12 March 2013	ITEM: 8
Health and Well-being Overview and Scrutiny Committee	
PUBLIC HEALTH CONTRACTING AND COMMISSIONING ARRANGEMENTS FROM 1 APRIL 2013	
Report of: Roger Harris – Head of Commissioning	
Wards and communities affected: All	**Key Decision:** Key
Accountable Head of Service: Roger Harris, Head of Commissioning / Andrea Atherton, Director of Public Health / Debbie Maynard, Head of Health Improvement	
Accountable Director: Jo Olsson, Director of People Services	
This report is public.	
Purpose of Report: To note the new contracting arrangements for those areas of public health services that are transferring over from the SW Essex Primary Care Trust to Thurrock Council from 1 April 2013 and their financial value.	

EXECUTIVE SUMMARY

As part of the reforms contained within the Health and Social Care Act 2012, responsibility for commissioning certain public health functions will transfer from Primary Care Trusts to Local Authorities upon the abolition of PCTs on 31 March 2013.

This report updates HOSC as to the new commissioning and contracting arrangements that will operate from 1 April. A parallel report is going to Cabinet on 13th March.

1. RECOMMENDATIONS:

That HOSC notes and comments on the following:

1. **It is proposed for 2013/14, for those services listed in 2.4, Thurrock will enter into the standard NHS 2013/14 form of contract with the relevant provider, and a formal commissioning agreement with the relevant Clinical Commissioning Group (CCG) as follows :**

a. **Thurrock CCG for North East London Foundation Trust (NELFT) services.**
b. **Basildon and Brentwood CCG for Basildon and Thurrock University Hospital (BTUH) services.**
c. **Castlepoint and Rochford CCG for South Essex Partnership Trust (SEPT) services.**
d. **Southend CCG for Southend University Hospital Foundation Trust (SUHFT) services.**

2. **It is proposed to contract with GP practices and pharmacists in Thurrock for the delivery of designated services detailed in 3.8 using the standard 2013/14 form of contract released by the Department of Health.**

3. **It is proposed that the final budget for these agreements is agreed by the Director of People's Services in consultation with the Portfolio Holder for Adult Social Care and Health provided that the final budget is contained within the Public Health Grant allocation of £ 7,417k and is line with the approach outlined in 3.4 below.**

The standard form NHS 2013/14 contract, the formal commissioning agreement and the standard form Department of Health 2013/14 health contract for primary care services are not attached. Copies can be provided on request and are available in the member's room

2. INTRODUCTION AND BACKGROUND:

2.1 Local government has a long and proud history of promoting and protecting the public's health dating back to the Victorian times. Indeed it was only in 1974 that the NHS took over most public health functions. The government is returning responsibility for improving public health to local government for several reasons – their population focus; ability to shape services to meet local needs; ability to influence wider social determinants of health and ability to tackle health inequalities. Taking a population perspective, which is at the heart of public health, is a natural part of the role of local government.

2.2 Local authorities are well placed to release innovation, trying new ways to tackle intractable public health issues. They have considerable expertise in building and sustaining strong relationships with local citizens and service users through community and public involvement arrangements which will help extend the engagement of local people in the broader public health improvement agenda. This is currently evident with the work the local authority is leading on Local Area Co-ordination.

2.3 Local government has moved from a focus on delivering services to a much wider role in shaping local place. Having taken on the key role in promoting economic, social and environmental well-being at the local level it is well placed to adopt a wider health and well-being role.

2.4 The local authority will be responsible for commissioning a number of public health and health improvement services from 1st April 2013. This will be primarily led by the health needs assessment contained within the JSNA and the Health and Well-being strategy.

There are a number of mandatory public health services that local authorities must commission or provide. These include:

- Appropriate access to sexual health services (excluding abortion services which will be commissioned by clinical commissioning groups and Sexual Assault Referral Centres, which will be commissioned by the NHS Commissioning Board)
- The National Child Measurement Programme
- NHS Health Check Assessments
- The duty to ensure that there are plans in place to protect the health of the population
- Ensuring NHS Commissioners receive the public health advice they need (the public health 'core offer')

The more discretionary responsibilities of local authorities will include local activity on:

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services*
- Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19)
- Obesity and community nutrition initiatives
- Increasing levels of physical activity in the local population
- Public mental health services
- Dental public health services
- Accidental injury prevention
- Population level interventions to reduce and prevent birth defects
- Behavioural & lifestyle campaigns to prevent cancer and long term conditions
- Local initiatives on workplace health
- Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation programmes
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Role in dealing with health protection incidents and emergencies
- Promotion of community safety, violence prevention and response
- Local initiatives to tackle social exclusion
- Local initiatives that reduce public health impacts of environmental risks

Local authorities will commission children's public health services from pregnancy to 5 by 2015, but in the short term the NHS Commissioning Board will be responsible for commissioning health visitors.

2.5 The local authority has been actively involved in some of these areas but was not the lead agency. From 1st April the local authority will have the lead responsibility for assessing need, identifying gaps in service and, where appropriate, being the lead commissioner for any service provision.

2.6 Local authorities are able to choose to commission a wide variety of services under their health improvement duty and indeed local authorities are encouraged to be innovative as they embrace their new duties. This freedom is being kept quite wide to encourage locally driven solutions underpinned by a robust analysis of the needs and assets of the local population.

2.7 Local authorities will be expected to work alongside Public Health England (the new national body responsible for overseeing the improvement in health outcomes) and our local Clinical Commissioning Group – CCG (the local commissioning body that will be the successor to the PCT for most commissioning areas outside of Public Health) in securing the best possible health outcomes for the local population.

3. ISSUES, OPTIONS AND ANALYSIS OF OPTIONS:

3.1 The bulk of the current public health spend is with two NHS Foundation Trusts – North East London Foundation Trust (NELFT) for most of the Stop Smoking services, breast feeding support, adult and children's weight management, 5-19 years healthy child programme (school nursing) and sexual health services. South Essex Partnership Trust (SEPT) for most of the drug, alcohol and mental health services. There is a small contract with Basildon and Thurrock University Hospital Trust (BTUH) and with Southend University Hospital Foundation Trust. There are also a number of "Local Enhanced Services" (LES) with GP practices and pharmacies to deliver specific services, which present their own series of issues and these are dealt with below.

3.2 The best estimate for the amount actually being spent on public health duties in Thurrock in this financial year, 2012/13, is **£ 8.5m**. The contracts were not specifically commissioned on a Thurrock or Basildon/Brentwood basis but were principally commissioned on a SW Essex basis.

3.3 On 7 January 2013, after a considerable delay, the Public Health Grant (PHG) allocations for the whole of England were announced. This amounted to £ 7,417k for Thurrock for 2013/14. So a £ 1.1m **shortfall** compared to what is estimated is currently being spent in 2012/13 on public health services in Thurrock. We continue to make representation to the Department of Health and to Essex County Council to get a fair share of the PHG which more accurately reflects the amount spent locally.

3.4 We have had a series of discussions with our two main providers NELFT and SEPT to identify potential savings which do not impact on service delivery in light of the significant reduction in funding that Thurrock has received. The approach has been to identify efficiency savings in the first instance, protect

our statutory duties and ensure front line services are protected as far as possible. Negotiations with the provider Trusts have not reached a conclusion at the time of writing this report.

3.5 The next issue is what should be the appropriate contractual arrangements between the local authority and providers. It has not been possible to undertake the usual procurement exercise so 2013/14 will need to be an interim year whilst the Public Health team – in conjunction with procurement and commissioning teams already within Thurrock – clarify the exact nature of these contracts, review services and agree what should be subject to a full procurement exercise going forward.

3.6 This has been discussed with legal colleagues, officers in Southend and Essex County Council to see if there is any merit in doing this jointly and so ensuring some economies of scale but also maximising our commissioning focus. It will also be the case that the PCT will technically be signing the contracts prior to the close down of the PCT on 31st March as these agreements need to be in place before the 1st April handover. However, this will only be done with the agreement of the local authority and so we are directing the current contract negotiations – both for the services we want to see delivered and the financial value of those services.

Option 1 - We could contract directly with the main providers NELFT, BTUH, SUHFT and SEPT using the standard NHS 2013/14 form of contract.

Option 2 - We could enter into a Section 75 agreement with the relevant local Clinical Commissioning Group for these four main contracts. That would mean in effect the contract would be held between the relevant CCG and the four providers. We would still retain a separate schedule which would include a detailed service and activity analysis of the services we were commissioning but the transfer of funding would be between the local authority and the CCG. We would also agree a clear performance and accountability framework.

Option 3 – We could become an associate commissioner alongside the lead CCG by entering into the standard NHS 2013/14 form of contract and also entering into a formal commissioning agreement with the lead CCG. Unlike the Section 75 arrangement we would retain a greater degree of control through having a formal commissioning agreement with the lead CCG which sets out a separate performance schedule, a separate service specification and the payment would be to the provider direct. Furthermore, as a direct contracting party under the NHS standard contract we would have the right to enforce the contract against the provider. Also, unlike option 1, we would be working alongside our CCG partners.

Option 3 is preferred as it allows for an integrated commissioning approach between ourselves and the CCG where we share a common interest and where there are significant links with services that the CCG is also commissioning. It also gives us a greater degree of control during what will inevitably will be a transition year allowing us to get beneath the contracts and undertake service reviews.

3.7 Local Enhanced Services – There are a range of services currently being commissioned by the PCT from GPs and pharmacist that come within the remit of the local authority under the new public health responsibilities:

These include:

NHS Health Checks – GP practices
Stop Cessation – GP Practices
Community Pharmacy Smoking Cessation
Chlamydia – GP Practices
Pharmacy Sexual Health – Chlamydia, EHC and C-Card
IUCD, Implants and Injections – GP Practices

Discussions have been held with the Local Pharmacy Committee (LPC) and the Local Medical Committee (LMC) as the representative bodies for those professions about the best way forward for commissioning these services. The view remains that GPs and Pharmacists remain in the best position to deliver these services during 2013/14 because of their access to patients via their registers and the opportunity the services present for lifestyle interventions and increasing access to interventions (e.g. IUCD, Implants and Injections)

The Department of Health has produced a model contract for these LES services. This is under negotiation between Essex County Council and the LPC and LMC in the south Essex region. It is recommended that we enter into a local agreement with GPs and Pharmacists in Thurrock for the following services using the agreed national contract on the same terms as that being entered into by Essex County Council and Southend Unitary Council to maintain consistency with the LPC and LMC for the transition year. The financial value is to be agreed by the Director of Public Health in consultation with the relevant Portfolio Holder.

4.0 REASONS FOR RECOMMENDATION:

4.1 The recommendation to enter into the standard NHS 2013/14 contracts and the formal commissioning agreements with the relevant CCGs secures the twin objectives of strengthening our commissioning links with our CCG partners but also gives the local authority maximum flexibility. The agreement is only for one year and will be reviewed for 2014/15.

5. CONSULTATION (including Overview and Scrutiny, if applicable)

5.1 This report is going to HOSC on 12th March, we have had extensive consultations with our CCG colleagues and officers from provider Trusts.

6. IMPLICATIONS

6.1 Financial

Implications verified by: **Mike Jones**
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The funding for the integration of Public Health Services is provided via a ring fenced grant to the Local Authority. This is to be used in order to meet the statutory requirements relating to the services which will be under the remit of Thurrock Council.

As detailed in Para 3.5, it has been identified that there is a possible £1.1m shortfall of funding in relation to the existing level of service. This will need to be financed through a reduction in the cost of the service whilst ensuring that statutory duties are met, as currently, there is no growth identified in the Councils Medium Term Financial Strategy.

6.2 Legal

Implications verified by: **Wade Turner**
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This services described within this report are classified as "Part B" services under Schedule 3 of the Public Contract Regulations 2006 (as amended) and are therefore not subject to full EU-wide tendering, although requirements regarding transparency and advertising apply. Cabinet or the officer with delegated authority may waive the requirements for full tendering under its Constitution. The Council will need to ensure that it complies with the Best Value Duty contained in section 3 of the Local Government Act 1999.

It is essential that contract documentation is completed by 1 April 2013 in line with the statutory transfer process. Legal Services will assist with the contract arrangements to be put in place by that date.

6.3 Diversity and Equality

Implications verified by: **Samson DeAlyn**
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The transfer of Public Health responsibilities from the Primary Care Trust to the local authority represents a significant opportunity for local government. This area of work was traditionally seen as core business for local government up until 1974 and was used to secure significant health improvements over the course of the 20th century. Some of the most significant improvements in health and life expectancy came about because of initiatives led by local government, particularly in the field of public health.

The Joint Strategic Needs Assessment and the draft Health and Well-being Strategy highlight some of the significant health challenges facing Thurrock where there are wide variations in life expectancy and the quality of health outcomes. The PHG should be used to minimise these variations, challenge some of the inequalities in health outcomes that exist and work with Thurrock's communities to improve health outcomes.

There may be some decommissioning proposals that are required as a result of the reduction in the PHG. It is important that any diversity implications and community impact are fully assessed before they are finalised.

6.4 **Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

None

BACKGROUND PAPERS USED IN PREPARING THIS REPORT (include their location and identify whether any are exempt or protected by copyright):

- Health & Social Care Act 2012
- LGA Factsheets

APPENDIX 1 – List of key abbreviations

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Appendix One : Key Abbreviations

- **BTUH** – Basildon and Thurrock University Hospital Trust. The main local acute hospital for Thurrock.

- **CQC** – The Care Quality Commission. CQC is responsible for registering and monitoring the quality and standards of care in all health and social care providers across England.

- **CCGs** – Clinical Commissioning Groups : CCGs will become formally established from April 1st 2013 when they take over the bulk of the commissioning responsibilities from Primary Care Trusts. They will be our key commissioning partner. Thurrock CCG will be based in the Civic Offices.

- **CSU** – Commissioning Support Unit. CSUs will formally start operating on 1st April 2013. They will be running most of the support functions such as finance, HR, ICT, contract management etc that were previously run by the PCT. Our CSU covers the whole of Essex.

- **HWBB** – Health and Well-Being Board. From 1st April HWBBs will become statutory bodies reporting to the Council. They are partnership bodies representing all partners locally – CCGs, the Council, Healthwatch and the NCB. The Thurrock HWBB is chaired by Cllr Barbara Rice.

- **DPH** – Director of Public Health. From 1st April 2013 DPHs will be employed directly by local authorities. They will provide key public health advice to members and senior officers of the Council. Thurrock's DPH is Dr Andrea Atherton and this is a shared post with Southend Council.

- **NCB** – The National Commissioning Board. This is responsible for overseeing the performance of NHS services in England. Locally it will commission all primary care providers and it will oversee the performance and funding of CCGs. We have a local office covering Essex. This is known as the Essex Area Team (EAT) of the NCB.

- **NELFT** – North East London Foundation Trust. NELFT runs the majority of our local community services such as District Nursing, therapy services and most services based at the Thurrock hospital.

- **PCT** – Primary Care Trust. From 31st March 2013 PCTs will be abolished and their responsibilities passed to a number of successor bodies.

- **PHE** – Public Health England. A new national body which starts officially on 1st April 2013 with the responsibility to oversee Public Health policy and implementation across England.

- **SEPT** – South Essex Partnership Trust. SEPT is our local mental health provider delivering mental health services across the whole of South Essex.