immunisation Programme to protect girls against cervical cancer.

88. Despite continuing support at local level, and some improvement in uptake of vaccines as a result, significant challenges remain. Although significant improvement in the uptake of the first dose of MMR has been achieved (Lewisham's performance increased by ten percentage points and the borough was identified as the most improved in London), this has been difficult to sustain. In addition, uptake of the second dose of MMR and the uptake of preschool booster remain at unacceptably low levels and amongst the worst in London.

89. After two very successful years in increasing and maintaining high levels of uptake of Human Papilloma Virus vaccine in schoolgirls, uptake of this vaccine has fallen backwards in the most recent school year; despite this fall, Lewisham remains in the top third of London Boroughs in relation to this vaccine.

90. Uptake of Flu vaccine increased in 2013/2104, and in some subgroups, uptake in Lewisham was amongst the best in SE London.

91. There has been little change in the coverage of breast screening in Lewisham over the past six years despite a range of initiatives to promote uptake. To support an increase in coverage of breast screening NHS England have negotiated with the screening provider the following: when a woman does not attend their appointment they will be sent another invitation with a timed appointment, reminder letters are sent to women and they will be sent a text of their appointment time.

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92. The latest data for bowel screening uptake is for May 2014, uptake was 43.5% below that of the national target of 60%. To support an increase in uptake in bowel cancer screening the Health Promotion Specialist based at the screening centre held a range of promotion sessions in the community and attended the Lewisham GP Neighbourhood Forums to inform and promote bowel screening.

93. The coverage of the cervical screening programme in Lewisham improved in 2012-13, although Lewisham does not meet the national target of 80% coverage.

94. With the transfer of immunisation and screening responsibilities to NHS England, the challenge is to ensure effective partnership working and performance management, particularly in primary care where performance is variable, and to support the development of new co-commissioning arrangements between the CCG, NHS England and the council.

<u>Local authority role in dealing with health protection incidents, outbreaks and emergencies</u>

95. Local authorities have a new health protection duty to provide information and advice to certain persons and bodies, with a view to promoting the preparation of appropriate health protection arrangements. In practice this means that the DPH must ensure that NHS England (London) and PHE (London) have appropriate plans in place. NHS England will provide the assurance that NHS organisations have appropriate emergency plans in place. The assurance will be through the London Health Resilience Partnership. A Health Protection Committee, chaired by the DPH, reports to the Borough Resilience Forum and to the Health & Wellbeing Board.

96. Incidents and outbreaks are reported to or detected, and managed by the Health Protection Teams in Public Health England.

97. The Council's public health function includes an infection control nurse who: facilitates Health Protection Committee meetings including the production of an annual health protection report for the Health & Wellbeing Board; promotes good antibiotic prescribing and infection control in primary care as part of the department's support to the CCG; monitors MRSA bacteraemia and C. Difficile cases and investigates those that are community acquired, again as part of the support to the CCG.

98. Public Health has provided a lead role in ensuring that accurate and timely advice on Ebola has been communicated to all relevant partners in the borough, including GPs, schools and the Police.

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99. Whilst health protection is an issue relevant to all working and living in the borough of Lewisham, issues such as TB and sexually transmitted infections disproportionately affect some local minority groups and higher rates of these infections exist in areas of higher deprivation.

100. Public Anxiety about Ebola has abated, but efforts to address such anxiety are likely to be necessary for some time. The rising incidence of community acquired C. Difficile infections is a challenge, as is the poor air quality in Lewisham.

Public health advice and support to clinical commissioners

101. Public Health has worked in partnership with Lewisham CCG and trained seventy pharmacy counter assistants as part of the Healthy Living Pharmacy initiative. A total of 70 pharmacy staff across Lewisham have now qualified as healthy living champions and are able to assist the people of Lewisham with stopping smoking, accessing vitamin D and treatment for minor illness helping to relieve pressure on other local services.

102. Since March 2013 Public Health worked in partnership with NHS Lewisham Clinical Commissioning Group and Diabetes UK and recruited and trained 15 volunteers from the community to be Diabetes Community Champions. Their role is to raise awareness of diabetes in their communities and help prevent people developing the condition. To date the Diabetes Community Champions have organised a total of 16 diabetes awareness events in their communities. A diabetes JSNA has also been completed.

103. Through a bid led by a public health consultant, the CCG secured funding from Macmillan to fund a two year "An End of Life Transformation Programme" and has appointed a GP lead for cancer.

104. Neighbourhood Profiles of health need have been produced for the CCG Members Forum and will be used to inform the development of neighbourhood based primary care networks and integrated health and social care neighbourhood teams. In addition a borough wide needs analysis has informed the development of the CCG Commissioning Strategy 2013-2018.

105. The public health team also undertook an audit of childhood asthma admissions in Lewisham and made a number of recommendations for improvement in the pathway for the management of asthma in primary and secondary care.

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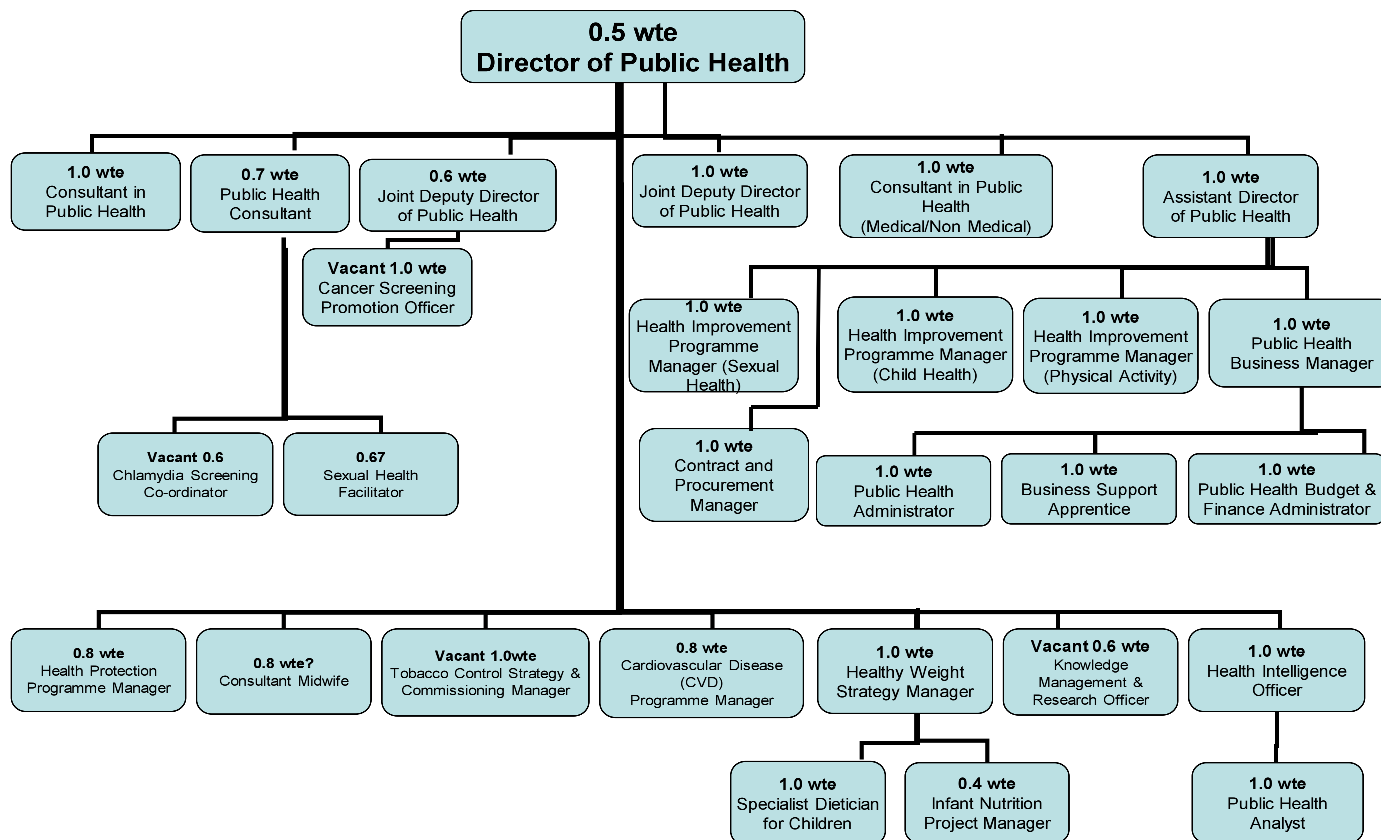
Structure Chart **Appendix B**

Appendix 1: Public Health Organisational Structure – October 2014



Public Health Working Group					
Title	Additional Information requested by the Working Group			**Item No.**	3
Class	Part 1	**Date**	13 January 2015		

This information has not been available for 5 clear working days before the meeting and the Chair is asked to accept it as an urgent item. The information was not available for despatch on Tuesday 6 January due to additional input being required prior to publication. The report cannot wait until the next meeting due to the Council's savings programme timeframes.

1.1 At its meeting on 15 December 2014, the working group requested the following information:

(1) Detailed information on the public health budget (including the legal basis); its constraints and flexibilities in terms of funding positive public health outcomes; and the requirement to submit an annual statement to Public Health England demonstrating that public health outcomes have been met.
(2) A copy of the latest annual statement and annual public health report.
(3) Finance information quantifying the headroom and tolerances within the public health budget to ensure that mandatory health protection activity in response to emergencies can always be carried out.
(4) Information on actual spend to date/outturns in terms of the public health budget.
(5) Information on the level of funding provided by Lewisham to the advice sector compared to other London boroughs.
(6) Information on how people will get advice, including specialist debt advice, from April 2015.
(7) Results of the consultation with the Lewisham Clinical Commissioning Group on the public health savings proposals.

1.2 A copy of the latest annual statement and annual public health report (2) has been provided to the Working Group by email as background information. Information on the level of funding provided by Lewisham to the advice sector compared to other London boroughs (5); and information on how people will get advice, including specialist debt advice, from April 2015 (6) will be provided to the Working Group by email as background information.

1.3 The remaining information can be found overleaf.

For more information on this report please contact Charlotte Dale, Interim Overview and Scrutiny Manger, on 020 8314 9534.

Results of the consultation with the Clinical Commissioning Group

HEALTHIER COMMUNITIES SELECT COMMITTEE			
Report Title	**Public Health Savings Response to Consultation with Lewisham CCG, with commentary by the Director of Public Health**		
Key Decision	Yes	Item No.	
Ward	All		
Contributors	Executive Director for Community Services, Director of Public Health		
Class	Part 1	Date:	14 January 2015

1. Purpose

1.1 The purpose of this report is to update the Healthier Communities Select Committee on the response to the consultation with key partners on the public health savings proposals that will need to be agreed by the Mayor & Cabinet in order to set the budget in February 2015 for the 2015/2016 financial year.

2. Recommendation/s

Members of the Healthier Communities Select Committee are recommended to:

2.1 Note and comment on the response to the consultation process by Lewisham CCG, and on the commentary by the Director of Public Health;

3. Policy Context

3.1 Under the Health and Social Care Act, the majority of public health responsibilities and functions transferred to the Council on 1 April 2013. This included all public health staff and most contracts for commissioned public health functions.

4. Background

4.1 Lewisham Council has to make savings of £85m over the next 3 years. Following a review of all transferred public health staff and all contracts for commissioned functions, £1.5M of initial savings were identified which could be made with minimal impact through more efficient use of resources and an uplift to the public health grant. A further £1.15M has been identified which will require a more substantial reconfiguration of public health services. This consultation relates to both of these savings proposals.

4.2 The public health budget is ring fenced in 2015/16. Where savings have been identified from the current public health budget these will be used to support public health outcomes in other areas of the council. The guiding principle for the re-investment will be to support areas where reductions in council spend will have an adverse public health outcome.

5. Consultation Process

5.1 This consultation was with Lewisham CCG and was not a public consultation.

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5.2 The savings proposals have been considered by: The Children & Young People's Select Committee, The Healthier Communities Select Committee, and the Public Accounts Committee during a pre-consultation phase in autumn 2014.

5.3 The savings proposals have also been discussed at partnership meetings with the CCG and Lewisham and Greenwich Trust.

5.4 The CCG received the consultation document by email and was given 2 weeks to respond on the Public Health savings proposals.

5.5 The responses to the consultation are being reported here to the Healthier Communities Select Committee which will oversee the consultation process, and to the Health & Wellbeing Board. Both the response to the consultation and subsequent responses by the Healthier Communities Select Committee and the Health & Wellbeing Board will then be considered by Mayor & Cabinet in February 2015.

6. Lewisham CCG Response with Commentary by the Director of Public Health

6.1 Lewisham CCG responded to the consultation on the Public Health savings proposals on 29th December 2014 (see Appendix 1). In doing so, the CCG considered the impact of the proposals on its own plans and against a number of overarching criteria:

- Commissioning that is population-based
- Equitable access
- Tackling health inequalities
- The aims or goals of our joint commissioning intentions
- Stronger communities for adult integrated care and for children and young people

6.2 The CCG highlighted a number of general issues and then commented specifically on each public health programme in relation to the savings proposals. Both the general and specific responses are reported below, with a commentary by the Director of Public Health on each response.

6.3 Highlighted Issues

6.3.1 The CCG responded - “Given the importance of health improvement and prevention, and its prominence in our local Health and Wellbeing Strategy and nationally in the NHS ‘Five Year Forward View’, we are concerned that money is being taken away from the current public health budget priorities without a comprehensive assessment of the implications on health outcomes and inequalities.”

6.3.2 DPH commentary – the proposed disinvestments in current public health initiatives were prioritised for disinvestment on the basis that these initiatives would result in the least loss of public health benefit per pound spent when compared across all current public health investments. In this way the likelihood that re-investment in other areas of current council spend will result in equal or greater public health outcome and reduction in inequalities is maximised; however, it is acknowledged that a full and comprehensive assessment of the implications of this re-allocation of funds cannot be undertaken until the areas for investment have been identified.

6.3.3 The CCG responded – “In reviewing the proposals our response on their impact is necessarily restricted by the absence of details from the council of how monies will be reinvested.”

6.3.4 DPH commentary – this is covered in the above DPH response.

6.3.5 The CCG responded – “Overall we would expect that the savings proposals are accompanied by redesign of services so that they will achieve positive health impacts, and that any changes are monitored accordingly to ensure that the expected benefits are realised. “

6.3.6 DPH commentary – Much of the mitigation of potential negative impacts on public health outcomes arising from the proposed savings is predicated on successful re-design and re-configuration of commissioned services. The council public health department intends to monitor closely the changes and fully expects to be asked to provide

regular update reports to the relevant scrutiny committees and the Health & Wellbeing Board.

6.3.7 The CCG responded – “The need for voluntary organisations that previously accessed public health grants to be supported to access the council’s mainstream grant programme.”

6.3.8 DPH commentary – the council has already ensured that those voluntary organisations that previously accessed public health grants can now access the council’s mainstream grant programme.

6.3.9 The CCG responded – “The criteria that you will use to identify substantial development or variation in service should be made available as soon as possible.”

6.3.10 DPH commentary – the council agrees with this response.

6.3.11 The CCG responded – “Assessments of equalities implications should be carried out and made available at the outset of the savings programme.”

6.3.12 DPH commentary – the council has already undertaken an initial equalities assessment and these are described in the savings proposal; however, as has been acknowledged above a comprehensive assessment can only be carried out once the re-investment plans and the impact of service re-configurations are known.

6.3.13 The CCG responded – “The areas of greatest concern are proposals that have negative impacts on smoking reduction and health inequalities.”

6.3.14 DPH commentary – the DPH shares these concerns. Smoking is still the single largest cause of health inequalities within Lewisham and between Lewisham and the England average for premature mortality.The proposals as they stand look to re-configure how smoking services are organised. They will essentially be integrated into the neighbourhood model of working which should give a more comprehensive use of staff resources and reduce the current level of overhead costs. If however, these proposals were not successfully implemented then consideration would need to be given to re-instating this level of funding. The DPH will be monitoring the progress of these proposals and will be able to provide a further progress report. The illegal tobacco sales work has been supported by public health funding and consideration will need to be given by the new enforcement service as to how this work should be continued. Smoking cessation will continue to be a priority for public health and new funding sources will be pursued to test new initiatives.

6.3.15 Lewisham's Community Outreach NHS Checks team, commissioned from the Lewisham & Greenwich Trust Community Health Improvement Service, won the Heart UK Team of the Year award in 2014. It is envisaged that these services will be reconfigured with less overheads as part of the neighbourhood working but again this needs to be monitored.

6.3.16 Area based health improvement programmes have been shown locally to improve health outcomes and have been identified as an example of best practice by the GLA Well London Programme. The council has successfully leveraged extra resources, including from the GLA, to extend the work that has been shown to be effective in Bellingham and North Lewisham to Lewisham Central and Downham.

6.4 Service specific responses

6.4.1 Sexual Health: the CCG responded – "As the lead commissioner the CCG will advise the council as its agent in the proposed contract renegotiation with LGT. Public Health will be fully involved in the appropriate contracting forum. Further detail is required about how sexual health services will be delivered through a neighbourhood model. The CCG would seek assurance that the health improvement package will be taken up by schools if the SRE funding is reduced. Where some services have been provided on a limited pilot basis we support the move to enable a wider population coverage. Where incentive funding is withdrawn from GP practices we need to take into account the total impact from all the proposed changes. The CCG Medicines Management team can provide professional advice in the further development of pharmacy needs assessment ."

6.4.2 DPH commentary – the council acknowledges and appreciates the CCG's role as lead commissioner with LGT, and its desire to involve public health fully in the contracting process. The CCG will be kept fully appraised of sexual health service re-configuration within the neighbourhood model as plans emerge. The council would welcome the CCG's help and support to influence and persuade schools of the benefits of taking up the health improvement packages, in particular SRE. The council would also welcome the CCG's support in jointly assessing the impact of any funding withdrawal from GP practices, and the continued support of the Medicines Management Team in the pharmacy needs assessment.

6.4.3 NHS Health Checks: the CCG responded – "We agree with the highlighted risks concerning the pre-diabetes intervention. This may have an impact on the CCG's plans for long-term conditions, for risk stratification and around variation in primary care. The removal of the Health Checks facilitator post and reduction of GP advisor time may mean that the focus is on maintenance rather than the continuing development of the programme We support the continuing integration of the pharmacy into the neighbourhood resources to deliver the health

checks programme. Further detail is required about how health checks will be delivered through a neighbourhood model to achieve efficiency and effectiveness."

6.4.4 DPH commentary – the council would welcome the CCG's financial support to invest in diabetes prevention alongside public health investment in the NHS Health Checks programme in line with NHS England's recently published five year forward view operational plan for 2015-16. The CCG will be kept fully appraised of the NHS Health Checks service re-configuration within the neighbourhood model as plans emerge.

6.4.5 Health Protection: the CCG responded – "We acknowledge that this service has not been proven to be a cost effective intervention. "

6.4.6 DPH commentary – the council welcomes the CCG's acknowledgement.

6.4.7 Public Health Advice to CCG: the CCG responded – "We will adopt responsibility for the Diabetes and cancer GP champion posts from April 2015."

6.4.8 DPH commentary – the council welcomes the CCG's adoption of this responsibility.

6.4.9 Obesity / Physical Activity: the CCG responded – "This area is a Health & Wellbeing Board priority. As with the reduced SRE funding, we would seek assurance that the health improvement package will be taken up by schools, and where some services have been provided on a limited pilot basis we support the move to enable a wider population coverage. The reduction in funding for the community nutritionist and withdrawal of clinical support may mean that the focus is on maintenance rather than the continuing development of the programme. This is an area that should be part of a whole programme approach to neighbourhood development. "

6.4.10 DPH commentary – please see 6.3.6 and 6.4.2 above.

6.4.11 Dental Public Health: the CCG responded – "This may represent a missed developmental opportunity to improve dental health particularly for children and young people."

6.4.12 DPH commentary – the DPH shares this concern, but the reality is that this budget has not been spent for several years prior to the transfer of public health to the local authority, and there has been no expenditure in 2013-14 or 2014-15. The number of decayed, missing and filled teeth at the age of five is one of the few measures of children's health on which Lewisham has done consistently well. The council will continue to monitor this performance indicator which is based on a national survey.

6.4.13 Mental Health: the CCG responded – "We recognise the potential benefits of pooling resources with other neighbourhoods but need to highlight the potential difficulties inherent in working across multiple organisations and sectors that may make this difficult to achieve."

6.4.14 DPH commentary – the council also recognises the potential difficulties and challenges of working with other boroughs and organisations but also recognises the need to overcome these challenges.

6.4.15 Health Improvement Training: the CCG responded – "This area has a potential impact on achievement of the 'Every Contact Counts' strategy. This will need to be mitigated further through additional development via HESL resourcing, development of neighbourhood teams, and SEL Workforce Supporting Strategy."

6.4.16 DPH commentary – the council welcomes these suggestions for further mitigation of potential impact on achieving 'Every Contact Counts' and would welcome the CCG's support in leveraging resources from HESL and from the SEL workforce supporting strategy.

6.4.17 Health Inequalities: the CCG responded – "We support the neighbourhood model as an integral part of the integration programme. But investment and implementation requirements should be defined that support the development of the four hub approach, in particular how they will address health inequalities where services are decommissioned, such as the money advice service which can be an important enabling factor in supporting health improvement. We support changes to a whole neighbourhood approach away from specific groups, and building community capacity to tackle inequalities; again, this may require further resources to ensure continuing support to vulnerable population groups. Where there are proposed changes to the LGT contract these must be assessed for their impact and likely success for linking to the neighbourhood model. We recognise the mitigation in respect of the 'warm homes' funding but seek assurance that this will be strong enough."

6.4.18 DPH commentary – please see 6.3.6, 6.3.8, 6.3.15, and 6.3.16 above.

6.4.19 Smoking & Tobacco Control: the CCG responded – "Both the local and SEL JSNAs identify the impact of smoking on mortality rates, inequalities and QALYs. The CCG has identified smoking quitters as one of its local quality premium outcomes. This is therefore an area of considerable importance for local population health and the CCG. As with other aspects of the LGT contract, the CCG will advise the council as its lead commissioner in the proposed contract renegotiation. Public Health will be fully involved in the appropriate contracting forum. Further detail is required about how efficiencies in the stop smoking service will be achieved without reducing its effectiveness."

6.4.20 DPH commentary – please see 6.3.14 above.

6.4.21 Maternal & Child Health: the CCG responded – "Recognising that change to the sessional commitments of the child death liaison nurse will not prevent its delivery of the main purpose of the role, there may be an impact on support for bereaved families which may need to be provided or commissioned differently. We have significant concerns about the reduction in support to breastfeeding cafés and peer support and the possible impact on our UNICEF status. This is an identified priority for the CCG and for SEL. While the peer support proposal is actually a reduction in the supporting infrastructure so should not have an impact, the support for the cafés could. But if this can be maintained for a further 6 months and alternative can be put in place this may avoid a negative impact."

6.4.22 DPH commentary – the council welcomes the CCG's view that support for bereaved families may need to be provided or commissioned differently. The DPH also shares the CCG's concerns that disinvestment in breastfeeding peer support and breast feeding cafes may jeopardise Lewisham's final stage submission to achieve the highly prestigious UNICEF baby friendly status, after successfully completing stages one and two. The council may wish to consider extending funding for these initiatives for at least 6 months, but this would mean that the level of anticipated savings would not be achieved in 2015-16.

6.4.23 Department Efficiencies: the CCG responded – "We would seek assurance that any revised structures or functions can deliver our agreed memorandum of understanding (MOU) of PH support to the CCG, for instance by freeing up time for PH consultants and intelligence support, and working with us around the commissioning cycle. A clear, agreed work plan will be essential to realise delivery of this service. "

6.4.24 DPH commentary – the council can provide reassurance that any revised structures or functions will be designed to deliver the council's mandatory responsibilities to provide public health support to CCG commissioning. The council has already advertised for a public health intelligence officer at a higher grade and salary than the equivalent NHS grade and salary of the previous post holder. A clear work plan will be agreed with the CCG for 2015-16.

Financial implications

6.1 Failure to meet the health and wellbeing strategic objectives, particularly in relation to child health and wellbeing, obesity in adults and children, and maintaining the health and independence of older people, could result in additional financial burdens being placed upon health and social care services in the short, medium and long term.

7. Legal implications

7.1 There are no legal implications arising from this report.

8. Crime and Disorder Implications

8.1 It is not possible to fully assess the Crime and Disorder Implications without knowing how the proposed savings will be re-invested in public health.

9. Equalities Implications

9.1 It is not possible to fully assess the Equalities Implications without knowing how the proposed savings will be re-invested in public health.

10. Environmental Implications

10.1 It is not possible to fully assess the Environmental Implications without knowing how the proposed savings will be re-invested in public health.

11. Conclusion

11.1 This report describes the response of the CCG to the consultation on the public health savings proposals for the 2015/2016 financial year, together with a commentary on the general and service specific issues identified by the CCG in its response, and sets out the Committee's role in the next stage in the consultation process.

If there are any queries on this report please contact **Dr Danny Ruta**, **Director of Public Health**, 020 8314 ext 49094**.**

The public health budget – Ensuring that mandatory health protection activity in response to emergencies can always be carried out.

The Public Health budget has been set at a level that would cover the normal, ongoing level of mandatory health protection activity. It would not necessarily be sufficient to cover the Council's response to an exceptional event. However, if there were a need to increase spend in this area in response to an emergency this would not prevent the Council making its response. If the additional cost could not be met from within the Community Services budget additional resources would be sought from the reserves held by the council to address such risks.

The public health budget – actual spend to date

Spend to date on public health budgets at 5th January 2015

Cost Centre Level 4 Name	Cost Centre Level 5 Name	Spend to date	2014/15 budget
CHILDREN 5-19 PUBLIC HEALTH PROGRAMMES	CHILDREN 5-19 PUBLIC HEALTH PROGRAMMES	39,071	150,700
CHILDREN 5-19 PUBLIC HEALTH PROGRAMMES Total		39,071	150,700
HEALTH PROTECTION	HEALTH PROTECTION	239,239	419,090
HEALTH PROTECTION Total		239,239	419,090
NHS HEALTH CHECK PROGRAMME	NHS HEALTH CHECK PROGRAMME	212,464	558,200
NHS HEALTH CHECK PROGRAMME Total		212,464	558,200
OBESITY	OBESITY: ADULTS	301,383	297,100
	OBESITY: CHILDREN	277,481	481,100
OBESITY Total		578,864	778,200
OTHER PUBLIC HEALTH SERVICES	OTHER PUBLIC HEALTH SERVICES – ADMIN EXPENSES PLUS SCHOOL NURSING AND PRESCRIBING	1,796,724	2,494,790
	OTHER PUBLIC HEALTH SERVICES (1) – AREA BASED SERVICES INCLUDING COMMUNITY DEVELOPMENT	1,107,788	1,608,750
	OTHER PUBLIC HEALTH SERVICES (2) - NORTH LEWISHAM	86,248	99,000
	OTHER PUBLIC HEALTH SERVICES (3) – HEALTH AND HOUSING	111,508	176,000
OTHER PUBLIC HEALTH SERVICES Total		3,102,268	4,378,540
PHYSICAL ACTIVITY	PHYSICAL ACTIVITY: ADULTS	117,649	170,000
	PHYSICAL ACTIVITY: CHILDREN	20,000	70,000
PHYSICAL ACTIVITY Total		137,649	240,000
PUBLIC HEALTH ADVICE	PUBLIC HEALTH ADVICE	269,103	500,500
PUBLIC HEALTH ADVICE Total		269,103	500,500
SEXUAL HEALTH	SEXUAL HEALTH SERVICES: ADVICE, PREVENTION AND PROMOTION	94,429	480,500
	SEXUAL HEALTH SERVICES: CONTRACEPTION	2,737,171	3,902,470
	SEXUAL HEALTH SERVICES: STI TESTING AND TREATMENT	519,403	2,753,830
SEXUAL HEALTH Total		3,351,003	7,136,800

SMOKING AND TOBACCO	SMOKING AND TOBACCO: STOP SMOKING SERVICES AND INTERVENTIONS	499,304	706,810
	SMOKING AND TOBACCO: WIDER TOBACCO CONTROL	28,732	226,000
SMOKING AND TOBACCO Total		528,035	932,810
Grand Total		8,457,697	15,094,840

DRUG ACTION TEAM	DAAT-ADULTS SUBSTANCE MISUSE SERVICE	2,396,420	3,580,204
	DAAT-ALCOHOL SERVICE	131,560	419,000
	DAAT-YOUNG PERSONS SUBSTANCE MISUSE	275,250	232,000
	DAAT-ADULTS DRUG INTERVENTION PROGRAMME	282,420	369,000
	DAAT-ADULT PLACEMENTS	170,050	292,000
DRUG ACTION TEAM Total		3,255,700	4,892,204

The public health budget – the legal basis and constraints and flexibilities

1. The background to local authorities' responsibilities is set out in the attached note from the House of Commons library[1]. This note sets out the main statutory duties that were conferred on local authorities by the Health and Social Care Act 2012 and includes information of public health funding, how local authorities have been spending their ring-fenced grants and on accounting arrangements.

   Section 1 sets out local authorities' statutory public health responsibilities.

   Section 2 addresses public health funding including the proportion of total funding going to local authorities (some funding was retained by NHS England) and how public health funding is allocated.

   Section 3 related to local authority spending of the ring-fenced grant including conditions for spending the grant .

   Section 4 addresses local authority administration of public health including the roles of the Director of Public Health and the Health and Wellbeing Board.

   Section 5 describes accountability arrangements for local authorities.

2. It is important to note that before the transfer of responsibilities from health with associated funding local authorities were already funding activities that had public health benefits. Total spend eligible for funding from the Public Health Grant was therefore greater than the value of the grant itself.

3. Specific arrangements for the 2014/15 grant are set out in the attached DH circular "Public Health Ring-Fenced Grant Conditions 2014/15[2]"

4. Paragraph 3 on use of the grant states that:

   The public health grant is being provided to give local authorities the funding needed to discharge their public heath responsibilities. It is vital that these funds are used to:

   - Improve significantly 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

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[1] www.parliament.uk/briefing-papers/SN06844.pdf

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/269464/local_authority_circular_dh_2013_3_a.pdf

- Ensure the provision of population healthcare advice.

5. Paragraphs 10 and 11 (Reporting of grant expenditure) state:

   In giving funding for public health to local authorities, it remains important that funds are only spent on activities whose main or primary purpose is to improve the public health of local populations (including restoring or protecting their health where appropriate) and reducing health inequalities.

   Local authorities will need to forecast and report against the sub-categories in the Revenue Account (RA) and Revenue Outturn (RO) returns to Public Health England (PHE) who will review them on behalf of the Department of Health. Given that the RO form is used as a way of monitoring the usage of the grant, it is important that the contacts responsible for this section of financing are content with the figures submitted. Authorities will need to ensure that the figures are verified and in line with the purpose set out in the grant conditions. A list of the reporting categories has been provided at Annex B. Local authority Chief Executives will also need to return a statement confirming that the grant has been used in line with the conditions.

6. Paragraph 23 on the Outcomes Framework states:

   In setting their spending priorities it is important that local authorities are and the need to tackle the wider determinants of health, for example, through addressing the indicators within the Public Health Outcomes Framework, such as violent crime, the successful completion of drug treatment, smoking prevalence and child poverty.

7. The detailed grant conditions state that:

   Subject to paragraph 5, the grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006 ("the 2006 Act").

8. The functions mentioned in that subsection are:

   (a) functions under section 2B, 111 or 249 of, or Schedule 1 to, the 2006 Act

   (b) functions by virtue of section 6C of the 2006 Act

   (c) the Secretary of State's public health functions exercised by local authorities in pursuance of arrangements under section 7A of the 2006 Act

   (d) the functions of a local authority under section 325 of the Criminal Justice Act 2003 (local authority duty to co-operate with the prison service

with a view to improving the exercise of functions in relation to securing and maintaining the health of prisoners)

(e) such other functions relating to public health as may be prescribed under section 73B(2)(e).

Local authorities' public health responsibilities (England)

Standard Note: SN06844
Last updated: 13 March 2014
Author: Sarah Heath
Section Social Policy Section

This note sets out the main statutory duties for public health that were conferred on local authorities by the *Health and Social Care Act 2012*. The note includes information on public health funding; how local authorities have been spending their ring-fenced public health grants; and on accountability arrangements.

Local authorities have, since 1 April 2013, been responsible for improving the health of their local population and for public health services including most sexual health services and services aimed at reducing drug and alcohol misuse. The Secretary of State continues to have overall responsibility for improving health – with national public health functions delegated to Public Health England.

Health is a devolved matter in Scotland, Wales and Northern Ireland although the devolved administrations currently retain substantially the same legislative framework.

In addition to their new public health responsibilities, local authority social services have existing duties to provide welfare services such as residential accommodation for those who are in need of care, because of age, illness or disability, which they cannot otherwise obtain. Primary health needs continue to be met by the NHS and disputes can arise over whether an individual's care should be paid for by the NHS or by the local authority on a means tested basis. The Library note, *NHS Continuing Healthcare in England*, provides information about the division of responsibilities between local authorities and the NHS.

The separate Library note, *Health and Wellbeing Boards (England)*, provides information on HWBs, which were introduced as statutory committees of all upper-tier local authorities under the 2012 Act. These boards are intended to; improve the health and wellbeing of the people in their area; reduce health inequalities; and, promote the integration of services.

This information is provided to Members of Parliament in support of their parliamentary duties and is not intended to address the specific circumstances of any particular individual. It should not be relied upon as being up to date; the law or policies may have changed since it was last updated; and it should not be relied upon as legal or professional advice or as a substitute for it. A suitably qualified professional should be consulted if specific advice or information is required.

This information is provided subject to our general terms and conditions which are available online or may be provided on request in hard copy. Authors are available to discuss the content of this briefing with Members and their staff, but not with the general public.

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1 Local authorities' statutory public health responsibilities

Local authorities' statutory responsibilities for public health services are set out in the *Health and Social Care Act 2012* (subsequently referred to as the '2012 Act'). The Act conferred new duties on local authorities to improve public health. It abolished primary care trusts and transferred much of their responsibility for public health to local authorities from 1 April 2013. From this date local authorities have had a new duty to take such steps as they consider appropriate for improving the health of the people in their areas. Local authorities also inherited responsibility for a range of public health services previously provided by the NHS including most sexual health services[1] and services to address drug or alcohol misuse.

In November 2010 the Government launched a consultation, *Healthy Lives, Healthy People: Our strategy for public health in England*, on the changes to be included in the 2012 Act. A separate consultation on the division of commissioning responsibilities, *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*, included a provisional list of what should be funded by local authorities from the public health budget, and who the principal commissioner for each activity should be.[2]

A factsheet from the Department of Health, *The new public health role of local authorities* gives an overview of the changes. The Library standard note, *The reformed health service, and commissioning arrangements in England*, contains further information about the recent reforms to the health service which came into effect on 1 April 2013.

NHS England will continue commissioning certain public health services such as national screening and immunisation programmes, public healthcare for those in prison and children's public health services from pregnancy to age 5, including health visiting.[3]

The Public Health Outcomes Framework sets out the key indicators the Department of Health expects local authorities to work towards. In addition, since 1 April 2013 a new executive agency, Public Health England (PHE), has been in place to provide evidence, advice and support to local authorities about fulfilling their new public health responsibilities.

PHE was established as an executive agency of the Department of Health to bring together public health specialists from more than 70 organisations, including Health Protection England, into a single public health service. Further information about the role and responsibilities of PHE is available on its website.

The rest of this section sets out the main statutory duties for public health that were conferred on local authorities by the 2012 Act.

1.1 Duty to improve public health

Section 12 of the 2012 Act[4] introduced a new duty for all upper-tier and unitary local authorities in England to take appropriate steps to improve the health of the people who live in their areas. The Secretary of State continues to have overall responsibility for improving health – with national public health functions delegated to PHE.

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1 HIV treatment and care, abortion, vasectomy and sterilisation services will continue to be commissioned by the NHS.

2 Department of Health, *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*, December 2010, See Table A: Public Health Funded Activity.

3 Department of Health, Public health functions to be exercised by NHS England: Variation to the 2013-14 agreement, April 2013

4 under section 2B added to the *NHS Act 2006*

Section 12 of the Act lists some of the steps to improve public health that local authorities and the Secretary of State are able to take, including:

- carrying out research into health improvement, providing information and advice (for example giving information to the public about healthy eating and exercise);
- providing facilities for the prevention or treatment of illness (such as smoking cessation clinics);
- providing financial incentives to encourage individuals to adopt healthier lifestyles (for instance by giving rewards to people for stopping smoking during pregnancy); and,
- providing assistance to help individuals minimise risks to health arising from their accommodation or environment (for example a local authority may wish to improve poor housing where this impacts on health).

Subsection 12(4) of the 2012 Act gives local authorities powers to make grants or lend money to organisations or individuals in order to improve public health; it is for the local authority to determine the appropriate terms of such grants or loans.

A *Public Health Toolkit for local authorities in England* has been produced by the Department of Health, the Local Government Association and PHE. The toolkit is intended as a guide to help local authorities work with local businesses to encourage then to make “simple changes which make it easier for their staff and customers to make the healthy choice” in order to reduce the occurrence of “behaviour-driven health problems”. The guidance includes a national Responsibility Deal which local authorities are encouraged to sign up to and promote to small and medium sized businesses in their area.

1.2 Regulations on the exercise of local authority public health functions

Regulations made under Section 6C of the *NHS Act 2006* require local authorities to take particular steps in exercise of their public health functions, or aspects of the Secretary of State’s public health functions. Part 2 of the *Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013* (SI 2013/351) makes provision for the steps to be taken by local authorities in exercising their public health functions. In particular:

- **Regulation 3** requires local authorities to provide for the weighing and measuring of certain children in their area (including age and school type).
- **Regulations 4 and 5** relate to the duties of local authorities to provide or make arrangements to provide for health checks for eligible people (depending upon age and health status). The regulations specify the type of information to be recorded. Local authorities must also provide information about dementia to older people.
- **Regulation 6** requires local authorities to provide, or make arrangements to secure the provision of open access sexual health services in their area. HIV treatment and care, abortion, vasectomy and sterilisation services will continue to be commissioned by the NHS.
- **Regulation 7** creates a duty on local authorities to provide or make arrangements to secure the provision of a public health advice service, in relation to their powers and duties to commission health services, to any Clinical Commissioning Groups (CCGs)

in their area. The matters covered by the advice service is to be kept under review and should be agreed between local authorities and CCGs.[5]

- **Regulation 8** imposes a duty on local authorities to provide information and advice to certain persons and bodies within their area in order to promote the preparation of, or participation in, health protection arrangements against threats to the health of the local population, including infectious disease, environmental hazards and extreme weather events.

1.3 Charges for local authority public health functions

These regulations also cover the making and recovery of charges in respect the exercise of local authorities' public health functions. Part 3, Regulation 9, provides for a local authority to charge for certain actions in its health improvement duty. The charging regulations mean that when local authorities provide services as part of the comprehensive health service[6] these services must be free at the point of use just as they were when provided by the NHS, except in some limited circumstances set out in legislation.[7]

1.4 Duties of directors of public health

Section 30 of the 2012 Act[8] requires each upper-tier local authority, acting jointly with the Secretary of State, to appoint a director of public health whose role is integral to the new duties for health improvement and health protection.[9] The responsibilities of directors of public health are set out in the Explanatory Notes to the Act, and include:

> a) the new health improvement duties that this Act would place on local authorities;
>
> b) the exercise of any public health functions of the Secretary of State which the Secretary of State requires the local authority to exercise by regulations under section 6C of the NHS Act;
>
> c) any public health activity undertaken by the local authority under arrangements with the Secretary of State;
>
> d) local authority functions in relation to planning for, and responding to, emergencies that present a risk to public health;
>
> e) the local authority role in co-operating with police, probation and prison services in relation to assessing risks of violent or sexual offenders; and,
>
> f) other public health functions that the Secretary of State may specify in regulations (e.g. functions in relation to making representations about the grant of a license to use premises for the supply of alcohol).

See section 4.1 of this note for further information about Directors of Public Health.

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5 Department of Health, *Public Health Advice to CCGs*, 26 June 2012

6 provided for under the 2006 Act.

7 Department of Health, *Guidance for local authority charging on public health activity*, 28 February 2013

8 which inserts new section 73A into the 2006 Act.

9 PCTs were previously required to appoint directors of public health to provide local leadership and co-ordination of public health activity. See Department of Health, *Role of the Director of Public Health in Local Authorities*, 2012

1.5 Duty to have regard to guidance: Public Health Outcomes Framework

Section 31 of the 2012 Act[10] requires local authorities to have regard to guidance from the Secretary of State when exercising their public health functions; in particular this power requires local authorities to have regard to the Department of Health's Public Health Outcomes Framework (PHOF).[11] *A public health outcomes framework for England*[12] sets out the Government's overarching vision for public health, the desired outcomes and the indicators that will be used to measure improvements to and protection of health. *Improving outcomes and supporting transparency*, provides a summary technical specifications of public health indicators.[13]

Section 237 of the 2012 Act also requires local authorities to comply with National Institute for Health and Care Excellence (NICE) recommendations to fund treatments under their public health functions.

1.6 Responsibility for dental services and services for prisoners

Section 29 of the 2012 Act amended the *NHS Act 2006* so as to transfer primary care trusts' existing functions around oral public health to local authorities, such as water fluoridation, and extend to local authorities a duty to help deliver and sustain good health among the prison population.[14]

While local authorities have these new duties to improve the oral health of their populations and public health within prisons, the commissioning of dental services and all non-emergency services for prisoners has been the responsibility of NHS England since 1 April 2013. NHS England is therefore responsible for commissioning all NHS dental services including those carried out in hospitals and high street dental practices and is required to commission services to meet the needs of the local population, for both urgent and routine dental care.

1.7 Responsibility for sexual health services

As this NHS England manual explains, CCGs are responsible for commissioning the promotion of opportunistic testing and treatment of sexually transmitted infections, while local authorities commission testing of sexually transmitted infections, including HIV. Local authorities also commission sexual health advice, prevention and promotion.[15] The Gov.uk website provides further information on how the commissioning of sexual health services is divided between local and national bodies:

Local authorities commission:

- comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception

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[10] which inserts new section 73B into the 2006 Act.

[11] The Explanatory Notes to the 2012 Act state that "the public health outcomes framework sets out the Government's goals for improving and protecting the nation's health and for narrowing health inequalities through improving the health of the poorest, fastest." See section 4.3 of this note for further details of the PHOF.

[12] The purpose and structure of which is explained in this note from the Department of Health: *The Public Health Outcomes Framework 2013 to 2016*

[13] The Department also produced an impact assessment and equalities impact assessment for the framework.

[14] See part 4 of The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 (SI 2012/3094).

[15] NHS England, *NHS England manual*, p53

- sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

CCGs commission:

- most abortion services
- sterilisation
- vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology including any use of contraception for non-contraceptive purposes

NHS England commissions:

- contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for PEPSE)
- promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs
- sexual health elements of prison health services
- sexual assault referral centres
- cervical screening
- specialist fetal medicine services[16]

CCGs are advised to negotiate joint commissioning arrangements with their local authority where they are commissioning related services. See this Commissioning fact sheet (page 1).

National public health functions are delegated by the Secretary of State to PHE which supports commissioning by NHS England[17] of sexual health services at a regional level through 15 local centres and 4 regions (north of England, south of England, Midlands and east of England, and London). NHS England commissions services, generally, where particular conditions affect a small number of patients and are expensive to treat. This NHS England manual provides details of the centrally commissioned specialist services. The Gov.uk website explains that:

> Local authorities commission comprehensive open access sexual health services (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Some specialised services are directly commissioned by clinical commissioning groups (CCGs), and at the national level by NHS England.
>
> [...] Across England there is considerable regional variation in how sexual health services are provided and commissioned. They vary from distinctly separate general practice and community-based contraceptive provision with hospital-based abortion and genito-urinary medicine (GUM) services, to fully integrated sexual health services in the community. The variations occur because of differences in commissioning and contractual models used in local areas.

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[16] Public Health England, *Commissioning regional and local HIV sexual and reproductive health services, [as at 11 March 2014]*

[17] Some services, carried out through the NHS, are commissioned by NHS England on behalf of PHE.

2 Public heath funding

2.1 Proportion of total health funding going to local authorities

Funding for health services comes out of the total budget for the Department of Health (DH) of £110 billion (figures are for 2013-14 unless otherwise indicated). This is divided between NHS England (£95.6 billion) and DH's other agencies and programmes (£15.7 billion).[18]

NHS England's budget (£95.6 billion) is used for delivering its mandate from DH. It is responsible for allocating resources to local health economy commissioners: local authorities and clinical commissioning groups (CCGs). The overall budget for local commissioners for 2013-14 was £65.6 billion with the vast majority, £63.4 billion, allocated to CCGs. The remaining £2.66 billion which goes to local authorities is a ring-fenced grant to be spent on fulfilling their public health obligations. The allocations for each upper-tier and unitary local authority in England for 2013-14 and 2014-15 are available here.[19]

Information about the conditions placed on the use of the ring-fenced grant and the ways in which local authorities have been spending it can be found in section 3 of this note.

Funding for NHS England commissioned public health functions

NHS England has a budget of £25.4 billion (2013-14) from DH for directly commissioning certain services on a national level, covering specialised healthcare, primary care and military and offender services. Of this, £1.8 billion is for NHS England's public health responsibilities on behalf of Public Health England, which broadly comprise immunisation, screening and health visiting.[20]

Integration of services: the pooled health and social care budget

In addition to the £2.66 billion in ring-fenced public health grant from DH, £3.8 billion is coming across from the health service budget to provide adult social care now known as the Better Care Fund.[21] The Chancellor announced in the 2013 Spending Round the creation of a pooled budget for health and social care of £3.8 billion for 2015-16, designed to promote joint working and reduce hospital admissions. In addition £200 million would be made available from the NHS budget in 2014-15[22] for investment in new systems and ways of working by local authorities.[23]

£1.9 billion of the £3.8 billion Fund available in 2015-16 will consist of payment by results funding. Further information on this funding can be found in this *Statement on the health and social care Integration Transformation Fund*, published on 8 August 2013 and on the NHS England Better Care Fund planning website. Chapter three of the Health Select Committee report, *Public Expenditure on Health and Social Care*, published in February 2014, discusses the introduction of the Better Care Fund.[24]

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18 The indicative budget allocations for 2013/14 were: Arm's length bodies (£0.7 billion); Health Education England (£4.9 billion); DH programmes and administrative expenditure (£3.9 billion); Public Health England (£0.5 billion); local authorities (£2.8 billion); service providers: NHS Trusts and Foundation Trusts (£2.9 billion). Department of Health, *Corporate Plan 2013 to 2014*, Updated 2 October 2013

19 Department of Health, *Public health Grants to Local Authorities 2013-14 and 2014-15*, April 2013

20 NHS England, *NHS allocations for 2013/14*, (accessed on 22 November 2013)

21 Originally known as the Integration Transformation Fund.

22 In addition to the £900 million already announced.

23 HM Treasury, *Spending Round*, 26 June 2013

24 Health Select Committee, *Public Expenditure on Health and Social Care*, February 2014, p25ff

One of the aims of transferring public health responsibilities to local authorities was to better integrate health and social care services and other activities that affect health such as housing and maintenance of public spaces. For example, Health and Wellbeing Boards (HWBs), hosted by local authorities, have a duty to encourage integrated working (information about HWBs appears later in this note). The 2012 Act also placed a duty on NHS England and clinical commissioning groups to ensure that organisations work together to improve outcomes for people. Subsequently, clause 3 of the Care Bill if enacted[25] would place a duty on local authorities to "carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services, such as housing". During the consultation on the Bill there were calls to emphasise the provision of adequate housing as a health-related service. The Government set out is changes to the Bill and the reasons for them in *The Care Bill explained,* in which it said:

> This clause is intended to apply broadly across the local authority's functions, and to reflect the partner duty on the NHS to promote integration in the Health and Social Care Act 2012. Whilst we agree with those who said that housing should be included as one example of a 'health-related service', we have not sought further to be prescriptive about how and when local authorities (including housing authorities) should integrate. Instead, we want to encourage local authorities to innovate and make decisions according to the needs the people in their area. [26]

In its consultation response document on the Care Bill, the Government identified greater integration of services as important for local authorities to be able to provide improved services with limited resources.[27]

2.2 How public health funding is allocated

In April 2013 The King's Fund published *Improving the allocation of healthcare resources in England*, which discusses the new arrangements for funding public health. The report observed that:

> The coalition government's reforms affect three big decisions about health resource allocation. First, the Secretary of State for Health will make a new allocation decision: how much should be spent 'on the NHS' overall, and how much 'on public health'. Two further decisions flow from this one: how then to allocate NHS funding and public health funding.
>
> From April 2013, and for the first time since the NHS was established, someone other than the Secretary of State for Health will decide how NHS resources – totalling more than £95 billion in 2013/14 – are allocated. The reforms hand responsibility for this decision to the new national NHS Commissioning Board [now NHS England]. But while the Secretary of State loses the power to make one key decision, he takes on new responsibility for another: how to allocate resources for public health.[28]

The Secretary of State for Health, advised by PHE, is responsible for setting the total budget for public health; allocating that funding between PHE[29] and the local authority ring-fenced grant; and deciding how to allocate the ring-fenced grant between each authority. Asked by

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25 Which was in Committee Stage in the House of Commons on publication of this note.

26 Department of Health, *The Care Bill explained: Including a response to consultation and pre-legislative scrutiny on the Draft Care and Support Bill*, May 2013, p13

27 Department of Health, *The Care Bill explained: Including a response to consultation and pre-legislative scrutiny on the Draft Care and Support Bill*, May 2013, p56

28 The King's Fund, *Improving the allocation of healthcare resources in England*, April 2013, p13

29 PHE would then allocate a portion of its funding to NHS England for it to carry out its public health functions.

the Secretary of State to devise an approach to public health allocations, the Advisory Committee on Resource Allocation (ACRA), recommended in 2012 that the majority of funding should be allocated on the basis of each local authority's 'under-75 years standardised mortality ratio' (SMR). Areas with higher prevalence of early, preventable deaths and other problems would, as a result, receive higher relative funding.[30] The Department accepted this recommendation in principle and, following amendments in response to consultation, issued ring-fenced allocations to local authorities for 2013/14 and 2014/15.[31]

Previously, allocations for local authorities made by primary care trusts (PCTs) out of their overall budget using a formula where need was measured using the 'indices of deprivation'. The use of SMRs rather than deprivation has been criticised for moving funding away from the most deprived areas – see for example: This *Guardian* article on 'Unfair Health Funding'.

The population based formula developed by ACRA for CCG allocations for 2013/14 was subject to similar issues and was rejected in favour of temporarily continuing with the existing PCT formula known as the 'Weighted Allocation Formula'. In response to criticism of ACRAs recommended allocation formula for CCGs NHS England conducted a fundamental review of healthcare resource allocation during 2013.[32] In December 2013 a new formula for funding CCGs was agreed by NHS England for 2014/15 and 2015/16. This Library note on *Clinical commissioning group (CCG) funding*, provides further information.

Multiple funding streams

In light of NHS England's fundamental review of CCG funding The King's Fund urged the Government to also review the funding system for public health.[33] It argued that the new funding arrangements for public health are an obstacle to integration:

> The NHS in England, like its counterparts in other developed countries, is facing two major, interlinked challenges: an increasingly frail older population with complex care needs, and public health problems associated with unhealthy lifestyles. Addressing these challenges requires a more integrated approach to commissioning across public health, health care and social care – something that present and previous governments in the United Kingdom have acknowledged.
>
> However, [...] the reforms create multiple funding streams and dramatically increase the complexity of subsequent commissioning. We are moving away from a system where PCTs, whatever their faults, had population-based budgets that covered all the needs and associated costs for their population, and were held accountable for keeping expenditures in line with their budget.
>
> The new system fragments this into clinical commissioning group budgets for secondary and community care, and the NHS Commissioning Board for primary care and highly specialist services, while public health budgets are split between Public Health England, local authorities and the NHS. This will make it more difficult to commission integrated forms of provision.[34]

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30 ACRA, Public health formula: *summary of recommendations*, 2012

31 Department of Health, *Public health grants to local authorities 2013 to 2014 and 2014 to 2015*, updated 6 January 2014

32 NHS England, *Fundamental review*, 15 August 2013

33 The King's Fund, *Improving the allocation of healthcare resources in England*, April 2013, p13

34 The King's Fund, *Improving the allocation of healthcare resources in England*, April 2013, p15

The report suggested that some of the other reforms to the health system, such as the new role of Health and Wellbeing Boards and aligning CCG and local authority boundaries, might compensate for the new, more fragmented, funding structure. However, it commented that:

> it remains to be seen whether the boards will consider it part of their role to bring these allocations together, and if so, whether they will have the capacity and capability to do so.[35]

3 Local authority spending of the ring-fenced public health grant

3.1 Conditions for spending the grant

Following consultation responses published in March 2011,[36] the Government published *Healthy Lives, Healthy People: Update and way forward*,[37] in which it said that it would place limited conditions on the spending of the ring-fenced public health grant:

> to maximise flexibility we will place only a limited number of conditions on the use of the grant. The core conditions will centre on defining clearly the purpose of the grant, to ensure it is spent on the public health functions for which it has been given, and ensuring a transparent accounting process. We will work with stakeholders to consider if any possible additional conditions might be necessary, although in considering any possible additional conditions we will need to be mindful of the need to maintain local flexibility.[38]

A ring-fenced public health grant of £5.46 billion for 2013-14 and 2014-15[39] was announced on 10 January 2013 to support upper-tier and unitary local authorities in carrying out their new public health functions from April 2013.[40] The local authority grant circular for 2013-2014, published in January 2013, set out the broad conditions that govern the use of the grant. It states that:

> The public health grant is being provided to give local authorities the funding needed to discharge their new public heath responsibilities. It is vital that these funds are used to:
>
> - improve significantly the health and wellbeing of local populations
> - carry out health protection 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.[41]

The Government has said that the ring-fenced grant is expected to be spent in-year but that any under-spend may be carried over into the next financial year. However, the conditions for

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[35] The King's Fund, *Improving the allocation of healthcare resources in England*, April 2013, p16

[36] Department of Health, *Healthy Lives, Healthy People: consultation responses*, March 2011. See Department of Heath, *Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health*, December 2010 and *Healthy Lives, Healthy People: Our strategy for public health in England*.

[37] Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2011

[38] Department of Health, *Healthy Lives, Healthy People: Update and way forward*, July 2011, p11

[39] £2.66 billion for 2013-14 and £2.79 billion for 2014-15.

[40] Details of the public health allocation to individual local authorities for 2013-14 and 2014-15 can be found here: HC 5 November 2013 cc169-70W

[41] Department of Health, *Ring-fenced public health grant circular*, 10 January 2013, p3. An updated Local Authority Circular was published

spending the grant would continue to apply and repeated large under-spends would lead the Department to consider reducing allocations in subsequent years.[42]

Spending on specific public health services

By the end of the first quarter of 2013/2014 (June 2013), of the £2.66 billion allocated to local authorities for public health, £542 million had been spent (20 per cent of the total allocation).[43] At the end of the second quarter (September 2013), £1.18 billion had been spent (44.2 per cent of the total allocation).[44] Quarter three data is due to be published in March 2014.[45]

The Government does not monitor the way in which the ring-fenced grant is spent other than that which is spent on prescribed functions. Annex B of the Local Authority Circular published in December 2013 lists the categories of public health spend against which local authorities must report to the Department.[46] Brandon Lewis, Parliamentary Under-Secretary of State for Communities and Local Government, said:

> The ring-fenced Public Health Grant is transferred from the Department of Health to local authorities and the allocation covers both services mandated through regulation and all other services that local authorities may wish to commission locally. It is left for local authorities to decide what proportion of spending should be devoted to different services.[47]

Annex A of the statistical release, *Local Authority Revenue Expenditure and Financing: 2013-14 Budget, England*,[48] published on 31 July 2013, shows the total amount local authorities estimated they would spend in 2013-14 on public health. See table below: prescribed functions are highlighted in bold.

A significant proportion of the ring-fenced grant is expected to be used to fund sexual health services as well as treatment for alcohol and drug addiction. Local authorities are now responsible for most of these services. See section 1.7 above for details of local authorities' duties relating to sexual health.

Local Authority General Fund Revenue Accounts Budget Estimate 2013-14 for public health (£ thousand)[49]

	Net current expenditure (2012-13)	**Net total cost excluding specific grants (2013-14)**
Sexual health services - **STI testing and treatment**	366,912	367,148
- **Contraception**	155,592	155,756
- Advice, prevention and promotion	114,109	114,158
NHS health check programme	86,219	86,254
Local authority role in health protection	40,757	40,760

42 Department of Health, *Public Heath ring-fenced grant conditions - 2014/15*, 13 December 2013
43 HC 29 November 2013 cc469-70W
44 HC 3 February 2014 cc71-72W
45 HC 3 February 2014 cc71-72W. The following responses to Parliamentary Questions in November 2013 and February 2014 include the total grant allocation to individual local authorities in England and the total spent per authority in the first and second quarters of 2013/14 respectively.
46 Department of Health, Local Authority Circular, 13 December 2013
47 HC 11 September 2013 cc745W
48 DCLG, *Local Authority Revenue Expenditure and Financing: 2013-14 Budget, England*, 31 July 2013, p15
49 Source: DCLG, *Local Authority Revenue Expenditure and Financing: 2013-14 Budget, England*, 31 July 2013, p15. Prescribed functions, spending on which local authorities are required to report to the Department, are highlighted in bold.

National child measurement programme	22,500	22,518
Public health advice	64,539	64,548
Obesity -Adults	68,183	68,211
- Children	28,461	28,466
Physical activity - Adults	31,334	31,362
- Children	10,953	10,974
Substance misuse –drug misuse	568,767	569,138
- Alcohol misuse	204,080	204,286
- Drugs and alcohol – youth services	54,958	55,025
Smoking and tobacco – smoking cessation and interventions	136,290	136,382
- Wider tobacco control	22,084	22,087
Children 5-19 public health programmes	230,808	230,997
Miscellaneous public health services	492,679	493,206
Total public health	**2,699,221**	**2,701,272**

The figures for public health may include spending in addition to the ring-fenced public health grant as local authorities are able to allocate money from previous under-spends and other budgets for public health.

Spending public health funds on non-health related areas

Concern has been raised about the pressures on local authority budgets in relation to their new public health responsibilities. An article in *The Guardian* in April 2013 highlighted the potential for improving local commissioning by handing control of the public health budget to local authorities but warned that the pressures on local government finance could lead to the public health allocation being siphoned off into other areas. The article said:

> The large, ringfenced budget will attract attention from less fortunate colleagues that are having to impose cuts. The final public health settlement for local government was surprisingly large, and Duncan Selbie, the chief executive of Public Health England, has made clear he is in no hurry to lift the ringfence. But the fence is likely to develop holes, and quickly, all in the name of integrating services.
>
> Despite government pressure some councils have persisted in placing the public health director under the control of the director of adult services, rather than have them report to the chief executive. This is likely to prove a mistake. Public health is a high profile and substantial operation which deserves a place on the senior management team. Among other advantages, that will maximise opportunities for integrating public health with other services, which is the whole point of the change – if that doesn't happen then all the upheaval has been for nothing.
>
> Public health will touch almost every area of policy – planning, licensing, transport, highways, education, housing, public safety, leisure, economic growth, older people and much more besides. The joint strategic needs assessment for health and social care, overseen by health and wellbeing boards in close collaboration with local clinical commissioning groups, will power much of the integration between services.
>
> But there will also be conflict. For example, developing the night-time economy may well be at odds with drug and alcohol objectives, while the relentless round of cuts to leisure services undermines work to tackle obesity.[50]

The *Health Service Journal* (HSJ) reported on 12 June 2013 that some local authorities were proposing to spend a “small proportion” of their public health allocation on areas including

[50] ‘Councils have opportunity to show effectiveness in public health’, *The Guardian*, 5 April 2013

driver education, working with 'troubled families', debt advice and leisure services.[51] The sister publication to HSJ, the *Local Government Chronicle* compared the published spending plans for 2013/14 of five councils and found that each prioritised different areas of spending, though much of the budgets were used for sexual health and drug and alcohol misuse services. In addition to this the comparison showed that:

> Norfolk Council is spending 6 per cent of its budget on obesity, nutrition and physical activity, compared with the 1 per cent Haringey Council plans to spend. Smoking cessation services will consume a tenth of Hampshire Council's budget, compared with just 3 per cent of Haringey's. Sandwell Council has focused strongly on preventive services, keeping a third of its grant for these. [52]

The article suggested that public health spending was likely to change further in the coming years, as much of the spending for 2013/14 related to previous contracts put in place by primary care trusts.[53] In an article on 4 September 2013, the *Health Service Journal* reported that the public health grant was expected to continue as a ring-fenced grant for 2015/16.

Concern has also been raised about the proportion of public health spending on childhood obesity. On 10 March 2014 *The Independent* reported that 'Less than 1% of public health budget is used to treat obesity in children'. The article said that:

> less than one per cent of local council public health budgets is being allocated towards treating children. Figures obtained by Freedom of Information requests found just 2.5 per cent of local council budgets were spent treating adult obesity and even less – 0.9 per cent – in children.
>
> The figures, which incorporate responses from 109 local authorities across England and Wales, are dwarfed by budgets allocated towards tackling other issues such as substance misuse (29 per cent according to the study) and sexual health (21 per cent).[54]

4 Local authority administration of public health

There was a large amount of critical commentary in 2012 on the preparedness of local authorities to implement the changes in the run-up to the transition date of 1 April 2013.

In December 2012, the Local Government Association (LGA) conducted a 'stocktake' of progress toward the transfer of public health functions and published its findings in the form of a briefing note.[55] It reported that, in some areas, there were delays in appointing directors of public health as well as finalising staffing structures, funding mechanisms and calculating local authority responsibilities for existing public health service contracts.

On 27 March 2013, the Communities and Local Government Select Committee published its report on *The role of local authorities in health issues*.[56] The Committee broadly welcomed the changes to public health, but made some recommendations for further action and was critical of the delay in the Government's announcement on funding allocations which, it said,

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51 'Councils' public health spending plans revealed', *Health Service Journal*, 12 June 2013 [Log in required]

52 'Councils' public health spending plans revealed', *Health Service Journal*, 12 June 2013 [Log in required]

53 'Councils' public health spending plans revealed', *Health Service Journal*, 12 June 2013 [Log in required]

54 'Less than 1% of public health budget is used to treat obesity in children', *The Independent*, 10 March 2014

55 LGA, *Public health transition at local level LGA national summary of progress*, December 2012

56 Communities and Local Government Select Committee, *The role of local authorities in health issues, Eighth Report of Session 2012–13,* HC 694, pp 3-4

left local authorities with little time to finalise preparations for the changes. The Government response to the report can be found here.

On 28 March 2013, the UK Faculty for Public Health (FPH) issued a press release in advance of the changes due on 1 April (The FPH describes itself as the "standard-setting body for specialists in public health in the United Kingdom").[57] It welcomed some of the changes but highlighted risks for other areas – including threats to the continuity of immunisation programmes. It said that, without the right structures and systems in place, there is a risk that:

> - People with complex conditions like diabetes will not get the joined-up health care they should,
> - Young people and vulnerable adults will be at risk from abuse because safeguarding systems will not be effective, and
> - Immunisation programmes for children and other screening programmes will be disrupted.
>
> Roles and responsibilities must be clear - both nationally and at the intensely practical local level - if the system is going to be safe. Otherwise lives could be at risk if outbreaks of infectious diseases and similar health protection matters are not dealt with efficiently.

The LGA produced an updated online resource with information and case studies relating to local authorities preparations for taking over responsibility for public health which can be found here.

4.1 Directors of public health

Upper-tier local authorities are required by the 2012 Act to—jointly with the Secretary of State—appoint an individual to have responsibility for its new public health functions, known as the director of public health. The Department of Health provided *Guidance on appointing directors of public health from 1 April 2013*, in October 2012. The guidance states that:

> That individual could be shared with another local authority where that makes sense (for example, where the senior management team is shared across more than one authority).[58]

There were initial concerns about the number of director of public health vacancies after 1 April 2013. The journal *Pulse* ran an article on 8 April 2013, 'One in ten public health director roles remain unfilled', in which it argued that unfilled director posts could cause a 'leadership vacuum' and may be problematic in the event of a public health emergency or outbreak.[59]

This answer to a Parliamentary Question in November 2013 by Parliamentary Under-Secretary for Health, Jane Ellison, provides information about the employment of directors of public health:

> Nationally there are 152 local authorities (LAs) who employ 134 Directors of Public Health (DPH) (taking into account agreed sharing arrangements). There are 33 LAs who have agreed sharing arrangements. Most of these arrangements are where one

[57] See: http://www.fph.org.uk/about_us

[58] Department of Health, *Directors of Public Health in Local Government: ii) Guidance on appointing directors of public health from 1 April 2013*, October 2012, p19

[59] 'One in ten public health director roles remain unfilled', *Pulse,* 3 April 2013

> DPH covers two LAs (nine instances covering 18 LAs), a smaller number have a three-way sharing arrangement (three instances covering nine LAs) and a single instance where one DPH covers six small LAs.
>
> Currently 105 of the 134 (78%) DPH posts are filled substantively by Directors of Public Health, i.e. a permanently appointed DPH is in post.
>
> There are currently 29 vacancies, all (100%) of which are all covered on an interim basis and, of the 29 current vacancies, 11 (38%) are under active recruitment in which adverts have been released and/or interview dates set.[60]

An updated list of the current directors of public health and the local authority areas they cover can be found on the Gov.uk website.

In January 2013 the Association of Directors of Public Health (ADPH) published the results of a survey of its members on the transition of directors and public health teams to local authorities in 2013: *English transition 2013 '6 months on' survey – summary results* (based on 107 responses). The main results of the survey were that:

- There were a continuing and "worryingly high" number of vacancies. Some respondents said that, due to recruitment delays not all of the budget would be spent in 2013-14.
- There was a high level of continued turnover of directors representing "a considerable risk to the public health system".
- The role of Directors was expanding into areas including environmental health; emergency planning; community and neighbourhoods; social care; intelligence and research; housing; trading standards.
- 80 per cent of respondents said their Council had a clear vision for public health but only 17 per cent understood the importance of public health (which was down from 33 per cent the previous year).
- Public health teams were structured in a wide variety of ways in different authorities and further structural changes were expected. 49 per cent reported to the CEO or equivalent post; 28 per cent to a 'super director'; and 20 per cent to another Director (usually the Director of Adult Social Services).
- 75 per cent of Directors said they had direct day-to-day control of the ring-fenced budget.
- 78 per cent reported that their council was investing the entire ring-fenced funding amount in public health (15 per cent reported that their council was investing more than the ring-fenced budget).
- 68 per cent were "fairly confident" that local authority base public health teams would deliver better outcomes. The report said that "Most comments mention the general

[60] HC 21 November 2013 Column 1002-3

reduction in [local authority] resources as the largest concern along with the potential effects on inequalities of welfare reform and the wider economic downturn”.[61]

4.2 Health and Wellbeing Boards (HWBs)

The *Health and Social Care Act 2012* established HWBs as statutory committees of all upper-tier local authorities to act as a forum for key leaders from the local health and care system to jointly work to:

- improve the health and wellbeing of the people in their area;
- reduce health inequalities; and,
- promote the integration of services.[62]

The Government’s 2010 White Paper *Equity and Excellence: Liberating the NHS* said that, as part of the wider changes it was proposing to the health service:

> The Government will strengthen the local democratic legitimacy of the NHS. Building on the power of the local authority to promote local wellbeing, we will establish new statutory arrangements within local authorities – which will be established as "health and wellbeing boards" or within existing strategic partnerships – to take on the function of joining up the commissioning of local NHS services, social care and health improvement. These health and wellbeing boards allow local authorities to take a strategic approach and promote integration across health and adult social care, children's services, including safeguarding, and the wider local authority agenda.[63]

The Library note, *Health and Wellbeing Boards (England)*, provides further information about HWBs. It also contains information about the role of Healthwatch England and local Healthwatch organisations which aim to represent local populations in the reformed health service.

4.3 Local authority performance indicators

Because of the relatively short time that the changes have been in place there is limited evidence available so far about how effectively local authorities have been discharging their new duties since 1 April 2013.[64]

As mentioned above, Public Health England has produced a Public Health Outcomes Framework (PHOF), which is updated quarterly and provides data for available indicators at England and local authority levels against which local authorities should measure their performance. These indicators are grouped into several ‘domains’:

- Improving the wider determinants of health;
- Health improvement;
- Health protection;
- Healthcare public health and preventing premature mortality, and,

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[61] The Association of Directors of Public Health, *English transition 2013 ‘6 months on’ survey – summary results,* January 2013

[62] See section 197 to 199 of the Act

[63] Department of Health, *Equity and Excellence: Liberating the NHS*, p34

[64] Shadow Health and Wellbeing Boards (HWBs) were in operation for the year prior to April 2013.

- Overarching indicators.

This *Introduction to the Public Health Outcomes Framework for England, 2013-2016*, provides further information on the framework.

The PHOF is not designed as a management tool for the performance of local authorities or HWBs but it can provide an indication over time of public health needs and any improvements within an area. Current performance against the PHOF indicators for each local authority area can be found on the PHOF website (scroll to the bottom of this webpage to browse indicators by domain). The tool uses a traffic light system to indicate whether a local authority area is performing below, at or above the base level for each of the above domains. It allows local authorities to measure their outcomes in comparison with other authorities in their area and against the national average.

5 Accountability arrangements for local authorities

Public health and wellbeing directors are accountable to the Chief Executive of each council for ensuring the health protection of the local population.[65] The Explanatory Notes for the 2012 Act state that Subsection 31(5) and (6) "require directors of public health to publish annual reports on the health of their local population and that local authorities publish that report. The reports are intended to help directors of public health to account for their activity and to chart progress over time". The first set of annual reports should become available shortly after April 2014.

Financial accountability

The Government consulted local authorities on the accountability arrangements for the spending of public health funding.[66] As set out in the updated Local Authority Circular, local authorities will have to provide the Department of Health with a Revenue Outturn (RO) form detailing public health expenditure (Annex B of the circular lists the categories of public health spend against which local authorities must report to the Department). In addition, Chief Executives will need to provide added assurance that the grant has been used as intended in the form of a statement of assurance confirming the grant has been used as intended and that the RO returns are an accurate reflection of that expenditure. The use of the grant will also be subject to existing local authority financial management requirements and the External Auditor is required to highlight any issues of concern to the Department.

Complaints about local authorities in relation to public health

Section 32 of the 2012 Act[67] gives the Secretary of State powers to make regulations setting up procedures for dealing with complaints about the exercise of public health functions by local authorities in England. As a result, Regulations 19–33 of the *NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012* made provision in respect of complaints about local authority public health functions. The regulations specify that:

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[65] For example see Northamptonshire CC website for its description of director of public health responsibilities, 'What is Public Health?'. Sections 29-32 of the 2012 Act deal with the role of local authorities and directors of public health.

[66] See: Public Health grant to local authorities: *Summary of responses to the publication of the draft grant Determination (Conditions) and draft grant Circular*. The updated circular on the use of the ring-fenced public health grant, published in December 2013, can be found here.

[67] Which added the new section 73C to the NHS Act 2006.

- Local authorities must designate a ‘responsible person’—the Chief Executive —who has the function of ensuring compliance with the complaints handling arrangements and ensuring that action is taken, if necessary, following a complaint.
- Generally, complaints must be made within 12 months of the matter coming to the complainant’s attention. Complaints may be made orally, in writing or electronically.
- Complaints must be acknowledged within three working days of receipt and a written response to a complaint must be sent as soon as reasonably practicable after the conclusion of the investigation but must in any event be sent within 6 months of receipt of the complaint.
- Local authorities (and service providers) must make available to the public information about the complaints process.
- Local authorities are required to record complaints and their outcomes. An annual report in respect of complaints must also be produced.

Further reading

Published in October 2012, this Factsheet for local authorities provides further information in on their new public health responsibilities.

Department
of Health

Local Authority Circular LAC(DH)(2013)3

To: The Chief Executive
County Councils
District Councils (excluding District Councils with a County Council)
London Borough Councils
Council of the Isles of Scilly
Common Council of the City of London
Directors of Finance
Directors of Public Health

Date: 13 December 2013

PUBLIC HEALTH RING-FENCED GRANT CONDITIONS - 2014/15

1. In January 2013 the Department of Health allocated public health ring fenced grants to local authorities (upper tier and unitary local authorities) in England, a two year allocation totalling £5.46 billion for the financial years 2013/14 and 2014/15. The funding was intended to enable relevant local authorities to discharge their new public health responsibilities. The Secretary of State duly determined, on 10 January 2013, under section 31 of the Local Government Act 2003, to pay grants to relevant authorities in the amounts indicated in the determination (determination 31/2241). This circular sets out the conditions that will govern the use of the 2014/15 grant. The conditions are the same as the conditions that applied to determination 31/2100 dated 10 January 2013 which were published on that date.

2. The grant for the financial year 2014/15 is also to be administered under Section 31 of the Local Government Act 2003, which allows Ministers, with the consent of the Treasury, to pay grants to any local authority towards any expenditure.

3. The circular contains 3 annexes:

   - Annex A comprises the grant determination and conditions, which set out the detailed arrangements for administering the grant.

   - Annex B lists the categories of public health spend against which local authorities will need to report to the Department.

   - Annex C is the statement local authority Chief Executives will need to send back confirming that the grant has been used in accordance with the conditions.

Use of the grant

4. The public health grant is being provided to give local authorities the funding needed to discharge their public heath responsibilities. It is vital that these funds are used to:
   - improve significantly 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.

5. The grant will be made to upper-tier and unitary local authorities in England and paid in quarterly instalments on the dates specified in the Appendix.

6. The grant will be made under Section 31 of the Local Government Act 2003 and we have set down some conditions to govern its use. The primary purpose of the conditions is to ensure that the grant is used to assist the local authority to comply with it's public health duties and mandatory services, that it is spent appropriately, and accounted for properly.

7. The expectation is that funds will be utilised in-year, but if at the end of the financial year there is any underspend this can be carried over, as part of a public health reserve, into the next financial year. In utilising those funds the next year, the grant conditions will still need to be complied with. However, where there are large underspends repeatedly the Department will consider whether allocations should be reduced in future years.

Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs)

8. In drawing up their priorities, local authorities, as members of health and wellbeing boards will have a duty to work with clinical commissioning groups (CCGs) and other partners such as the police and community safety partnerships to undertake Joint Strategic Needs Assessments (JSNAs) – an assessment of the current and future health and social care needs and assets of the local community. Based on these they will have to develop Joint Health and Wellbeing Strategies (JHWSs) – a strategy for meeting the identified needs in the local area based on evidence in JSNAs. Under amendments made by the Health and Social Care Act 2012 to the Local Government and Public Involvement in Health Act 2007, JSNAs and JHWSs must inform local authority commissioning plans, and so will impact on how the grant is spent.

9. Performance information supporting the Public Health Outcomes Framework alongside the Adult Social Care Outcomes Framework, NHS Outcomes Framework and eventually the NHS Commissioning Outcomes Framework could also inform JSNAs; however, national measures should not overshadow local priorities based on evidence of local needs.

Reporting of grant expenditure

10. In giving funding for public health to local authorities, it remains important that funds are only spent on activities whose main or primary purpose is to improve

the public health of local populations (including restoring or protecting their health where appropriate) and reducing health inequalities.

11. Local authorities will need to forecast and report against the sub-categories in the Revenue Account (RA) and Revenue Outturn (RO) returns to Public Health England (PHE) who will review them on behalf of the Department of Health. Given that the RO form is used as a way of monitoring the usage of the grant, it is important that the contacts responsible for this section of financing are content with the figures submitted. Authorities will need to ensure that the figures are verified and in line with the purpose set out in the grant conditions. A list of the reporting categories has been provided at Annex B. Local authority Chief Executives will also need to return a statement confirming that the grant has been used in line with the conditions. A draft is attached at Annex C.

12. The reporting categories are sufficiently flexible to allow local decisions about what services are commissioned to be reflected sensibly. Guidance has been provided to local authorities in the Service Reporting Code of Practice (SeRCOP) on how activity should be recorded against the sub-categories.

In-year reporting

13. Local authorities will need to submit quarterly returns of spend on public health as part of the existing Quarterly Revenue Outturn reports. At the end of the financial year they will need to return a more detailed RO return.

14. For the detailed list of grant conditions please refer to the Grant Determination and conditions in Annex A.

Charging

15. Under section 2B of the National Health Service Act 2006, each local authority has a duty to take steps, as it considers appropriate, for improving the health of the people in its area. A local authority may also be required by regulations under section 6C of the NHS Act to take steps to protect the public in England from disease or other dangers to health. These steps are services which form part of the comprehensive health service and are therefore subject to the general prohibition on charging under section 1(3) of the NHS Act unless exempted through regulations.

Guidance

16. Local authorities must have regard to other forms of guidance when discharging their public health responsibilities such as:
    - guidance issued by the Department e.g. the Public Health Outcomes Framework;
    - the revised Best Value statutory guidance issued by the Department for Community & Local Government (2011), which is equally applicable to local authorities public health functions. The duty to secure best value under the Local government Act 1999 will also apply to these public health responsibilities.

17. Local authorities might also want to consider other forms of guidance, e.g. from the National Institute for Health and Care Excellence, in discharging their public health duties.

Clinical Governance

18. In commissioning services using funds from this grant, local authorities should also ensure that appropriate clinical governance arrangements are put in place.

Mandatory Functions

19. As set out in *Healthy Lives, Healthy People: Update and way forward*, the National Health Service Act 2006 now provides for regulations that allow the Secretary of State to prescribe that certain services should be commissioned or provided by local authorities, and certain steps taken.

20. The services and steps that have been prescribed are set out in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, S.I. 2013/351.

Outcomes Framework

21. These reforms are aimed at improving the health and wellbeing of the nation and delivering better outcomes. We have therefore put in place a new strategic outcomes framework for public health at national and local levels, based on the evidence of where the biggest challenges are for health and wellbeing, and the wider factors that drive it. The outcomes framework sets out a high-level vision for public health outcomes, focused on increasing healthy life expectancy and reducing inequalities in health.

22. The Public Health Outcomes Framework presents a broad spectrum for public health. These outcomes will be measured through a range of indicators grouped into four domains that provide a focus on tackling the wider determinants of health, health improvement, health protection and healthcare public health. Some of these indicators reflect the contribution local authorities already make to public health whilst others reflect new areas of responsibility. Local authorities will want to have regard to the Public Health Outcomes Framework in deciding how to use their public health funding.

23. In setting their spending priorities it is important that local authorities are mindful of the overall objectives of the grant, as set out in the grant conditions, and the need to tackle the wider determinants of health, for example, through addressing the indicators within the Public Health Outcomes Framework, such as violent crime, the successful completion of drug treatment, smoking prevalence and child poverty.

24. The new health premium will be designed to reward communities for making progress against certain indicators particularly which are in the Public Health Outcomes Framework. The selected health premium indicators will be communicated to local authorities by March 2014. The first incentive payment will be in the year 2015/16 to ensure LAs are rewarded for the improvements

they make. Information on the development of the health premium incentive scheme can be found at the link below: https://www.gov.uk/government/policy-advisory-groups/health-premium-incentive-advisory-group

Enquiries

25. Enquires about this Circular should be addressed to the Public Health Policy and Strategy Unit, Department of Health, email address: publichealthpolicyandstrategy@dh.gsi.gov.uk

Annex A

DETERMINATION UNDER SECTION 31 OF THE LOCAL GOVERNMENT ACT 2003 OF A RING-FENCED PUBLIC HEALTH GRANT TO LOCAL AUTHORITIES FOR 2014/2015

PUBLIC HEALTH RING-FENCED GRANT DETERMINATION 2014/15: No 31/2241

The Secretary of State for Health ("the Secretary of State"), in exercise of the powers conferred by section 31 of the Local Government Act 2003, makes the following determination:

Citation

1) This determination may be cited as the Public Health Ring-fenced Grant Determination 2014/15: No 31/2241.

Purpose of the grant

2) This grant can be used for both revenue and capital purposes.
3) The purpose of the grant is to provide local authorities in England with the funding required to discharge the public health functions detailed in paragraphs 2-4 on page 7.

Grant conditions

4) Pursuant to section 31(4) of the Local Government Act 2003, the Secretary of State determines that the grant will be paid subject to the conditions set out from pages 7.

Determination

5) The Secretary of State determines as the authorities to which the grant is to be paid and the amount of grant to be paid in the financial year 2014/15, the authorities and the amounts for the financial year 2014/15 set out in the Appendix.

Treasury consent

6) Before making this determination the Secretary of State obtained the consent of the Treasury.

Signed by authority of the Secretary of State for Health

Tim Baxter
Deputy Director of Public Health Policy & Strategy
Department of Health
13 December 2013

GRANT CONDITIONS

1. In this Determination:

   "an authority" means an upper tier or unitary local authority identified in the Appendix.

   "the Department" means the Department of Health;

   "financial year" means a period of twelve months ending 31st March 2015.

   "NHS body" means an NHS body within the meaning of section 75 of the National Health Service Act 2006;

   "grant" means the amounts set out in the Ring-fenced Public Health Grant Determination 2014/15: No 31/2241

   "upper tier and unitary local authorities" means: a county council in England; a district council in England, other than a council for a district in a county for which there is a county council; a London borough council, the Council of the Isles of Scilly; and the Common Council of the City of London.

Use of the grant

2. Pursuant to Section 31 of the Local Government Act 2003, the Secretary of State hereby determines that the public health grant shall be paid towards expenditure incurred, or to be incurred, by upper tier and unitary local authorities in the financial year 2014/15. The relevant authorities are listed in Appendix 1.

3. Subject to paragraph 5, the grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006 ("the 2006 Act").

4. The functions mentioned in that subsection are:
   (a) functions under section 2B, 111 or 249 of, or Schedule 1 to, the 2006 Act
   (b) functions by virtue of section 6C of the 2006 Act,
   (c) the Secretary of State's public health functions exercised by local authorities in pursuance of arrangements under section 7A of the 2006 Act,
   (d) the functions of a local authority under section 325 of the Criminal Justice Act 2003 (local authority duty to co-operate with the prison service with a view to improving the exercise of functions in relation to securing and maintaining the health of prisoners), and
   (e) such other functions relating to public health as may be prescribed under section 73B(2)(e).

5. A local authority may use the grant to contribute to a fund made up of –

(a) contributions by the authority from both the public health grant and other sources of funding e.g. from other local authority funding, or from payments made by a private sector or civil society organisation; or
(b) contributions by the authority and one or more of any of the following bodies
    (i) another local authority,
    (ii) an NHS or other public body, or
    (iii) a private sector or civil society organisation;

provided the conditions specified in paragraph 6 are met.

6. The conditions referred to in paragraph 5 are that –
    (a) the fund must be one out of which payments are made towards expenditure incurred in the exercise of, or for the purposes of, the functions described in paragraph 3;
    (b) if payments are made out of the fund towards expenditure on other functions of a local authority or the functions of an NHS body, other public body, or a private sector or civil society organisation, the authority must be of opinion that those functions have a significant effect on public health or have a significant effect on, or in connection with, the exercise of the functions described in paragraph 3;
    (c) the authority must be satisfied that, having regard to the contribution from the public health grant, the total expenditure to be met from the fund and the public health benefit to be derived from the use of the fund, the arrangements provide value for money.

7. A local authority must, in using the grant, have regard to the need to reduce inequalities between the people in its area with respect to the benefits that they can obtain from that part of the health service provided in exercise of the functions referred to in paragraph 3.

8. The public health grant will only be paid to local authorities to support eligible expenditure.

Eligible expenditure

9. Eligible expenditure means expenditure incurred by an authority or any person acting on behalf of an authority, between 1 April 2014 and 31 March 2015, for the purposes of carrying out the public health functions referred to in paragraphs 3 and 4.

10. If an authority incurs any of the following costs, those costs must be excluded from eligible expenditure:
    a) contributions in kind
    b) payments for activities of a political or exclusively religious nature
    c) depreciation, amortisation or impairment of fixed assets owned by the authority
    d) input VAT reclaimable by the authority from HM Revenue & Customs
    e) interest payments or service charge payments for finance leases

f) gifts, other than promotional items, with a value of no more than £10 in a year to any one person subject to the exception in paragraph [11].
g) entertaining (Entertaining for this purpose means anything that would be a taxable benefit to the person being entertained, according to current UK tax regulations)
h) statutory fines, criminal fines or penalties.

11. Expenditure on promotional items in fulfilment of the local authority's health improvement duty under Section 2B of the 2006 Act such as products, goods or services which are given for health improvement purposes may form part of eligible expenditure. This could include for example, vouchers for gym or fitness classes, nicotine patches or other expenditure which corresponds with the health improvement objectives of the public health grant.

12. An authority must not deliberately incur liabilities for eligible expenditure before there is an operational need for it to do so.

13. For the purpose of defining the time of payments, an authority shall account for it's spend from the grant using the accrual basis of accounting.[1].

Payment arrangements

14. Grants will be paid in quarterly instalments by Public Health England.

Reporting

In-year reporting

15. An authority will need to submit three high-level public health returns (Quarterly Revenue Outturns) at quarterly intervals during the year, for the quarters ending in June, September and December. In accordance with existing practice, this will be submitted to the Department for Communities & Local Government (DCLG) who will share them with Public Health England (PHE). PHE will review the returns on behalf of the Secretary of State for Health.

End-of year reporting

16. Each authority shall prepare a return setting out how the grant has been spent using the Revenue Outturn (RO) form at the end of the financial year covering the period 1 April 2014 to 31 March 2015. In accordance with existing practice, this will be submitted to DCLG who will share the information with PHE. A list of the lines of expenditure (categories) that will need to be reported on is attached at Annex B. The RO form must provide details of eligible expenditure in the period, against each relevant category.

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[1] "Accrual accounting depicts the effects of transactions and other events and circumstances on an authority's economic resources and claims in the periods in which those effects occur, even if the resulting cash receipts and payments occur in a different period." Code of Practice on Local Authority Accounting 2012/13 pp8-9.

17. The returns must be certified by the authority's Chief Executive that, to the best of his or her knowledge, the amounts shown on the Statement are all eligible expenditure and that the grant has been used for the purposes intended, as set out in this Determination. Chief Executives have been provided with a statement of assurance for their signature at Annex C. This should be sent to Public Health England at: publichealthgrant@phe.gov.uk

18. The Secretary of State may require a further external validation to be carried out by an appropriately qualified independent accountant or auditor of the use of the grant where the RO return referred to in paragraph 16 above fails to provide sufficient assurance to the Secretary of State that the grant has been used in accordance with these conditions.

19. While the grant should not be used for interest or service charge payments or finance leases it can be used for capital spend on items that do not entail borrowing or a finance lease. Capital expenditure should be noted as a Capital Expenditure from Revenue Account (CERA) payment on the RO form and details provided on the Capital Outturn Return (COR) form issued by the Department for Communities & Local Government (DCLG). Further guidance will be supplied with the forms that DCLG send out.

20. In accordance with existing practice, local authorities should send the RO to DCLG.

Financial Management

21. Each authority must maintain a robust system of internal financial controls and inform the Department promptly of any significant financial control issues raised by its internal auditors in relation to the use of the public health grant.

22. If an authority identifies any overpayment of the grant, the authority must repay this amount within 30 days of it coming to their attention.

23. If an authority has any grounds for suspecting financial irregularity in the use of any grant paid under this funding agreement, it must notify the Department immediately, explain what steps are being taken to investigate the suspicion and keep the Department informed about the progress of the investigation. For these purposes "financial irregularity" includes fraud or other impropriety, mismanagement, and the use of the grant for purposes other than those for which it was provided.

External audit arrangements

24. Appointed auditors are responsible for auditing the financial statements of each authority and for reaching a conclusion on an authority's overall arrangements for securing economy, efficiency and effectiveness in the use of resources. The use of, and accounting for, the public health grant and the arrangements for securing economy, efficiency and effectiveness in doing so fall within the scope

of the work that appointed auditors may plan to carry out, having regard to the risk of material error in the authority's accounts and significance.

Records to be kept

25. Each authority must maintain reliable, accessible and up to date accounting records with an adequate audit trail for all expenditure funded by grant monies under this Determination.

26. Each authority and any person acting on behalf of an authority must allow:
    a) the Comptroller and Auditor General or appointed representatives; and
    b) the Secretary of State or appointed representatives;

    free access at all reasonable times to all documents (including computerised documents and data) and other information as is connected to the grant payable under this Determination, or to the purposes for which grant was used, subject to the provisions in paragraph 27.

27. The documents, data and information referred to in paragraph 26 are such as the Secretary of State or the Comptroller and Auditor General may reasonably require for the purposes of the Secretary of State's or the Comptroller and Auditor General's financial audit or that any department or other public body may reasonably require for the purposes of carrying out examinations into the economy, efficiency and effectiveness with which any department or other public body has used its resources. An authority must provide such further explanations as are reasonably required for these purposes.

28. Paragraphs 25 and 26 do not constitute a requirement for the examination, certification or inspection of the accounts of an authority by the Comptroller and Auditor General under section 6(3) of the National Audit Act 1983. The Comptroller and Auditor General will seek access in a measured manner to minimise any burden on the authority and will avoid duplication of effort by seeking and sharing information with the Audit Commission.

Breach of Conditions and Recovery of Grant

29. If an authority fails to comply with any of these conditions, or any overpayment is made under this grant, or any amount is paid in error, or if an authority 's Chief Executive is unable to provide reasonable assurance that the RO form, in all material respects, fairly presents the eligible expenditure, in the relevant period, in accordance with the definitions and conditions in this Determination, or any information provided is incorrect, the Secretary of State may reduce, suspend or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State and notified in writing to the authority. Such sum as has been notified will immediately become repayable to the Secretary of State who may set off the sum against any future amount due to the authority from central government.

Underspends

30. If there are funds left over at the end of the financial year they can be carried over into the next financial year as part of a public health reserve. All the conditions that apply to the use of the grant will continue to apply to any funds carried over. However, where there are large underspends DH reserves the right to reduce allocations in future years.

Appendix

Local Authorities total public health ring fenced grant for 2014/15 with quarterly allocations (£) and payment dates
England

ONS LA Name	Total 2014/15 PH Grant	Q1 PH grant allocations - Payment date: *17 April 2014*	Q2 PH grant allocations - Payment date: *18 July 2014*	Q3 PH grant allocations- Payment date: *17 October 2014*	Q4 PH grant allocations - Payment date: 16 *January 2015*
Barking and Dagenham	14,213,200	3,553,300	3,553,300	3,553,300	3,553,300
Barnet	14,334,800	3,583,700	3,583,700	3,583,700	3,583,700
Barnsley	14,242,600	3,560,650	3,560,650	3,560,650	3,560,650
Bath and North East Somerset	7,384,100	1,846,025	1,846,025	1,846,025	1,846,025
Bedford	7,343,300	1,835,825	1,835,825	1,835,825	1,835,825
Bexley	7,574,100	1,893,525	1,893,525	1,893,525	1,893,525
Birmingham	80,837,900	20,209,475	20,209,475	20,209,475	20,209,475
Blackburn with Darwen	13,133,500	3,283,375	3,283,375	3,283,375	3,283,375
Blackpool	17,945,700	4,486,425	4,486,425	4,486,425	4,486,425
Bolton	18,906,000	4,726,500	4,726,500	4,726,500	4,726,500
Poole	6,056,700	1,514,175	1,514,175	1,514,175	1,514,175
Bournemouth	8,296,200	2,074,050	2,074,050	2,074,050	2,074,050
Bracknell Forest	3,048,800	762,200	762,200	762,200	762,200
Brent	18,848,200	4,712,050	4,712,050	4,712,050	4,712,050
Brighton and Hove	18,694,600	4,673,650	4,673,650	4,673,650	4,673,650
Bristol, City of	29,122,300	7,280,575	7,280,575	7,280,575	7,280,575
Bromley	12,953,600	3,238,400	3,238,400	3,238,400	3,238,400
Buckinghamshire	17,249,400	4,312,350	4,312,350	4,312,350	4,312,350
Bury	9,619,100	2,404,775	2,404,775	2,404,775	2,404,775
Calderdale	10,678,800	2,669,700	2,669,700	2,669,700	2,669,700
Cambridgeshire	22,298,700	5,574,675	5,574,675	5,574,675	5,574,675
Camden	26,367,600	6,591,900	6,591,900	6,591,900	6,591,900
Central Bedfordshire	10,149,500	2,537,375	2,537,375	2,537,375	2,537,375
Cheshire East	14,274,400	3,568,600	3,568,600	3,568,600	3,568,600
Cheshire West and Chester	13,889,400	3,472,350	3,472,350	3,472,350	3,472,350
Bradford	34,699,100	8,674,775	8,674,775	8,674,775	8,674,775
City of London	1,697,600	424,400	424,400	424,400	424,400
Cornwall	18,338,600	4,584,650	4,584,650	4,584,650	4,584,650
Coventry	19,614,800	4,903,700	4,903,700	4,903,700	4,903,700
Croydon	18,824,600	4,706,150	4,706,150	4,706,150	4,706,150
Cumbria	15,593,800	3,898,450	3,898,450	3,898,450	3,898,450
Darlington	7,184,400	1,796,100	1,796,100	1,796,100	1,796,100
Derby	14,484,100	3,621,025	3,621,025	3,621,025	3,621,025
Derbyshire	35,651,300	8,912,825	8,912,825	8,912,825	8,912,825

Devon	22,060,200	5,515,050	5,515,050	5,515,050	5,515,050
Doncaster	20,198,200	5,049,550	5,049,550	5,049,550	5,049,550
Dorset	12,889,200	3,222,300	3,222,300	3,222,300	3,222,300
Dudley	18,973,600	4,743,400	4,743,400	4,743,400	4,743,400
County Durham	45,780,100	11,445,025	11,445,025	11,445,025	11,445,025
Ealing	21,974,200	5,493,550	5,493,550	5,493,550	5,493,550
East Riding of Yorkshire	9,175,200	2,293,800	2,293,800	2,293,800	2,293,800
East Sussex	24,506,700	6,126,675	6,126,675	6,126,675	6,126,675
Enfield	14,257,400	3,564,350	3,564,350	3,564,350	3,564,350
Essex	50,242,000	12,560,500	12,560,500	12,560,500	12,560,500
Gateshead	15,831,700	3,957,925	3,957,925	3,957,925	3,957,925
Gloucestershire	21,793,300	5,448,325	5,448,325	5,448,325	5,448,325
Greenwich	19,061,100	4,765,275	4,765,275	4,765,275	4,765,275
Hackney	29,817,500	7,454,375	7,454,375	7,454,375	7,454,375
Halton	8,748,800	2,187,200	2,187,200	2,187,200	2,187,200
Hammersmith and Fulham	20,855,100	5,213,775	5,213,775	5,213,775	5,213,775
Hampshire	40,428,200	10,107,050	10,107,050	10,107,050	10,107,050
Haringey	18,189,400	4,547,350	4,547,350	4,547,350	4,547,350
Harrow	9,145,800	2,286,450	2,286,450	2,286,450	2,286,450
Hartlepool	8,485,900	2,121,475	2,121,475	2,121,475	2,121,475
Havering	9,716,700	2,429,175	2,429,175	2,429,175	2,429,175
Herefordshire, County of	7,969,800	1,992,450	1,992,450	1,992,450	1,992,450
Hertfordshire	37,641,700	9,410,425	9,410,425	9,410,425	9,410,425
Hillingdon	15,709,100	3,927,275	3,927,275	3,927,275	3,927,275
Hounslow	14,084,300	3,521,075	3,521,075	3,521,075	3,521,075
Isle of Wight	6,087,700	1,521,925	1,521,925	1,521,925	1,521,925
Isles of Scilly	72,930	18,233	18,233	18,233	18,233
Islington	25,429,200	6,357,300	6,357,300	6,357,300	6,357,300
Kent	54,827,100	13,706,775	13,706,775	13,706,775	13,706,775
Kingston upon Hull, City of	22,559,400	5,639,850	5,639,850	5,639,850	5,639,850
Kirklees	23,526,600	5,881,650	5,881,650	5,881,650	5,881,650
Knowsley	16,374,600	4,093,650	4,093,650	4,093,650	4,093,650
Lambeth	26,437,400	6,609,350	6,609,350	6,609,350	6,609,350
Lancashire	59,800,700	14,950,175	14,950,175	14,950,175	14,950,175
Leeds	40,540,400	10,135,100	10,135,100	10,135,100	10,135,100
Leicester	21,994,600	5,498,650	5,498,650	5,498,650	5,498,650
Leicestershire	21,862,600	5,465,650	5,465,650	5,465,650	5,465,650
Lewisham	20,088,100	5,022,025	5,022,025	5,022,025	5,022,025
Lincolnshire	28,505,900	7,126,475	7,126,475	7,126,475	7,126,475
Liverpool	41,436,500	10,359,125	10,359,125	10,359,125	10,359,125
Luton	13,064,600	3,266,150	3,266,150	3,266,150	3,266,150
Manchester	44,115,700	11,028,925	11,028,925	11,028,925	11,028,925
Medway	14,280,300	3,570,075	3,570,075	3,570,075	3,570,075
Merton	9,236,200	2,309,050	2,309,050	2,309,050	2,309,050
Middlesbrough	16,378,000	4,094,500	4,094,500	4,094,500	4,094,500

Milton Keynes	8,787,900	2,196,975	2,196,975	2,196,975	2,196,975
Newcastle upon Tyne	21,301,500	5,325,375	5,325,375	5,325,375	5,325,375
Newham	26,111,900	6,527,975	6,527,975	6,527,975	6,527,975
Norfolk	30,632,700	7,658,175	7,658,175	7,658,175	7,658,175
North East Lincolnshire	9,971,300	2,492,825	2,492,825	2,492,825	2,492,825
North Lincolnshire	8,463,900	2,115,975	2,115,975	2,115,975	2,115,975
North Somerset	7,593,000	1,898,250	1,898,250	1,898,250	1,898,250
North Tyneside	10,807,200	2,701,800	2,701,800	2,701,800	2,701,800
North Yorkshire	19,732,500	4,933,125	4,933,125	4,933,125	4,933,125
Northamptonshire	29,523,200	7,380,800	7,380,800	7,380,800	7,380,800
Northumberland	13,407,900	3,351,975	3,351,975	3,351,975	3,351,975
Nottingham	27,839,200	6,959,800	6,959,800	6,959,800	6,959,800
Nottinghamshire	36,119,000	9,029,750	9,029,750	9,029,750	9,029,750
Oldham	14,914,900	3,728,725	3,728,725	3,728,725	3,728,725
Oxfordshire	26,085,600	6,521,400	6,521,400	6,521,400	6,521,400
Peterborough	9,290,700	2,322,675	2,322,675	2,322,675	2,322,675
Plymouth	12,275,700	3,068,925	3,068,925	3,068,925	3,068,925
Portsmouth	16,178,100	4,044,525	4,044,525	4,044,525	4,044,525
Reading	8,212,100	2,053,025	2,053,025	2,053,025	2,053,025
Redbridge	11,411,300	2,852,825	2,852,825	2,852,825	2,852,825
Redcar and Cleveland	10,917,100	2,729,275	2,729,275	2,729,275	2,729,275
Richmond upon Thames	7,890,900	1,972,725	1,972,725	1,972,725	1,972,725
Rochdale	14,777,300	3,694,325	3,694,325	3,694,325	3,694,325
Rotherham	14,176,400	3,544,100	3,544,100	3,544,100	3,544,100
Kensington and Chelsea	21,213,700	5,303,425	5,303,425	5,303,425	5,303,425
Kingston upon Thames	9,302,300	2,325,575	2,325,575	2,325,575	2,325,575
Rutland	1,072,800	268,200	268,200	268,200	268,200
Salford	18,776,600	4,694,150	4,694,150	4,694,150	4,694,150
Sandwell	21,804,600	5,451,150	5,451,150	5,451,150	5,451,150
Sefton	19,951,800	4,987,950	4,987,950	4,987,950	4,987,950
Sheffield	30,747,900	7,686,975	7,686,975	7,686,975	7,686,975
Shropshire	9,843,000	2,460,750	2,460,750	2,460,750	2,460,750
Slough	5,486,500	1,371,625	1,371,625	1,371,625	1,371,625
Solihull	9,905,300	2,476,325	2,476,325	2,476,325	2,476,325
Somerset	15,513,300	3,878,325	3,878,325	3,878,325	3,878,325
South Gloucestershire	7,345,100	1,836,275	1,836,275	1,836,275	1,836,275
South Tyneside	12,917,300	3,229,325	3,229,325	3,229,325	3,229,325
Southampton	15,050,200	3,762,550	3,762,550	3,762,550	3,762,550
Southend-on-Sea	8,059,700	2,014,925	2,014,925	2,014,925	2,014,925
Southwark	22,945,600	5,736,400	5,736,400	5,736,400	5,736,400
St. Helens	13,035,400	3,258,850	3,258,850	3,258,850	3,258,850
Staffordshire	33,312,600	8,328,150	8,328,150	8,328,150	8,328,150
Stockport	12,834,300	3,208,575	3,208,575	3,208,575	3,208,575
Stockton-on-Tees	13,066,800	3,266,700	3,266,700	3,266,700	3,266,700
Stoke-on-Trent	20,241,800	5,060,450	5,060,450	5,060,450	5,060,450

Suffolk	26,288,500	6,572,125	6,572,125	6,572,125	6,572,125
Sunderland	21,233,900	5,308,475	5,308,475	5,308,475	5,308,475
Surrey	25,561,200	6,390,300	6,390,300	6,390,300	6,390,300
Sutton	8,619,200	2,154,800	2,154,800	2,154,800	2,154,800
Swindon	8,680,300	2,170,075	2,170,075	2,170,075	2,170,075
Tameside	12,599,900	3,149,975	3,149,975	3,149,975	3,149,975
Telford and Wrekin	10,912,900	2,728,225	2,728,225	2,728,225	2,728,225
Thurrock	7,624,400	1,906,100	1,906,100	1,906,100	1,906,100
Torbay	7,350,600	1,837,650	1,837,650	1,837,650	1,837,650
Tower Hamlets	32,261,000	8,065,250	8,065,250	8,065,250	8,065,250
Trafford	10,455,800	2,613,950	2,613,950	2,613,950	2,613,950
Wakefield	20,796,700	5,199,175	5,199,175	5,199,175	5,199,175
Walsall	15,827,300	3,956,825	3,956,825	3,956,825	3,956,825
Waltham Forest	12,276,600	3,069,150	3,069,150	3,069,150	3,069,150
Wandsworth	25,430,900	6,357,725	6,357,725	6,357,725	6,357,725
Warrington	10,439,500	2,609,875	2,609,875	2,609,875	2,609,875
Warwickshire	21,810,400	5,452,600	5,452,600	5,452,600	5,452,600
West Berkshire	4,819,100	1,204,775	1,204,775	1,204,775	1,204,775
West Sussex	27,445,300	6,861,325	6,861,325	6,861,325	6,861,325
Westminster	31,234,900	7,808,725	7,808,725	7,808,725	7,808,725
Wigan	23,665,000	5,916,250	5,916,250	5,916,250	5,916,250
Wiltshire	14,586,600	3,646,650	3,646,650	3,646,650	3,646,650
Windsor and Maidenhead	3,510,700	877,675	877,675	877,675	877,675
Wirral	26,440,100	6,610,025	6,610,025	6,610,025	6,610,025
Wokingham	4,222,800	1,055,700	1,055,700	1,055,700	1,055,700
Wolverhampton	19,296,000	4,824,000	4,824,000	4,824,000	4,824,000
Worcestershire	26,528,300	6,632,075	6,632,075	6,632,075	6,632,075
York	7,304,800	1,826,200	1,826,200	1,826,200	1,826,200
England total	**2,793,775,130**	**698,443,783**	**698,443,783**	**698,443,783**	**698,443,783**

Annex B

Categories for reporting local authority public health spend

Prescribed functions:

1) Sexual health services - STI testing and treatment

2) Sexual health services – Contraception

3) NHS Health Check programme

4) Local authority role in health protection

5) Public health advice

6) National Child Measurement Programme

Non-prescribed functions:

7) Sexual health services - Advice, prevention and promotion

8) Obesity – adults

9) Obesity - children

10) Physical activity – adults

11) Physical activity - children

12) Drug misuse - adults

13) Alcohol misuse - adults

14) Substance misuse (drugs and alcohol) - youth services

15) Stop smoking services and interventions

16) Wider tobacco control

17) Children 5-19 public health programmes

18) Miscellaneous, which includes:

   - Non-mandatory elements of the NHS Health Check programme
   - Nutrition initiatives
   - Health at work
   - Programmes to prevent accidents
   - Public mental health

- General prevention activities
- Community safety, violence prevention & social exclusion
- Dental public health
- Fluoridation
- Local authority role in surveillance and control of infectious disease
- Information & Intelligence
- Any public health spend on environmental hazards protection
- Local initiatives to reduce excess deaths from seasonal mortality
- Population level interventions to reduce and prevent birth defects (supporting role)
- Wider determinants

Annex C

Draft Statement of Assurance

[Insert name of local authority]

Date: DD/MM/YYYY

Statement of Assurance: Ring-fenced Public Health Grant Determination 2014/15: No 31/2241

The ring-fenced public health grant, in the amount of £………, has been provided to this local authority towards expenditure incurred, or to be incurred, in the financial year 2014/15.

As the authority's Chief Executive, I have reviewed the health Revenue Outturn (RO) form and can confirm that the grant has been used to discharge the public health functions described in Section 73B (2) of the National Health Service Act 2006. I also confirm that the amounts stated in the RO form are a true reflection of how the grant has been spent, including any amounts held in the authority's public health reserve.

I affirm that where funding has been combined ('pooled') with funds from other sources, this has been in accordance with the relevant conditions in paragraphs 5 and 6 of the grant Determination.

[Signed]