

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.
- 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 apprised 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 apprised 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 library¹. 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 health 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

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).