Meeting	Health Overview and Scrutiny
Date	12 February 2013
Subject	Public Health Transition
Report of	**Transfer of Public Health Function**
Summary	Following an initial report approved by Cabinet Resources Committee for the development of a shared public health service between the London Boroughs of Barnet and Harrow, the report set out in Annex A requests delegated authority for the Cabinet Member for Public Health to sign the Inter-Authority Agreement for the Shared Service; approval for the transfer of Public Health contracts from the NHS to the Council and approval for the sign-off of the Public Health Commissioning Intentions.

Officer Contributors	Kate Kennally, Director of People Andrew Howe, Joint Director for Public Health, Barnet and Harrow
Status (public or exempt)	Public
Wards Affected	all
Function of	Health Overview and Scrutiny Committee
Enclosures	Annex A: Cabinet Resources Committee report
Contact for Further Information:	Richard McSorley Email: Richard.McSorley@barnet.gov.uk Tel: 020 8359 3877

1. RECOMMENDATIONS

1.1 That the Health Overview and Scrutiny Committee note the report.

2. RELEVANT PREVIOUS DECISIONS

2.1 As set out in the attached report at Annex A

3. CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 As set out in the attached report at Annex A

4. RISK MANAGEMENT ISSUES

4.1 As set out in the attached report at Annex A

5. EQUALITY AND DIVERSTIY ISSUES

5.1 As set out in the attached report at Annex A

6. USE OF RESOURCES IMPLICATIONS (finance, procurement, performance and value for money, Staffing, IT property, sustainability)

6.1 As set out in the attached report at Annex A

7. LEGAL ISSUES

7.1 As set out in the attached report at Annex A

8. CONSITITUTIONAL POWERS

8.1 The scope of the Overview and Scrutiny Committees is contained within Part 2, Article 6 of the Council's Constitution.

8.2 The Terms of Reference of the Scrutiny Committees are included in the Overview and Scrutiny Procedure Rules (Part 4 of the Council's Constitution). The Health Overview and Scrutiny Committee has within its terms of reference responsibility:

(i) To perform the overview and scrutiny role in relation to health issues which impact upon the residents of the London Borough of Barnet and the functions services and activities of the National Health Service (NHS) and NHS bodies located within the London Borough of Barnet and in other areas.

(ii) To make reports and recommendations to the Executive and/or other relevant authorities on health issues which affect or may affect the borough and its residents.

(iii) To invite executive officers and other relevant personnel of the Barnet Primary Care Trust, Barnet GP Commissioning Consortium, Barnet Health and Wellbeing Board and/or other health bodies to attend meetings of the Overview and Scrutiny Committee as appropriate.

9. BACKGROUND INFORMATION

9.1 As set out in the attached report at Annex A

10. LIST OF BACKGROUND PAPERS

10.1 As set out in the attached report at Annex A

This page is intentionally left blank.

ANNEX A

Meeting Date	**Cabinet Resources Committee 25 February 2013**
Subject	**Transfer of Public Health Function**
Report of	**Cabinet Member For Public Health**
Summary	**Following an initial report approved by CRC for the development of a shared public health service between London Boroughs of Barnet and Harrow, this report requests delegated authority for the Cabinet Member for Public Health to sign the Inter-Authority Agreement for the Shared Service; approval for the transfer of Public Health contracts from the NHS to the Council and approval for the sign-off of the Public Health Commissioning Intentions.**

Officer Contributors	Kate Kennally, Director for People Andrew Howe, Joint Director for Public Health, Barnet and Harrow
Status (public or exempt)	Public
Wards Affected	All
Key Decision	Yes
Reason for urgency / exemption from call-in	Not applicable
Function of	
Enclosures	• Appendix One – Principles for the Public Health Inter-Authority Agreement • Appendix Two Public Health Contracts Schedule and Contracting Plan • Appendix Three - Public Health Commissioning Intentions for 2013/14 • Appendix Four Draft Memorandum of Understanding between Barnet CCG and London Borough of Barnet
Contact for Further Information:	Richard McSorley Email: Richard.McSorley@barnet.gov.uk 020 8359 3877

RECOMMENDATIONS

1.1 Cabinet approves the delegation of authority to the Cabinet Member for Public Health in consultation with the Leader of the Council to sign by no later than the 1st of April 2013, the Inter-Authority Agreement for the shared public health service between the London Boroughs of Barnet and Harrow in line with the principles set out in Appendix One to this report;

1.2 Cabinet approves the delegation for the formal signing off of the NHS Transfer Orders for Public Health functions to the Cabinet Member for Public Health and for the signing off of NHS Handover Certificates to the Director for People.

1.3 Cabinet approves the plans for entering into contracts for the provision of Public Health functions as set out in Appendix Two to this report.

1.4 Cabinet approves the initial 'Public Health Commissioning Intentions' document set out in Appendix Three

1.5 Cabinet notes the progress on developing the Memorandum of Understanding between the London Borough of Barnet and Barnet Clinical Commissioning Group and delegates responsibility to sign off the Memorandum of Understanding to the Cabinet Member for Public Health.

2 RELEVANT PREVIOUS DECISIONS

2.1 Cabinet, 14 February 2011 (Decision Item 10) noted the proposal from Government regarding the transfer of Public Health responsibilities from the NHS to Local Government arrangements and the initial arrangements for a joint Director for Public Health with the NHS until 31st March 2013.

2.2 Cabinet Resources Committee, 20 June 2012 (Decision Item 14) – noted the range of Public Health functions that are being transferred from the NHS to Local Councils and approved the development of a shared public health service with London Borough of Harrow (LBH) to deliver London Borough of Barnet's (LBB) public health functions and statutory duties from the 1st of April 2013.

2.3 Barnet Health and Well-Being Board, 4th October 2012 (Decision Item 5) – approved the Barnet Health and Well-Being Strategy, 'Keeping Well, Keeping Independent'

2.4 Cabinet, 7th November 2012 (Decision Item 5) – Agreed draft new strategic priorities for consultation with the Public through the Finance and Business Planning Process and noted the draft commissioning priorities for Public Health for 2013/14.

3 CORPORATE PRIORITIES AND POLICY CONSIDERATIONS

3.1 The Health and Social Care Bill attained Royal Assent in March 2012. The transfer of Public Health functions to the Local Authority from April 2013 is one of the outcomes of the Health and Social Care Act and forms a key element of the new local health landscape, together with the development of the Barnet Health and Wellbeing Board and the Clinical Commissioning Groups. It offers significant opportunities for the Authority to set policy, provide leadership and commission activity that will contribute to improved health outcomes and wellbeing for the population of Barnet.

3.2 The 2012 Health and Social Care Act provides councils with new duties to deliver public health functions from the 1st of April 2013 and to ensure that there is a Health and Well-Being Board led by Councils to promote health and well-being and health and social care integration in conjunction with the NHS. In 2011 Barnet established in shadow form the Barnet Health and Well-Being Board and on 4th October 2012, the Health and Well-Being Board approved the Barnet Health and Well-Being Strategy, 'Keeping Well, Keeping Independent'.

3.3 The Barnet Health and Well-Being Strategy is consistent with the Council's proposed new strategic objectives for 2013-2016 of 'Support families and individuals that need it – promoting independence, learning and well-being' and associated priority outcomes of 'to create better life chances for children and young people across the borough'; .'To sustain a strong partnership with the local NHS, so that families and individuals can maintain and improve their physical and mental health'; 'To promote a healthy, active, independent and informed over 55 population in the borough so that Barnet is a place that encourages and supports residents to age well' and 'To promote family and community well being and encourage engaged, cohesive and safe communities'.

3.4 The Shared Public Health service will be required to lead on the implementation of the Barnet Health and Well-Being Strategy, with the annual report from the Director for Public Health setting out the levels of progress that have been made in the preceding year on the delivery of the strategy.

3.5 Public health contracts will transfer to LBB on the 1st April 2013. A contract management strategy and 'public health commissioning intentions' document have been developed to ensure efficiencies are delivered and public health expenditure delivers against Corporate Plan objectives and Health and Wellbeing outcomes.

4 RISK MANAGEMENT ISSUES

4.1 Risks will be actively managed in line with the corporate risk management approach. The key risks in respect of the transfer of public health functions

and their mandatory responsibilities to be delivered by the establishment of a shared Public Health service are as follows:

Risk	Mitigation
Financial allocation is inadequate to meet public health liabilities	Due diligence work has been undertaken on the contracts values which will be transferred to the Local Authority and the baseline allocation will be sufficient for both meeting all liabilities and ensuring that the Council's new statutory responsibilities for Public Health can initially be met. This will require investment in the provision of NHS health-checks in 2013/14..
London Borough of Harrow hosted shared service fails to meet London Borough of Barnet's public health mandatory and statutory duties	The Inter-Authority Agreement (IAA) and annual workplan which will be formally approved by the Joint Public Health Service Governance Board chaired by Barnet will monitor the delivery of the shared public health service on a quarterly basis. This will allow for opportunities to take remedial action should performance metrics show the need, whilst the IAA sets out the formal arrangements for dispute resolution and termination.
A shared Director of Public Health (DPH) may be less accessible for Members and Officers in Barnet.	The Director for Public Health (DPH) role will be evenly divided between both Boroughs. The Director for Public Health will be a core member of the Commissioning Group working with the Director for People to lead the Health and Well-Being agenda. A dedicated Public Health consultant post will be established in the shared service to deputise for the Director for Public Health to ensure that the Council receives the strategic health advice needed to discharge it's new responsibilities.
Financial risk for open-access demand-led sexual health services	The commissioning strategy for sexual health Genital Urinary Medicine services seeks to negotiate a cap on costs, irrespective of demand.
Risk of potential for prior year claims from NHS providers to be made to the Council in respect of Public Health	To be partly mitigated through formal handover meetings between NHS North Central London and the Council during February 2013 agreeing what if any level of risk this presents to the Council and process for managing it. However given that NHS North Central London will also cease to exist in 2013/14 it is considered prudent to hold a small contingency

	provision or earmarked reserve specifically for public health, funded by the ring-fenced Public Health grant to mitigate any risks that materialise during 2013./14.
Linkages between devolved Development and Regulatory Services (DRS) and Public Health may be affected.	The DRS Output Specification has stated that the contractor should run no fewer than three public health specific programmes per annum. The Director for Public Health, through the Health and Well-Being Board will ensure that the DRS provider's health and well-being initiatives are informed by the Council's Health and Well-Being Strategy and Public Health priorities.

4.2 Transition risks identified have included the Shared Public Health function not receiving clear level of handover from Barnet PCT / North Central London NHS on the public health services which have been delivered. To mitigate this risk, the transition process requires the completion of Handover Certificates by the NHS setting out by function, service and contract the position as at the point of transfer of the Public Health services in Barnet. These handover certificates will be developed by NHS North Central London in conjunction with the Joint Director for Public Health for sign off by the Director for People by mid March 2013.

4.3 In addition to the above mitigation, the Council has commissioned as part of its 2012/13 Audit Programme, an audit focused on Public Health which will report by the end of February 2013. This audit will examine the Council's state of readiness for the delivery of new statutory responsibilities from 1st April 2013, the robustness of the draft Inter Authority Agreement/ Governance arrangements and stakeholder management issues especially in relation to the delivery of the Public Health 'core offer' for Barnet Clinical Commissioning Group.

5 EQUALITIES AND DIVERSITY ISSUES

5.1 LBB's public health commissioning strategy is devised in part to meet the outcomes identified in the Barnet Health and Wellbeing Strategy, including to reduce health inequalities. An Equalities Impact Assessment (EQA) was carried out on the shared public health target operating model. The focus of the assessment was on the process of change needed in developing a Target Operating Model to establish transfer of public health services and functions to Barnet and Harrow Councils. The intention of the transfer is to ensure the delivery of statutory Public Health responsibilities to improve wherever possible the public health and wellbeing of residents in both boroughs. The new shared public health function will not have any adverse impacts on any group.

6 RESOURCE IMPLICATIONS

6.1 Financial Considerations

The Department of Health originally communicated the likely budget for Barnet Council to deliver its Public Health responsibilities in 2013-14 as approximately £11.2m based on the 2010/11 NHS returns of public health expenditure by Local Authority area. This return as previously reported to Cabinet Resources Committee and the Health and Well-Being Board would lead to the Barnet allocation being the 5th lowest in terms of spend per head in London, considerably lower than both the England and the London average.

6.2 However early in January 2013, the Department for Health published Local Authority allocations for 2013/14 and 2014/15 following consultation on proposed resource allocation framework for Public Health functions within Local Authorities. This resulted in the Barnet allocation being increased to £13.799 million per annum increasing to £14.355 million per annum in 2014/15. Whilst this is to be welcomed, the allocation at 2014.15 is equivalent to £38 per head, from an opening baseline of £35 per head. This is still lower than the England average of £40 per head based on the 2010/11 baseline with only the London Boroughs of Harrow and Bexley having lower spend per head allocations. The London Borough of Barnet will continue through London Councils to argue for a fair settlement for outer London Boroughs beyond 2014/15 allocations.

6.3 The publication of the two year grant settlement providers the Council with more certainty in planning public health services to March 2015 and in announcing the grant allocation, the DH have also published the grant conditions which allow under spends to be carried forward as part of a public health reserve into future financial years. However where there are repeatedly large under spends it is likely that the Department will consider whether allocations should be reduced in future years.

6.4 The ring-fenced Public Health Grant must be deployed to ensure that the Council is able to meet its mandatory Public Health functions as set out in the Health and Social Care Act 2012. The Council also needs to ensure that in the first year of 2013/14, that a detailed base-lining exercise of all transferring NHS contracts relating to Public Health activity is completed so that there is clarity on volumes, activity levels and value for money. Transferring Public Health contractual liabilities including public health staff costs attributed to London Borough of Barnet in the new service are just under £10m, of this £8.78m relate to contracts and £1.2m are salaries. This provides sufficient headroom for the Council to be able to invest in NHS Health-checks in line with Council's statutory responsibilities.

6.5 The initial Public health commissioning intentions as set out in Appendix Three have been developed to cover all liabilities, deliver statutory responsibilities and allocate additional expenditure to activities that support the delivery of the Barnet Health and Wellbeing Strategy and the Corporate Plan.

6.6 While the majority of spend will be commissioned and therefore controllable to a large extent, Members should note that genitourinary medicine (GUM) services for which the responsibility transfers from the NHS to Local Authorities will continue to be provided through the national agreement whereby anyone can access GUM services in any part of England and Wales. This presents a budgetary risk to Councils which we are seeking to ameliorate through joint working with London Councils and adopting a common negotiating position on sexual health contracts across North West London.

6.7 Efficiencies will be delivered both through a shared public health service with Harrow. The new staffing structure has been developed to deliver a 15% efficiency saving for both Councils on the 2010/11 staffing structure, and through efficiency savings on public health contracts. Running costs will capped at the level set out in the baseline returns for Public Health for Barnet and Harrow - £135,000 for Barnet and £166,000 for Harrow, providing a total envelope of approximately £300,000 for the joint service in relation to overhead costs which will be split 50/50 between each Council. The services for which overhead charges will be made include IT, finance, procurement, liability insurance (employers, public and clinical negligence), HR & payroll and accommodation. A detailed schedule of overhead charges will form part of the finalised Inter-Authority Agreement and will be revised and agreed on an annual basis through the Governance Board.

6.8 The Council has incurred transition costs in relation to the transfer of Public Health responsibilities which have been estimated to be £300,000. The Department of Health has provided a grant of £100k to the London Borough of Barnet as a contribution to these costs, the remaining amount has been funded Adult Social Care and Health monies transferred to the Council by the NHS through a section 256 agreement. No Council core funding has therefore been used to fund these transition costs.

6.9 HR Considerations The shared public health team will be hosted by Harrow Council, with those Barnet staff from NHS Barnet that form part of the shared public health team transferring to Harrow Council and becoming Harrow employees. Up to 40 Public Health NHS staff will transfer to London Borough of Harrow as the receiver organisation under the Department of Health transfer scheme under TUPE-like conditions. The London Borough of Harrow is anticipating receiving the HR Transfer Order by the end of January 2013.

6.10 A Target Operating Model and staffing structure for the Shared Public Health Service was developed during 2012/13 based on the operating principles agreed by Cabinet Resources Committee in June 2012. The staffing structure within the Target Operating Model has formed the basis for the selection and appointment of Harrow and Barnet Public Health NHS staff into roles in the shared service during quarter 3 and 4 of 2012/13. This has been an NHS led selection process designed to ensure that

Public Health staff had clarity on their future roles in advance of dissolution of Primary Care Trusts and has ensured that any redundancy costs have been contained within NHS budgets. However from the 1st of April 2013, any financial liabilities arising from any further staffing changes will need to borne by the Barnet and Harrow Councils in line with the terms of the Inter-Authority Agreement. The Inter-Authority Agreement will describe the exit and human resources strategy for staff transfers to LBB in the event the shared service is terminated. See Appendix One for further details.

6.11 The team will be led by the Joint Director of Public Health, Dr Andrew Howe who will be managed on a day-to-day basis by the Corporate Director of Community, Health and Wellbeing within Harrow Council. However the Joint Director of Public Health will have an accountability line to the Director for People within Barnet Council as part of the Commissioning Group.

6.12 The public health team will be largely based at Harrow Council premises: however there will be up to six health improvement leads based at the North London Business Park for approximately 80% of the time to provide support to Barnet GPs, officers and members. Office accommodation for the shared Public Health service has been calculated in joint running costs for the service.

6.13 IT Considerations – The Shared Public Health service IT requirements will be met by the London Borough of Harrow using LB Harrow software and hardware which will support remote working from office bases within Barnet. As the host authority, the London Borough of Harrow is responsible for ensuring that the capability to access public health data to support the Public Health function meet it's statutory responsibilities .To be capable of accessing NHS public health data local authorities require a 'N3 Connection', which requires councils to be compliant with the NHS Information Governance Toolkit. London Borough of Harrow will achieve compliance by June 2013 and for the intervening months, an agreement has been reached with Harrow Clinical Commissioning Group for the shared Public Health service to access public health data at their premises. Since the provision of public health responsibilities is not the only driver for acquiring a N3 Connection, LBB is separately working towards N3 Compliance to support the delivery of integrated health and social care services. This is important to have this capability if the two boroughs in the future were to decide to dismantle the shared agreement and provide public health functions separately.

6.14 Procurement Implications – The Department of Health has set out arrangements for the transfer of liabilities, assets and contracts to Local Authorities through the Transfer Scheme. The purpose of the Transfer Scheme is to provide certainty and clarity to all effected entities and enable the legal documents to be produced to implement the NHS transfer. Under the terms of the NHS Transfer Scheme, Barnet Public Health contracts will be transferred directly from the NHS to the London Borough of Barnet. The Council through the shared Public Health service will hold the

accountability for these contracts although they will be managed by Harrow under the terms of the Inter-Authority Agreement.

6.15 Barnet Council has been consulted to date on the proposed content of the Contracts/ Assets and Liabilities Transfer scheme and the national timescale requires North Central London NHS Cluster to submit to the Department of Health by the 14th of March 2013 the final Transfer Scheme in order for this to come into effect from the 1st April 2013. The Chief Executive of North Central London NHS Cluster will meet with the Interim Chief Executive of the Council and the Director for People prior to the 14th of March 2013 submission to allow for the Council to comment on the final Transfer Scheme.

6.16 The Transfer Scheme for Barnet includes all contracts, assets and data that will be transferred to Barnet on the 1st April 2013. Barnet is not expecting to receive any assets or estates as part of the transfer scheme. The total value of the contracts listed for Public Health services is £8.78million and those that are to be transferred to the Council are listed in Appendix Two. These include a number of Local Enhanced Schemes (LES) contracts which are provided by GPs and Pharmacies and which in the future, will need to commissioned and managed in partnership with the Clinical Commissioning Group.

6.17 The contracts will be managed by the public health commissioning team within the shared Public Health Service and this team will report regularly to the Director for Public Health on progress against key performance indicators, public health outcomes and on financial performance.

6.18 As part of the Public Health contracts transition process, a full review has been conducted on the robustness of the current NHS contracts for Public Health. This has identified some challenges and opportunities to improve value for money and ensure that there is clarity on the expected performance levels for each of the contracts. Work is ongoing to engage with the incumbent supplier base and finalise the service and costs/charges for 2013/14. This process is being led by the NHS in conjunction with the Public Health team.

6.19 Contracts for 2013/14 will be signed by both parties during March 2013 with a clear plan to commence the re-commissioned services from 1st April 2013.

6.20 In line with other Councils, Barnet's approach to contracts for year one (2013/14) has been to take a pragmatic approach and not to seek to re-tender services prior to the transfer to the Local Authority. The approach has been to novate some contracts directly from the NHS to the Council; to sign new contracts on Barnet Council's terms and conditions of contract with providers where existing NHS contracts expire before 1 April 2013 and merging or combining some contracts where, for example Barnet already has contracts in place with those providers and there are

synergies or sound commercial reasons to combine the transferred services with existing service provision. Appendix Two sets out by contract the proposed approach for Barnet Public Health contracts.

6.21 For year one of the shared Public Health service, the intention is to complete a detailed base-lining exercise and thorough review of contracts to support future de-commissioning or re-commissioning decisions as appropriate. Any future procurement will be undertaken in line with the Council's Contract Procedure Rules to ensure that the Council achieves best consideration.

6.22 Performance Implications - As the Public Health function is integrated into the Council the requirement to deliver the Public Health Outcomes Framework will be fully integrated into the Council's existing performance management framework and Corporate Plan. The Department of Health published the final outcomes framework at the end of November 2012 and produced by Borough an assessment of performance against the public health outcomes framework. For Barnet, the following areas scored significantly lower performance levels than regional / national average in respect of screening for cancers and sexual diseases; provision of NHS Health-checks, and pre-school immunisation rates for the MMR vaccine. These have all been identified as areas for improvement in the Barnet Health and Well-Being strategy and will require a joined up approach across the shared Public Health service with the NHS Commissioning Board who has responsibility for screening and immunisation services.

7 LEGAL IMPLICATIONS

7.1 The 2012 Health and Social Care Act gives councils new statutory responsibilities in respect of delivery of public health functions.

7.2 There will be an Inter-Authority Agreement (IAA) between Barnet and Harrow to ensure that the requirements of the service are clearly specified and agreed and legally binding. The key principles of the IAA are shown in Appendix One to this report and will ensure that Barnet Council is able to discharge its statutory responsibilities in respect of Public Health. These principles were agreed by the Cabinet of the London Borough of Harrow on the 13th December 2012. It is proposed that the finalised IAA will be entered into pursuant to authorisation by the Cabinet Member for Public Health in consultation with the Leader acting under executive powers prior to the implementation of the shared Public Health Service on the 1st of April 2013.

7.3 The proposal would be effected by a delegation by Barnet of its Public Health function to Harrow under section 101 of the Local Government Act 1972 and the relevant Executive Function Regulations. Staff working in the shared Public Health team will be made available to Barnet under section 113 of the Local Government Act 1972 which will enable each Council to delegate decisions to them as if they were their own staff.

8 CONSTITUTIONAL POWERS (Relevant section from the Constitution, Key/Non-Key Decision)

8.1 The Council's Constitution in Part 3 Responsibility for Functions, paragraph 3.6 states the terms of reference of the Cabinet Resources Committee including 'approval of schemes not in performance management plans but not outside the Council's budget or policy framework.'

8.2 The Council's Constitution will be reviewed and amended to reflect the new public health functions and statutory duties of the Local Authority with any changes approved by the Constitution, Ethics and Probity Committee on the 27th of February 2013.

9 BACKGROUND

9.1 The Health and Social Care Act 2012 became law in March 2012. One of its key proposals is the transfer of the existing Public Health functions currently being undertaken through Primary Care Trusts. These functions will be split between Public Health England the NHS Commissioning Board and Local Authorities. The Act identifies the expected and mandated public health commissioning responsibilities for local authorities from April 2013.

9.2 The publication of Healthy lives, Healthy people: Improving outcomes and supporting transparency: a Public Health Outcomes Framework for England 2013-2016 (Jan 2012) identified the 66 indicators that local authorities, Public Health England and the NHS Commissioning Board will use to measure progress against the two main national Public Health outcomes, a selection of which will be identified by local authorities to work towards as priorities locally and which will contribute towards achieving the health premium.

9.3 The decision to pursue a shared Public Health Service reflects Barnet and Harrow Council's common position that it is vitally important to establish a centre of Public Health expertise with a sufficient critical mass of Public Health specialists. A combined specialist team will create the necessary capacity and skill mix to effectively manage the Local Authorities' new statutory public health responsibilities and provide the necessary leadership to place public health at the heart of Local Authority policy development, commissioning and service delivery. This will also enable us to focus resources on frontline services and minimise staffing expenditure.

9.4 The Inter-Authority Agreement will govern the running of the shared service and an annual work-plan will be agreed between the two authorities to describe how public health expenditure will be used to meet the priorities identified in Barnet's Health and Well-being Strategy and to also meet the needs identified in the Joint Strategic Needs Assessment. It will also, amongst other things, ensure that no council profits from the

arrangement and issues of data sharing, contract management, staff transfers and appraisal are dealt with properly in accordance with the principles agreed between both councils. The agreement will be set for an initial term of 5 years but either party will have the ability to apply a no fault break, however a 12 month notice period will be required.

9.5 The shared public health team will need to maintain transparency on the spending of the ring fenced grants. Therefore the annual commissioning intentions and associated budget will be developed and agreed separately for each borough. It will be important however that the opportunity for efficiencies through joint work is captured during this process.

9.6 The Joint Public Health Governance Board will be the key Board for monitoring, reviewing and resolving contractual issues relating to the delivery of the shared public health team.

9.7 The Board will meet quarterly and be chaired by the non host Portfolio Holder, the current Cabinet Member for Public Health from the London Borough of Barnet. Barnet representatives on the Board will include the Director for People, Barnet Clinical Commissioning Group Board Member as well as the Cabinet Member. This Board will ensure that the partnership aspirations, service requirements including the core offer for Clinical Commissioning Groups and cost effectiveness are being delivered through the shared Public Health Service Key responsibilities include:

- Endorsing Commissioning Intentions for each of the Boroughs
- Forum to discuss and seek to resolve contract issues, concerns or complaints arising from the operation of the Inter Authority Agreement
- Resolve and negotiate the resolution of disputes
- Agree support changes/overheads of the joint public health team
- Recommend the MoUs for the CCG's Core Offer to LBB and LBH for approval
- Sign off the annual joint public health work-plans / business plan
- Review the biannual scrutiny review

9.8 <u>Public Health Core Offer to Clinical Commissioning Groups</u>
The Core Offer for Clinical Commissioning Groups is one of the mandatory roles of the public health function of Local Authorities. The basis of the Public Health core offer to Clinical Commissioning Groups is set out in a jointly agreed Memorandum of Understanding (MoU) between the Council

and the CCG covering how both parties will work together to ensure improvements in population health and well-being, through effective disease prevention, health improvement and commissioning of health and other services.

9.9 The MoU outlines a framework which sets out a series of principles for the relationship between the Council and the CCG and the expectations on each party and will be accompanied by an agreed CCG – Council work plan for each year, overseen by the Governance Board for the shared Public Health function.

9.10 Harrow and Barnet Councils through the shared Public Health service are looking at developing a schedule of rates which can be applied to any work requests that fall outside the scope of the core offer for the CCG.

9.11 Although the London Borough of Barnet will enter into a MoU with Barnet CCG, this will be operated by the London Borough of Harrow on the Council's behalf under the terms of the Inter-Authority Agreement. Barnet CCG has agreed in principle to the agreement and the draft MoU is attached as Appendix Four. .

9.12 It is recommended that the Cabinet Member for Public Health is authorised to sign off the final CCG Memorandum of Understanding for the Core Offer prior to the 1st of April 2013.

9.13 <u>Commissioning Priorities for 2013/14</u>

Barnet Council's Vision for Public Health is: *'Public Health will lead the health and wellbeing agenda for Barnet, underpinned by a strong evidence based approach and the JSNA; supporting the NHS and the wider Council to play their part in improving the health and wellbeing of Barnet's residents, reducing health inequalities and delivering the Health and Wellbeing Strategy. Through a skilled multi-disciplinary workforce, the Public Health function will make sure that the risk of avoidable harm is reduced through promoting healthy lifestyle choices and protecting the health of the population'.*

9.14 A Barnet Commissioning Intentions document (Appendix Three) has been created to set out how the public health responsibilities will be fulfilled. The document also sets out how the priorities identified in Barnet's Health and Well-being Strategy and the priorities arising from the Joint Strategic Needs Assessment will be addressed.

9.15 The public health allocation is ring-fenced, only to be spent on public health functions and the current contractual liabilities do not cover all of the mandatory functions for Councils in respect of Public Health. Historically in Barnet there has been no permanent budget line to cover NHS Health Checks. The 2013/14 commissioning plans therefore allocate £0.5m towards the provision of NHS Health Checks and the remaining budgets will be allocated towards a mixture of childhood obesity programmes,

support for early years and other public health programmes, particularly supporting maintaining a healthy weight and sport and physical activity.

10 BACKGROUND PAPERS

10.1 Target Operating Model for the Shared Public Health Function for Barnet and Harrow.

This report is available by email from Andrew Howe, Joint Director for Public Health, Barnet and Harrow, email: Andrew.Howe@brent-harrowpcts.nhs.uk

Appendix One: Principles underpinning development of an Inter-Authority Agreement

General

1. The agreement will last for 5 years but either party may give notice of an intention for it to be extended

2. The Corporate Director Community, Health and Wellbeing (Harrow Council) will be the contact for the host borough

Performance

3. A Task and Finish Group will be established to scrutinise the performance of the Joint Public Health Service and will report to both the Barnet and Harrow Overview and Scrutiny Committees every two years.

4. The Public Health Governance Board will be chaired by the non host Portfolio Holder

5. The Public Health Governance Board will meet at least twice a year timetabled to correspond with the Boroughs annual budget setting and prioritisation.

6. The Public Health Governance Board will review the performance of the shared public health team initially at a quarterly period during the first year of the agreement. Performance reports will include:

    a. Barnet Public Health performance
    b. Harrow Public Health performance
    c. Contract performance of the shared public health service

7. A risk register for the shared service will be developed which will be split into:
    a. risks specific to Barnet public health outcomes
    b. risks specific to Harrow public health outcomes
    c. Shared service risks

8. The shared public health service will identify a risk champion who will report corporate and operational risks to the Barnet and Harrow Council's risk management boards.

9. Separate annual returns will be submitted for the Harrow and Barnet public health ring fenced budgets. The returns will be signed by their respective Section 151 officers.

Commissioning Intentions

10. The shared public health team will work with each Council to determine and specify the Public Health Services to be provided for that year taking account of the Public Health Outcomes Framework, guidance issued by the Department of Health, the Joint Strategic Needs Assessment for the area and population and the Joint Health and Wellbeing Strategy

11. The public health services provided must cost no more than the allocated funding for each Borough.

12. The Commissioning Intentions for the shared public health service will be split into Barnet and Harrow to ensure transparency of each boroughs public health budget. The commissioning intentions will be broken down into the following two areas :

    a. mandatory services
    b. additional services

13. The annual Commissioning Intentions document for each borough will include the performance outcomes and targets expected to be achieved.

14. The draft Barnet Commissioning Intentions paper will be submitted to the host borough to negotiate the level of delivery that is achievable within the available budget and associated support costs.

15. Based on Barnet's draft Commissioning Intentions the host borough will calculate the cost of hosting the service annually.

16. The Inter Authority Agreement Financial appendix will include the breakdown of staff costs, contract costs and overhead costs.

Finance

17. The host borough will not make a profit from hosting the shared service

18. Barnet will make a fair contribution to the support service costs of the shared service. It is proposed that the overhead costs relating to the shared public health service are split 50/50.

19. It is proposed that the split of staffing costs within the shared service will be based on:

    a. If the staff provide a dedicated service to one borough, 100% of the staffing costs will be met by that borough
    b. If staff provides a shared function the staff costs will be split 50/50 e.g. Knowledge and Intelligence and Business Support.
    c. The Commissioning Teams will be split 60/40 (60% LBB / 40% LBH) based on value of current services and population size of each borough

20. A schedule of the split of staffing costs is to be prepared annually and agreed by the Public Health Governance Board.

21. The payment of the public health grant to the host borough will be paid quarterly up front

22. Any underspend or overspend will be allocated to the relevant Public Health grant and will be reported accordingly with the relating grant conditions

23. If an underspend or overspend is within a shared function, the overspend or underspend will be split 50/50.

24. Any one off grants (revenue or capital) nature will be managed within the specific grant conditions and host financial regulations.

Contracts

25. Barnet Council will hold the contract schedule for Barnet public health contracts and will hold the liability for these contracts.

26. Barnet Council to delegate authority to the host borough for the monitoring and financial arrangements of the public health contracts.

27. Financial liability for over performing contract values to be met by the relevant borough.

28. The Director of Public Health to alert any cost pressure identified for non capped contracts to the Corporate Director of Community, Health and Wellbeing at Harrow Council and the Director of People at Barnet Council.

Staffing

29. Staff to be employed by Harrow Council

30. Staff costs for the shared public health service will be split based on the annually agreed schedule of staffing costs. The 13/14 proposed split is attached as Appendix A

31. Those Public Health staff with identified Borough roles should spend the majority of their time working in the Borough for which they have specific responsibilities.

32. The Director of Public Health to be allowed the flexibility to utilise staff within the shared public health to ensure delivery of the agreed performance.

33. The Director of Public Health to spend half of his time physically at London Borough of Barnet offices

Redundancy

34. Redundancy costs for the Director of Public Health will be shared 50/50

35. Redundancy costs for the shared public health staff (except for the DPH) will be split based on the annually agreed schedule of staffing costs

Staff Terms and conditions

36. Public Health staff will transfer on the terms and conditions for Agenda for Change and any local terms and conditions for North Central London and North West London cluster

37. The Director of Public Health will be transferred to Harrow Council on his NHS terms and conditions.

Performance Management of DPH

38. The DPH will be managed by Harrow Council's Corporate Director, Community Health and Wellbeing and is answerable to the terms of employment for Harrow Council

39. Harrow Council will lead on the performance management of the DPH and will liaise with Barnet for their views and setting of objectives and targets as part of the appraisal process

Pension

40. Costs arising from Public Health staff who transfer to the local authority and choose to opt onto the NHS pension after 1st April will be shared based on the annually agreed staffing cost schedule.

Additional staffing costs

41. Additional costs over and above the structure costs such as cover for long term sickness will be shared based on the annually agreed staffing cost schedule.

Exit Arrangements (Clause 18 and appendix 5)

42. TUPE provisions will apply

43. Any resultant redundancies at the end of the contract to be split based on the pre transfer staff budget ratio

44. Barnet Council and Harrow Council to offer redeployment options for staff from the shared public health service

45. Either party may, at any time, give to the other written notice of not less than 12 months to terminate the Agreement. If such notice is given then the arrangements for termination within the Agreement shall apply. This brings into effect the arrangements that would apply in the event of any termination and this will ensure an orderly end of the arrangement and the transfer of services and staff to Barnet

Appendix Two: Public Health Contracts transferring to the London Borough of Barnet from 1st April 2013 and contracting approach.

1. Contract Values

The table below shows the total value of contracts to be transferred to the London Borough of Barnet valued at £8.78m based on 2013/14 contract values.

Contract	Provider	Value
Treatment services for Drugs and Alcohol Misuse		
Barnet Drug & Alcohol Service	Barnet, Enfield and Haringey Mental Health Trust	£1,332,316
Westminster Drug Project	Westminster Drug Project	£1,082,000
Inpatient Detox	Equinox Nth	£137,000
Haringey Advisory Group for Alcohol	Haringey Advisory Group for Alcohol	£164,000
Case Management System	Illy	£20,000
	Subtotal	**£2,735,316**
Sexual Health Services		
Claire Simpson Clinic GU service	Barnet and Chase Farm Hospitals NHS Trust	£1,009,000
Marlborough Clinic GU service	Royal Free Hospitals NHS Trust	£662,000
Mortimer Market and Archway GU services	Central and North West London Foundation Trust	£643,000
GU service	Barnet, Enfield and Haringey MH Trust	£166,000
GU service	Whitington Hospital NHS Trust	£32,516
GU service	Various providers	£837,500
Contraception and sexual health services	Central London Community Health	£910,153
Contraception and sexual health services	Barnet, Enfield and Haringey MH Trust	£15,000
Sexual and reproductive health LES	Barnet GPs	£17,000
Chlamydia screening	Barnet and Chase Farm Hospitals NHS Trust	£6,000
Hepatology	Central and North West London Foundation Trust	£6,000
	Subtotal	**£4,304,169**
Smoking Cessation		
Smoking Cessation Services	Central London Community Health NHS Trust	£333,332.00
Smoking Cessation Services	Royal Free Hampsted NHS Trust	£39,754.00
Smoking LES	Barnet GPs	£174,000.00
Licence for Quit Manager system - web based data system	North 51	£10,000.00
NRT spend in pharmacies	NRT spend in pharmacies	£15,941.00
	Subtotal	**£573,027.00**
School Nurses		
School Nursing Service	Central London Community Health NHS Trust	£1,147,544.00
School Nursing Service	Barnet, Enfield and Haringey MH Trust	£21,000.00
	Subtotal	**£1,168,544.00**
	Total	**£8,781,056**

2. Proposed Way Forward for Public Health Contracts

2.1 Section 1: Genito-Urinary contracts (Sexual Health Contracts)

Due to the clinical nature of the services and the number of service providers accessed by Barnet and Harrow residents, it has been agreed to keep GU services within the Standard NHS contracts with the relevant acute providers and for the local authorities to be named as associate commissioners to the contracts. This means that contracts will be negotiated by the relevant Commissioning Support Units (CSUs). This position is shared by the NWL boroughs and it is assumed at this point that NCL boroughs will also agree to this.

We are recommending seeking 'cap and collar' contracts with providers for GU in 13/14 to ensure that financial risk is managed and limited to the resources available. This means that there will be a maximum rate (cap) and a minimum rate (collar) applied. This will provide Barnet with the certainty of not paying more than the maximum rate. In addition, we are seeking better data reporting as many providers are not reporting activity on the GUM monthly access system and under current guidance and NHS commissioning rules, providers are not required to provide patient level data to commissioners due to the additional level of patient confidentiality attached to sexual health.

2.2 Central London Community Health

This provider currently provides school nursing, family planning and smoking cessation services for Barnet. These services form part of an overall block contract worth approx. £41m with the services due to novate worth approx. £2.4m per annum. The provider and NCL are currently undertaking a contract rebasing exercise as it was recognised that the values apportioned within the block are inaccurate. It has been agreed that the rebasing will be done without any change to the bottom line value of the contract. To date, the services due to novate to the LA have seen significant changes in the values with the current position showing an increase cost of £170k overall against these three services.

North Central London CSU will negotiate the contract with input from the public health team and the recommended option is to move the family planning and smoking cessation services onto the existing Barnet Council contract with CLCH.

Separate consideration of the school nursing service is covered in the section of this paper relating to Ealing Hospital Trust.

2.3 Barnet, Enfield and Haringey Mental Health Trust

This provider currently provides drug and alcohol service for Barnet. They also provide some family planning services under open access via their family planning services in Enfield and a cross border school nursing service.

It is proposed that the NCL CSU will negotiate the contract with input from the public health team. Letters setting out proposed levels of efficiencies to be achieved etc. have already been exchanged.

The contracting options available are:

- To keep the services within the standard NHS Contract with Barnet Council listed as an associate commissioner.
- To move the services onto a contract with Barnet council. This could involve negotiating a new contract with BEHMHT for these services or adding the drug and alcohol service line to the contract Barnet currently holds with BEHMHT.

Work is being undertaken to determine the most appropriate contracting mechanism however the preferred option is to move the drug and alcohol and family planning services onto the existing Barnet Council contract with BEHMHT.

2.4 School Nursing

Ealing Hospitals Trust (Integrated Care Organisation) (ICO) currently provides the school nursing service for Harrow and the issues for school nursing are shared across both Boroughs and apply to the situation for school nursing in Barnet with CLCH. The understanding to date is that both boroughs were going to have a contract with the relevant providers for school nurses rather than being associates to the current NHS contracts.

As well as the Child Measurement Programme, school nursing are responsible to deliver the Healthy Child Programme for 5-19 year olds and provide the main health input to child protection cases. This work for 0-5 year olds is delivered by the Health Visiting service which will be commissioned by the NHSCB in 13/14 and 14/15 with responsibility moving to the councils in April 2015.

Some London boroughs have already decided to leave the School Nursing services in NHS contracts for 13/14 and be associate commissioners to those contracts.

It is likely that the NHS Commissioning Board (NHSCB) will ask Clinical Commissioning Groups (CCGs) to keep Health Visiting within existing NHS contracts and be an associate commissioner to those rather than entering into separate contracts.

The public health commissioners are currently working towards understanding the plans the NHSCB have for commissioning Health Visiting in Harrow and to understand better the reasons behind the decision in other areas for the borough to be associate commissioners to NHS contracts for School Nursing.

Work is still in progress to agree an approach to commissioning school nursing for Harrow. The Council is keen to ensure that all future contracts however are under the terms and conditions of the Council and the contract clearly links to the expected deliverables.

2.5 All other contracts

For the most part, contracts held with non NHS providers are for single service lines and are generally straightforward transfer to the Council. The steps taken for these contracts have included:

- Reviewing council contract terms to ascertain if any additional schedules are needed
- Drafting new contracts for each provider and reviewing service specifications and contract schedules
- Agreeing costs, data requirements, KPIs and quality standards for 2013/14
- Aggregating contracts with existing provider contracts where appropriate
- Locally Enhanced Contracts are shared between GP Consortiums and local pharmacies and are currently valued at £473,000. Harrow is seeking to develop a framework with a call off period for the LES contracts and officers are liaising with the current service providers. Further guidance from Department of Health is anticipated to provide further clarity on these specific contracts.

The summary position for all Barnet contracts is shown in the table below

Contract	Commissioner	Value
Treatment services for Drugs and Alcohol Misuse		
Barnet Drug & Alcohol Service	LBB will be the lead commissioner and where possible will combine with existing LBB contracts with the relevant providers	£1,332,316
Westminster Drug Project		£1,082,000
Inpatient Detox		£137,000
Haringey Advisory Group for Alcohol		£164,000
Case Management System		£20,000
	Subtotal	**£2,735,316**
Sexual Health Services		
Claire Simpson Clinic GU service	LBB will be the associate commissioner; the NHS will be the lead commissioner and will directly manage the contract with these providers in conjunction with LBB. This is advantageous for LBB due to the number of providers for this open-access service. We will seek to negotiate a cap on the cost of Genital Urinary Medicine.	£1,009,000
Marlborough Clinic GU service		£662,000
Mortimer Market and Archway GU services		£643,000
GU service		£166,000
GU service		£32,516
GU service		£837,500
Contraception and sexual health services	LBB will be the lead commissioner and we will seek to integrate this into the existing contract between LBB with Central London Community Health Care NHS Trust	£910,153
Contraception and sexual health services	LBB will be the lead commissioner	£15,000
Sexual and reproductive health LES		£17,000
Chlamydia screening		£6,000
Hepatology		£6,000
	Subtotal	**£4,304,169**
Smoking Cessation		

Smoking Cessation Services	LBB will be the lead commissioner and we will seek to integrate this into the existing CLCH contract with LBB	£333,332.00
Smoking Cessation Services	LBB will be the lead commissioner	£39,754.00
Smoking LES	The plan is for LBB to be the lead commissioner; however with Local Enhanced Services there are issues to be resolved regarding clinical governance and GP relations.	£174,000.00
Licence for Quit Manager system - web based data system	LBB will be the lead commissioner	£10,000.00
NRT spend in pharmacies		£15,941.00
	Subtotal	**£573,027.00**
School Nurses		
School Nursing Service	LBB will be an 'associate commissioner' – for reasons of clinical governance and children pathways, the NHS will remain the lead commissioner	£1,147,544.00
School Nursing Service		£21,000.00
	Subtotal	**£1,168,544.00**
	Total	**£8,781,056**

Appendix Three: LBB Public Health Commissioning Intentions for 2013/14

Public Health service and budget proposal for financial year 2013-2014.

Summary

1. A number of Public Health responsibilities are transferring to Local Authorities on 1st April 2013 some of which will be mandatory duties. Barnet Council has agreed that the transfer of responsibilities will be on an 'as is' basis to minimise all risks inherent in the transfer and to ensure continuity of service for 2013-14. The budget proposals in this paper derive from this principle while accommodating new and additional Public Health requirements. This paper and the accompanying appendices set out proposals for the Public Health budget allocation for 2013-14 together with the detail of current contracts and services that will fall within the remit of the Local Authority. This information is provided to support decision making for Public Health commissioning intentions for 2013–14.

Key Messages

2. The ring-fenced Public Health Grant for Barnet Council will allow mandatory requirements to be met, core services to continue and the introduction of new services. The budget proposal is detailed in the table below this text.

3. The Commissioning Intentions support the four main themes of the Barnet Health and Wellbeing strategy which recognise that through the life course there are positive and negative effects on health and well-being. The following table shows where the Public Health commissioning intentions support delivery of the key themes of the Health and Wellbeing strategy.

Table 1: Planned public health spend mapped to 4 key themes of the H&WB Strategy

	Preparation for Healthy Life	Well-Being in the Community	How we Live	Care when Needed
Sexual Health	✓		✓	
School Nursing including NCMP	✓			
Drugs	✓	✓	✓	✓
Alcohol	✓	✓	✓	✓
Health Checks			✓	✓
Smoking cessation	✓	✓	✓	✓
Healthy eating	✓	✓	✓	
Lifestyle Interventions	✓	✓	✓	✓

4. For example, smoking is an issue that runs through each of the four key themes. Smoking in pregnancy is a risk factor for infant mortality, low birth weight babies and continued smoking increases the risk of a child having

respiratory problems, glue ear and makes them more likely to become smokers themselves. Both physical and mental wellbeing depend on a broad range of factors including where we live and the environment we live in. Simply put 'feeling good about where you live' is a key factor in 'feeling good about yourself.' Feeling good about oneself is key to making lifestyle changes which will bring about improvements in health like giving up smoking. Tobacco use is the most important preventable risk factor for death from cancer and cardiovascular disease and it is the highest underlying cause of death in Barnet. Stopping smoking once diagnosed with a chronic disease is often associated with a better prognosis.

5. All services contribute to the overarching outcomes of improving infant mortality, mortality from cancer and mortality from cardiovascular diseases (including heart disease and stroke). It should be noted that the major services commissioned specifically by the public health team include: improving recovery outcomes for drug and alcohol users (building on year on year improvement in outcomes in Barnet); reducing the number of people who smoke (again building on previous good performance and targeting the single biggest preventable killer); and increasing access to NHS Health Checks (a statutory service).

6. Endorsement of the commissioning priorities in this paper will ensure that service delivery continues to improve public health outcome indicators as outlined in the Public Health Outcome Framework and the Barnet and Harrow Public Health Team 'Target Operating Model', and supports delivery of the Barnet Health and Wellbeing Strategy.

7. As part of the due diligence process in respect of public health contracts, much work is being undertaken within the NHS to disaggregate contracts and to determine the likely costs of provision in 2013-14. However, there remain some areas of uncertainty and risk affecting the costs of contracts in 2013-14. For example there are some risk areas with potential for cost increases. Genito Urinary Medicine represents the highest area of spend and is an open access service. Due to the nature of the service and expectation of confidentiality there are currently fewer mechanisms for commissioners to challenge provider data. Current guidance for the NHS explicitly instructs commissioners to take provider data in this area 'on trust'. Agreeing a common approach to commissioning with other boroughs is critical to ensuring we achieve the preferred outcome which is a capped contract arrangement with additional requirements for reporting to ensure that the LA has a clear picture of activity and cost pressures in this area.

8. The additional requirements for 2013-14 can be met within the overall budget figure quoted above. The identified additional requirements are: the 0.5% contribution to pan London working costs associated with commissioning and contracting, and infection control. It will also be possible to add substantial investment in new areas. These would allow for delivery of wider aspects of the Health and Wellbeing strategy and are

outlined in the table below in the ‘Proposals for new investment in 2013-14’ section.

9. The table below lists the current contracts and services that fall within the Local Authority Public Health remit from 1st April 2013. The proposed areas for efficiencies are within Drug and Alcohol services where 5% contract efficiencies will be sought. If 3% efficiencies are achieved it will generate contract efficiencies of approximately 82k. Review of contracts to date suggests that there may be scope for further efficiencies by going to procurement but these are unlikely to be realised in 13/14.

Barnet Council Public Health Budget proposal for 2013-14

	Current 2012-13 Budget	Proposed 2013-14 Budget	Explanatory notes
Mandatory Services			
Health checks GP LES & Risk management activities/ drugs	150,000	500,000	Figure based on national calculator costs of implementation and an enhanced programme offering. This represents a large increase in investment compared to 2012-13. The final cost will depend on negotiations with providers on the unit cost of the health check element of the budget.
HiV Pan-London Prevention	52,527	52,527	This is subject to discussion at a Pan London level and final agreement
GUM	3,350,016	3,350,016	This service is currently being reviewed. It is unclear whether this will result in revised costs. The contract is currently managed by the Acute Commissioning Vehicle.
Family Planning	942,153	942,153	This service is currently being reviewed. It is unclear whether this will result in revised costs. The contract is currently managed by the Acute Commissioning Vehicle.
Commissioning Support Unit contract management cost for GUM		6,000	Negotiations are in hand with the CSU to manage this contract. Notional figure indicated.
Implanon LES	17,000	17,000	Breakdown of costs across the 3 LES not clear. This will be addressed during year one 2013/14 in conjunction with the CCG.
Sexual Health LES			
IUCD LES			
Integrated Sexual Health Tariff		225,000	While the Tariff has yet to be agreed across London it is highly likely that costs in this area will increase

National Child Measurement included within the School Nursing contract	1,147,544	1,147,544	This contract value is high and is being investigated. It is likely that more support and activity could be delivered for this cost. The cost of HPV administration is currently included in this value and will need to be disaggregated.
Total Cost of Mandatory Services		6,240,240	

Discretionary Services

Barnet Drug and Alcohol Service	1,332,316	1,292,347	Aiming for 5% efficiencies. The figure assumes achievement of 3% efficiencies which is £82,059
Westminster Drugs Project	1,082,000	1,049,540	
Equinox Nth - Inpatient detoxification	137,000	132,890	
Haringey Advisory Group for Alcohol	164,000	159,080	
Illy - Case management system	20,000	20,000	Drug & Alcohol monitoring/ reporting
Homeless Action in Barnet (Alcohol)	35,000	35,000	
Smoking cessation at Royal Free Trust	39,754	39,754	Contracting process to consider decommissioning this service due to value for money considerations.
Smoking Cessation service with CLCH	333,332	333,332	
Smoking cessation GP LES & Smoking cessation Pharmacy contract	174,000	135,000	Budget for this year appears overstated; reduced for next year to match anticipated spend in 12/13
North 51 - Quit manager system	10,000	10,000	
Nicotine Replacement Therapy Primary Care	165,000	165,000	

Additional resource to reduce smoking in pregnancy to 7.5%		20,000	Initial work identified this figure but detailed work and discussions are in hand to identify the actual cost of this iniative
Total cost of Discretionary Services		3,391,943	

Additional Responsibilities 2013-14

0.5% for Pan London work		56,180	Work is in hand to identify the most efficacious way to deploy this resource.
West London Alliance Subscription		25,000	This is to support the development of Public Health Procurement Hub as previously agreed through the West London Alliance
Procurement costs		70,000	It is anticipated that a number of contracts will benefit from retendering with efficiencies arising but this will require additional resources to undertake all of the work required in 2013-14.
Total cost of additional responsibilities		151,180	

Proposals for new investment in 2013-14

Weight management		200,000	Support for new healthy lifestyles initiatives
Childhood Obesity		150,000	To support the National Child Measurement Programme in schools as well as wider local initiatives
Parenting Support		100,000	
Support for first time mothers including breast feeding and mental health issues		75,000	
Local Health & Wellbeing Initiatives		250,000	

Later Years		100,000	
Local Sexual Health Promotion, Smoking Cessation and Drug awareness/ prevention work with Young People		175,000	Models such as Clinic in a Box and SRE work in schools provide potential models
Unemployment and Health including Learning Disability and Mental Health		100,000	
Housing and Health		60,000	
Total value new investment		1,210,000	

Staffing contribution	1,241,000	1,241,000	This is an approximate figure pending calculation of the final contribution to Harrow Council; it will not be any higher than this figure.
Overheads contribution			
Non pay contracts		120,000	This will cover expenditure to support staff - training, travel, journal and professional memberships and provide additional contracted staff capacity where required to ensure successful transition
Total contribution to Public Health Team		1,361,000	
Total cost of responsibilities 13-14		12,354,363	This represents commissioning intentions to date; work is in hand to identify further appropriate investment
Department Health allocation to Barnet Council		13,799,000	

Appendix Four – Clinical Commissioning Group Draft Memorandum of Understanding – Core Offer

MEMORANDUM OF UNDERSTANDING
between
LONDON BOROUGH of BARNET
and
BARNET CLINICAL COMMISSIONING GROUP

This agreement documents the understanding between London Borough of Barnet (the Council) and Barnet Clinical Commissioning Group (CCG) concerning how they will work together to ensure improvements in population health and wellbeing, through effective disease prevention, health improvement and commissioning of health and other services.

INTRODUCTION
The Health and Social Care Act (2012) (the Act) establishes new arrangements in England for health protection, health improvement and for commissioning health services.

Commissioning:
Clinical Commissioning Groups (CCGs) will be the main local commissioners of NHS services and the Act gives them a duty to continuously improve the effectiveness, safety and quality of services. The NHS Public health currently provides a range of support for NHS commissioning. The requirement for this support will not diminish under the new arrangements, and Department of Health guidance indicates that this support should be obtained from and made available to the Clinical Commissioning Group by an appropriately skilled, local public health specialist team.

Health Improvement:
The Act gives local authorities, such as the Council, statutory duties to improve the health of the population from April 2013. The CCG will also have a duty to secure improvement in health and to reduce health inequalities, utilising the role of health services. This will require joint action between the Council and the CCG along the entire care pathway from prevention to end of life.

Health Protection:
Under the Act, local authorities (LA) must appoint Directors of Public Health (DPH) who have local responsibilities in respect of health protection, in conjunction with Public Health England. These include preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of environmental hazards, and NHS resilience. The Act gives the CCG a duty to ensure that they are properly prepared to deal with relevant emergencies.

The Council, will by 1 April 2013, have established arrangements for the discharge of their statutory public health functions. The Council and the Clinical Commissioning Group (CCG) share the common aims of improving the health of the population and

tackling health inequalities in the borough. Robust partnership working between the Council and CCGs will be essential to achieve these.

PURPOSE

The purpose of this Memorandum of Understanding (MOU) is to establish a framework for relationships between the Council and the Clinical Commissioning Group (CCG), outlining the expectations and responsibilities of each Party and the principles and ways of working. It will be accompanied by an agreed CCG-Council public health work-plan for each year.

IT IS AGREED AS FOLLOWS:

A. Principles and Values

The Council and the CCG will

- Work in partnership to achieve agreed outcomes and ensure that a productive and constructive relationship continues to be developed and maintained
- Recognise and respect each others roles in improving the health of the population
- Support each other in finding the most efficient ways to deliver project requirements.
- Be honest, constructive and communicative in all dealings with each other.
- Have reasonable expectations of each other, consistent with agreed arrangements.
- Use the content and terms of this MOU to help in resolving any conflicts that arise in the working relationship.
- Be responsive to each others needs during the year, within the flexibility of a planned programme of work
- Owe each other a duty of confidentiality regarding business sensitive issues.

B. Objectives

The Council and the CCG will work together

- to deliver improvements in the health of the borough's population, through disease prevention, health protection and commissioning health services;
- to maintain performance on national and locally agreed outcome measures and priorities;
- to ensure that local commissioning fully reflects the population perspective;
- to implement a mutually agreed joint work plan to deliver both NHS commissioning and public health priorities for the local population

C. Governance and Accountability

- The Barnet and Harrow Public Health Governance Board will be the governing body for this agreement

- The DPH or nominated representative will attend the Clinical Commissioning Group Governing Body, as a non-voting member, to provide PH advice, support and challenge to commissioning discussions and decision-making.
- The DPH or nominated representative may attend other CCG committees, if requested.
- CCG clinical directors as members of the Health and Wellbeing Board will provide clinical input to partnership strategies and priority setting.
- There will be one named public health consultant to act as the key relationship manager to the CCG.
- The CCG will designate a clinical director to be the lead for population health
- The work-plan will be developed by negotiation and be based on CCG priorities drawn from their commissioning intentions and strategies.

- **Population Healthcare/ Health Services**

This core offer is based on the Department of Health issued guidance (July 2012 – see Appendix 1) and includes the generic activities, listed below. The specific offer is defined and limited by the work-plan, which is mutually agreed and consistent with the needs of the CCG and capacity and other public health priorities of the Council.

- Provide specialist, objective public health advice to the CCG in its strategic, commissioning and decision-making processes.
- Assess the health needs of the local population, through use and interpretation of the data and other sources, and analysis of how the needs can best be met using evidence-based interventions.
- Lead production of the joint strategic needs assessment (JSNA)
- Support actions within the commissioning cycle to prioritise and reduce health inequalities and better meet the needs of vulnerable/ excluded communities, for example including use of health equity audit; geo-demographic profiling, etc.
- Support the clinical effectiveness and quality functions of the CCG, including input into assessing the evidence in commissioning decisions, e.g. NICE or other national guidance, critical appraisal and evidence review.
- Support the CCG in its work in developing health care strategies, evidence based care pathways, service specifications and quality indicators to monitor and improve patient outcomes.
- Provide support to the Barnet QIPP (Quality Innovation Productivity Prevention) programme and other strategic commissioning plans and processes.
- Design monitoring and evaluation frameworks to assess services for the impact of commissioning policies; support collection and interpretation of the results
- Provide a professional source of expertise for research and evaluation of local health care as required and contribute to innovation and development of local solutions to help meet healthcare need.
- Assist in the process for setting priorities or making decisions about best use of scarce resources, for example through decision-making frameworks,

benchmarking/ ‘comparative effectiveness’ approaches linked to population need.

- Support the CCG in the achievement NHS Outcomes Framework indicators, particularly as regards action on Domain One – preventing people from dying prematurely, and in support of its contribution to the Public Health Outcomes Framework.
- Support the development of public health skills for CCG staff.
- Promote and facilitate joint working with local authority and wider partners to maximise health gain through integrated commissioning practice and service design.
- Lead the development of, and professional support for, the Barnet Health and Wellbeing Board and Joint Health and Wellbeing Strategy.
- Provide specialist technical reports and support in relation to individual funding requests.

The CCG will:

- Seek specialist public health advice to ensure that prioritisation and decision making processes are robust and based on population need, evidence of effectiveness and cost effectiveness.
- Work with the Council to develop its public health commissioning intentions in line with the HWB priorities, as informed by the JSNA.
- Utilise specialist public health skills to identify and understand high risk and/or under-served populations in order to target services at greatest population need and towards a reduction of health inequalities
- Utilise specialist public health skills to support development of its commissioning strategies, pathways and service improvement plans
- Contribute intelligence and capacity to the production of the JSNA, including through data-sharing agreements (see Appendix 2)
- Ensure necessary arrangements are in place to enable the Council to deliver the core public health offer and facilitate joint working, including sponsorship arrangements for NHSmail, accommodation/hot-desking, etc. (see Appendices 3 & 4)
- Mediate an agreement between the Council and the Commissioning Support Service to ensure clear communication and full access to required NHS data of the delivery of the Council’s public health functions

- **Health Improvement**

The Council will:

- Refresh its delivery and lead role in current health improvement strategies and action plans to improve health and reduce health inequalities, with input from the CCG
- Maintain and refresh metrics, as necessary, to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of key NHS and LA strategies

- Support primary care to deliver health improvements (appropriate to its provider healthcare responsibilities)–e.g. by offering training opportunities for staff and through targeted health behaviour change programmes and services
- Ensure commissioned health improvement services support the CCG in its role of improving health and addressing health inequalities
- Lead health improvement partnership working between the CCG, local partners and residents, to integrate and optimise local efforts for health improvement and disease prevention
- Embed health improvement programmes, such as stop smoking services, into front-line clinical services, with the aim of improving outcomes for patients and reducing demand

The CCG will:

- Contribute to strategies and action plans to improve health and reduce health inequalities
- Encourage constituent practices to maximise their contribution to disease prevention – e.g. by taking every opportunity to encourage uptake of screening opportunities
- Encourage constituent practices to maximise their contribution to health improvement – e.g. by taking every opportunity to address smoking, alcohol, and obesity in their patients and by optimising management of long term conditions
- Ensure primary and secondary prevention are included within all commissioned pathways
- Commission to reduce health inequalities and inequity of access to services
- Support and contribute to locally driven public health campaigns

- **Health Protection (this section may be revised, subject to further guidance from DH and/or PHE)**

The Council will:

- Assure that local strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, major incidents and provide assurance to PHE regarding the arrangements
- Assure that these plans are adequately tested
- Assure that the CCG has access to these plans and an opportunity to be involved in any exercises
- Assure that any preparation required – for example training, access to resources - has been completed
- Assure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements
- Assure adequate advice is available to the clinical community via Public Health England and any other necessary route on health protection and infection control issues
- Keep the CCG and other local partners apprised of local and national health protection arrangements as details are made available by Public Health England

The CCG will:

- Familiarise themselves with strategic plans for responding to emergencies
- Participate in emergency planning exercises when requested to do so
- Ensure that provider contracts include appropriate business continuity arrangements
- Ensure that constituent practices have business continuity plans in place to cover action in the event of the most likely emergencies
- Ensure that providers have and test business continuity plans and emergency response plans covering a range of contingencies
- Assist with co-ordination of the response to emergencies, through local command and control arrangements
- Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and through action by constituent practices
- Encourage constituent practices to maximise their contribution to health protection, e.g. by taking every opportunity to promote the uptake of and providing immunisations

- Performance
  - The Council and the CCG will work together to deliver their public health outcomes
  - The Council will support the CCG in achievement of non-public health outcome indicators, where possible.
  - The CCG will support achievement of the Council's public health PH outcome indicators, where possible, through support and challenge to member practices, as well as through commissioning health services.
  - The CCG and the Council will co-operate on achieving performance outcomes in the NHS and the Council's public health Outcomes Frameworks
  - The work-plan will include agreed key performance indicators for each work-stream/project by which progress will be monitored and both parties held to account.

- Term

  This agreement commences on the date signed by both parties and will continue until 31st March 2016 or until reviewed by mutual agreement.

Signature:	_____	Signature:	_____
Name:	_____	Name:	_____
Position:	_____	Position:	_____
Date:	_____	Date:	_____