Committee: CMT

Date: 10 December 2013

Agenda item:

Wards: All

Subject: **Embedding Public Health in Merton Council – Part 2**

Overall Budget and Proposals for unallocated budget for 2013/14

Lead officer: Dr Kay Eilbert / Simon Williams

Lead member: Cllr Linda Kirby

Forward Plan reference number:

Contact officer: Kay Eilbert

Recommendations:

CMT is asked to agree the proposed approach and new commitments for the uncommitted public health funds for 2013-14.

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1 Purpose of report and executive summary

This report provides a follow up to the August report on an update of Public Health transition into the London Borough of Merton. This follow up focuses on proposals for use of the Public Health grant. CMT is asked to

- agree the proposals for use of the Public Health grant in 2013/14

2 Introduction and Background

The introduction and background was set out in Part 1 of this report that went to CMT on 13th August 2013 and is attached. This paper sets out more clearly the strategic approach for use of the public health grant 2013/14.

3 Delivering a New Public Health - Our Vision

Our vision for the public's health in Merton over the next five years is to stem the increase in the significant inequalities in health outcomes between the East and West of Merton, providing more equal opportunities for all residents of Merton to be healthy.

Our vision for the public health team is to make health everyone's business, working with partners in the Council, Merton Clinical Commissioning Group and the voluntary sector to increase understanding of their contribution to and involvement in prevention and in reducing health inequalities, using evidence of best practice.

The move of public health to local government provides an opportunity for public health to expand a traditional focus on health care and lifestyles to working across the life course while prioritising the early years and using a social determinants framework to improve health, as recommended by the 2010 Marmot review of health inequalities.

Our approach to embedding public health across the London Borough of Merton involves targeting our resources to areas with significant health inequalities and making health everyone's business. Work on the influences on health includes levering existing Council spend through use of policy levers (e.g., education, employment, built and natural environment) that offer opportunities to work on the drivers of health inequalities in a cost effective way before they are created.

The current economic climate calls for working differently, using existing resources more effectively. We must encourage partners to take a longer view by taking on prevention within their work.

4. Proposed Public Health Expenditure

Our review over the first months in the London Borough of Merton points to gaps in provision of public health services and capacity in the public health team. We recognise that much can be done to improve health by building on existing assets and resources to complement our Health and Wellbeing strategy, ensuring that it creates opportunities for all residents of Merton to be healthy.

Specific proposals with indicative costs are set out in Appendix A. Using a life course and determinants of health approach, we propose to invest in

<u>Childhood</u>

- Early childhood development in children's centres
- Healthy schools – working through school clusters in the East of the borough, provision of agreed priorities such as diet and exercise for families
- Young People Drugs and Alcohol service – expanding to include prevention and align with services serving similar customers

<u>Adults and Older People</u>

- English for speakers of other languages
- Community outreach through health champions
- Tier 2/3 weight management – gap in public health services
- Embedding prevention in primary care
- Ageing Well

<u>Other</u>

- Healthy Workplace – LBM plus outreach
- Support to LBM use of Council levers for health
- Healthy Catering
- Training in prevention for frontline staff

The Merton Partnership conference in November 2013 offered an opportunity to complete the groundwork, along with the Community Plan and Health and Wellbeing strategy, to set out a paper that builds on a consensus of what a good life should look like in Merton and what we can do together to create more equal opportunities for health for all Merton residents. The Director of Public Health 2013/14 Annual Public Health report will bring all this together.

Capacity to Deliver this New Public Health

While we will work through partners to leverage our resources, this will necessitate an ability to manage the public health work as a programme, as well as to manage existing contracts. Colleagues in LBM have asked for increased analytical support to increase their use of needs assessments and the evidence of best practice. From 2015, we will inherit the Health Visitor service, which will make additional demands on the Public Health team.

The public health team that LBM inherited from the split of the NHS Sutton and Merton joint public health team consists of the equivalent of seven WTE professionals and 1 PA. This should have provided a minimum capacity to manage the resource that transferred from the NHS; however, the quality of contracts inherited is necessitating much work to bring them in line with quality standards and best practice.

The Merton team, along with that of Sutton, is among the smallest in London, if not England. A comparison with Councils with similar public health funding levels shows that we have far smaller public health teams; for example in South West London, the size of the public health teams is as follow:

Croydon	40+
Kingston	30+
Merton	7+
Richmond	20
Sutton	7+
Wandsworth	35+

This legacy reflects priorities of previous organisations that managed public health. This not only affected the size of the team but also the skills mix and the breadth of investments in public health services.

We have worked over the last few months to align our work with our clients in LBM directorates and the MCCG. We now have portfolios, led by a public health consultant/assistant director, for children and for adults across the respective Council directorate and Merton CCG. We are embedding an evidence-based approach.

The Senior Sexual Health Commissioning Manager is now in post. We have recruited to the permanent Consultant/AD and the public health intelligence specialist post.

Embedding health in Council and partners' work has the potential to reduce the need to create expensive new services in the future. Building public health analytical skills in Council work should improve needs analysis and use of best

practice. Cuts in Council staffing have meant that remaining staff are working at maximum capacity. We have therefore built into our proposals additional capacity within the relevant departments to take on health issues.

We therefore propose to create 4 new posts; 1 consultant level post to cover public health intelligence and prevention; 2 Management Grade C posts in addition to the existing one to support each consultant and 1 public health intelligence specialist. One of the MGC posts and the public health intelligence post will be shared with MCCG as part of the requirement to provide up to 40% of staff capacity to support MCCG work. Our work programme for 2013/14 is provided in Appendix B. Appendix C provides a gap analysis of the public health workload and required staff.

This would bring the total to 12 professional staff and bring the total investment for staff to about 10% of the total £9m public health budget, up from about 6.7%. Additional funds are set aside for short-term consultants to deliver one-off projects such as analytical support for the Integration Transformation Fund.

This increased capacity would provide additional public health expertise to support Council work and foresee the addition of health visiting from 2014, while remaining well below other public health directorates elsewhere.

Conclusion

This paper sets out an approach to develop an innovative public health service based on best practice and a fit-for-purpose team for creating more equal opportunities for improving the health and wellbeing of Merton residents.

CMT is asked to

- agree the proposed approach and new commitments for the uncommitted public health funds for 2013-14

5. Agree the Consultation undertaken or proposed

Discussions with all Council Directors.

6 Timetable

Public Health paper CMT 10 December 2013

7 Financial, resource and property implications

CMT is requested to agree the proposals to allocate £1,228,000 of the grant that is not committed, as detailed in Appendix A.

Summary of PH Existing Commitment and New Proposal	
	£000
Existing commitments	7,607
Projects to support MCCG from PH grant*	225
New Investments	1,153
Total Public Health Budget	**8,985**

*£150k non-recurrent; £75k recurrent;

Risk

MCCG claims that £640k was incorrectly included in the Council's allocation.

This is to be settled within the proposal and agreement by CMT for a **one-off non-recurrent contribution of £150k** to MCCG work on prevention and early detection by funding development work for the Community health centre in the East of the borough and support to primary care services.

In addition £100k will be allocated to fund recurrently 3 GP clinical leads. Two posts (senior public health commissioning manager and data analyst) will be shared between public health and MCCG. These posts are included in the proposal for public health staffing.

The PH grant is ring fenced and is to be carried over into the next financial year as part of a public health reserve. All conditions that apply to the use of the grant will continue to apply to any funds carried over . However where there are large underspends DH reserves the right to reduce allocations in future years.

Grant allocation for 2014/15 is £9.236m

Ring fencing of Public Health allocations have been extended through 2015/16, after which funding is uncertain.

8 Legal and statutory implications

The London Borough of Merton has a statutory duty to deliver public health, along with specified services.

9 Human rights, equalities and community cohesion implications

The proposal is designed to address health inequalities by proposing a more targeted approach to public health services and by committing to creating a healthy environment in which residents can make their health choices

10 Crime and Disorder implications

None

11 Risk management and health and safety implications

None

12 Appendices – the following documents are to be published with this report and form part of the report

Appendix A Public Health Budget with Proposals for Use of Uncommitted Funds

Appendix B 2013/14 Public Health Work Plan

13 Background papers

Embedding Public Health in Merton Council Public Health Budget 2013/14 – Part 1

Public Health Budget 2013-14 **Appendix A**
Existing Commitment & Proposals for Use of Uncommitted Funds

Existing Commitments	**Provider/ Partner**	**Allocated Budget £000**	**%**	**Status**
Sexual Health - Mandatory				
- GUM – acute sexual health services	Acute trusts Open access service	2,025	23%	To be reviewed in 2014/15
- Contraception	RMCS	582	6%	To be reviewed in 2014/15
- Sexual health advice, prevention and promotion	Chlamydia screening. – Terence Higgins Trust Pan-London HIV services	334	4%	One year extension - To be reviewed in 2014/15 London review on-going
NHS Health Checks – Mandatory	GPs plus exploring additional delivery options	226	3%	Looking for alternative providers as GPs not keen; developing spec
National Child Measurement Programme - Mandatory (part of universal school nursing service)	School Nursing RMCS	611	7%	Provided by school nurses, which is under review
Support to MCCG – up to 40% of staff capacity - Mandatory	Public Health team	Staff resource		Under development with MCCG
Assurance of health emergency preparedness - Mandatory	Director of Public Health	Staff resource		Developing understanding of Public Health role – working with borough resilience forum
Drugs and Alcohol	Safer Merton (LBM)	2,086	23%	Developing understanding of services
Smoking – universal service plus Live Well	Hounslow and Richmond	346	4%	Live Well – part of contract being

Existing Commitments	Provider/ Partner	Allocated Budget £000	%	Status
	Community Services			renegotiated to include outreach by health champions through community organisations
Obesity – diet and physical activity	RMCS	339	4%	Dietetics service under review – exclusively clinical service. Negotiating ph content of service
Falls prevention	RMCS	64	1%	Will be reviewed in 2014/15
Public Health Resources	RMCS	15		Will be reviewed in 2014/15
Community services Contract Estates		186	2%	Errors in invoicing being worked through to reflect budgetary amount
Surveillance and Control of Infectious Diseases		63	1%	Available for health protection ad hoc needs
Corporate Overheads		97	1%	LBM
Community Development and Health Course		7		
Public Health Salaries and non-pay		626	7%	
Total Existing Commitments		**£7,607**	85%	

New funding is allocated across the life course to support influences on health (mainly in LBM – Ageing Well, training frontline staff, healthy catering, ESOL), to work in settings (workplace and schools) and to fill gaps in provision such as weight management

Proposed New Investments	Provider / Partner	Amount £000	%	Status
Children's Centres	Early child development/ LBM	100		
Healthy Schools	Practical activities to promote healthy students/ Schools, LBM	100		
Young People Drugs and Alcohol	TBD/LBM	From D&A funding		Service being reviewed to include integration/efficiencies
Total Children's Services		**200**	**2%**	
English for Speakers of Other Languages	Language courses with health themes to increase integration and control over one's life/Adult Learning	50		
Community Outreach	LiveWell HRCS/MVSC to manage contracts with community groups	50		
Physical Activity	Most likely GLL	50		
Tier 2-3 weight management	Negotiating joint procurement with MCCG for Tier 3	165		NICE guidance says Tier 1 -4 should be available. Nothing in place for Tiers 3-4

Proposed New Investments	Provider / Partner	Amount £000	%	Status
Ageing Well	TBD	50		
Embedding Prevention and Early detection in primary care	Merton CCG	225		Plus 150 non recurrent from 13-14 underspend
Total Adults Services		**590**	**7%**	
Healthy Workplace	HR and PH	60		
Support to LBM use of Council levers	Directorates and PH			Staff resource – to use Council levers re alcohol, betting shops, fast food outlets
Healthy Catering	Environmental Health and PH	50		
Training for frontline staff across Merton	HR and PH	50		
Total Other Services		**160**	**2%**	
Public Health Staff to increase analytical and joint working capacity		278	3%	Total 10% with existing funds
Contingency Fund		150	1%	e.g., Sexual health open access; drugs for LESs
Total Proposed New Investments		**£1,378**	15%	
Total Existing Commitments		**£7,607**	85%	
TOTAL PUBLIC HEALTH		**£8,985**	100%	

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APPENDIX B

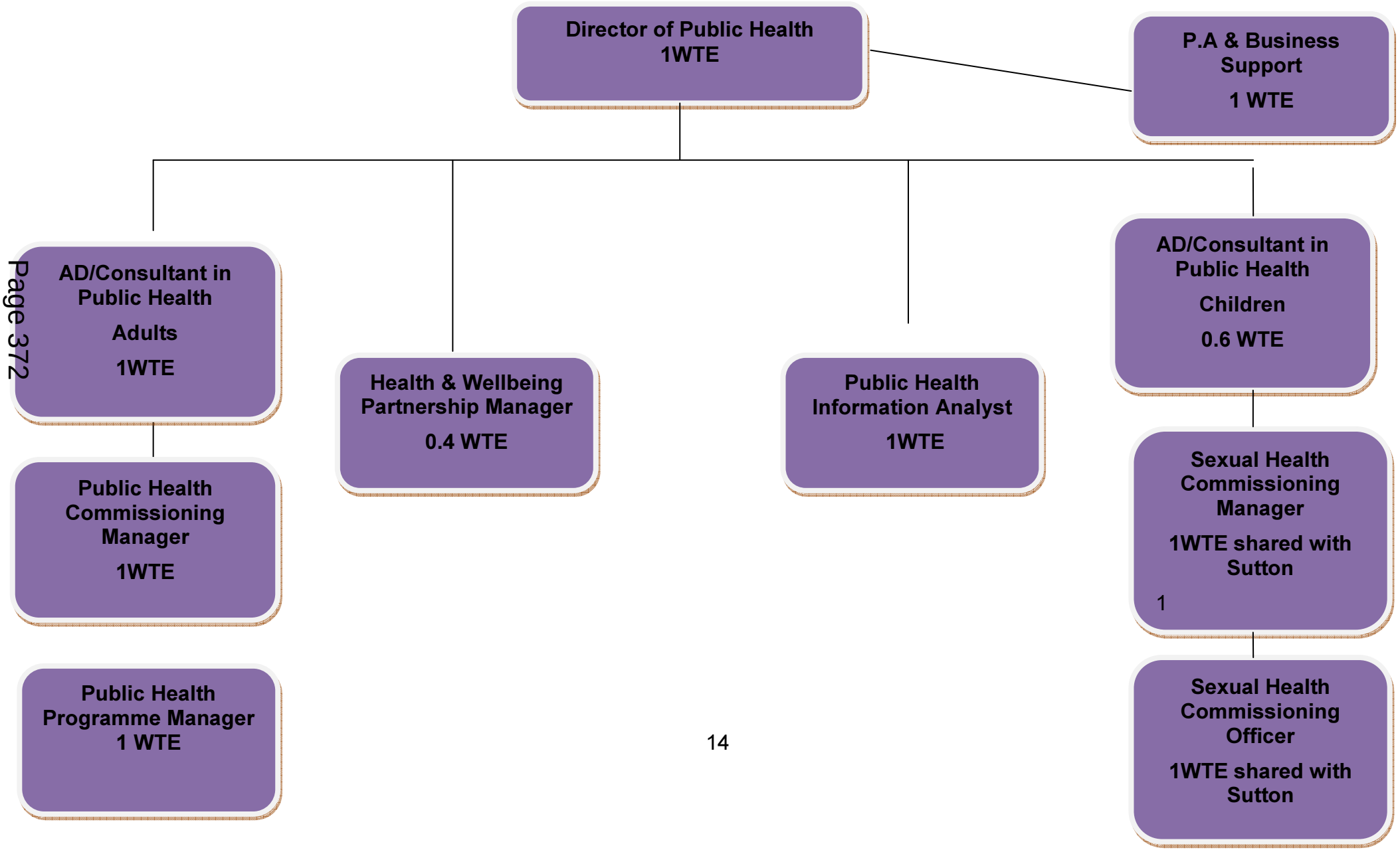
Public Health Directorate Workplan 2013-14

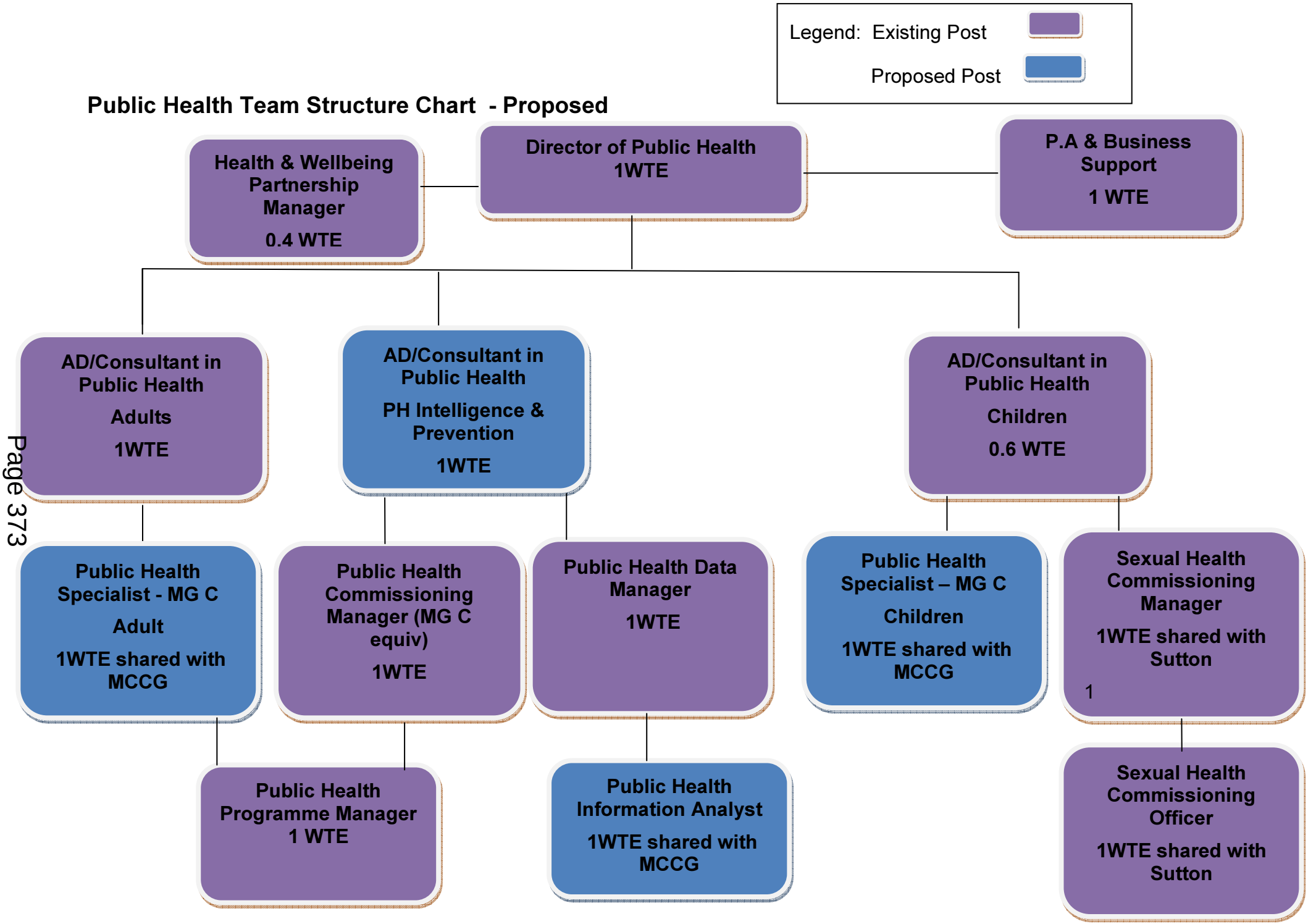
Area	Task	Evidence of Success	Responsibility	Comment
Ensure smooth transition of public health into LBM		Public Health embedded across LBM with ongoing, effective relationships	DPH/LBM	
Review public health team with a view to proposing fit-for-purpose structure within LBM		Options paper – CMT agreed option	DPH in consultation with team and Simon Williams	
Develop annual workplan for public health to deliver the mandated services as a minimum	• Staff in team propose and agree objectives • Discussions with CCG to agree PH inputs • Build objectives into annual workplan	Annual workplan agreed by CMT	DPH - Public health team	
Oversee directorate budget , ensuring expenditure stays within budget	• Finalise 2013/14 budget to reflect full cost of transferred services. • Work with CMT to agree 2014/15 budget for public health services	2013/14 budget agreed 2014/15 budget agreed	DPH - Public health team	
Ensure robust services are contracted for 2013-14 and 2014-15	• Ensure reviews of services inherited from the NHS take place • Develop plan to allocate remaining 2013/14 balance between short and medium-term services. • Using recommendations of reviews, put in place plan and procure services for 14/15 budget.	Reviews finalised with recommendations Pilot services in place 2013/14 2014/15 services procured in timely manner	PH staff for each review DPH with PH team PH team/LBM	

Area	Task	Evidence of Success	Responsibility	Comment
Ensure robust performance management in place for all contracts	• Agree KPIs for each service contract • Agree regular performance management arrangements for each contract • Participate in multi-borough contract monitoring	All contracts are performance managed with robust KPIs	PH staff responsible for each service	
Ensure monitoring data provided as required	• Agree public health monitoring data to be reported to various levels • Provide monitoring data • Make adjustments in delivery as indicated by data	Service delivery is adjusted to reflect monitoring results	PH Intelligence specialist PH team	
Provide leadership for public health across Merton partnerships	• Raise profile and understanding of public health in LBM and across partnership • Propose strategies to embed public health across LBM; e., health impact assessment • Develop strategies to make 'health everyone's business'	Partners understand their contribution to health HIA policy agreed Public health concerns embedded in contracts; e.g., leisure	DPH with PH team DPH with ph trainee DPH with PH team	
Produce annual public health report	Decide theme and prepare report	Annual Public Health Report available	DPH with PH Intelligence Specialist	
Provide Public Health leadership, advice, and support to deliver services	• Agree joint work and provide ongoing support to across LBM directorates • Undertake 3-4 in-depth needs assessment and/or strategy development e.g, mental health and alcohol in partnership with key stakeholders	workplans agreed with each directorate JSNA uses in-depth analysis to set out health needs Evidence-based strategies	DPH Julia Groom – children Anjan Ghosh - adults	

Area	Task	Evidence of Success	Responsibility	Comment
Develop good working relationships with key stakeholders in the Clinical Commissioning Group and voluntary sector	• Agree Memorandum of Understanding and annual workplan with MCCG • Develop partnership with voluntary sector	Public Health providing appropriate support to MCCG Public Health seen as important partner	DPH DPH and PH team	
Support the Health and Wellbeing Board and delivery of the Health and Wellbeing strategy	• Provide public health leadership to HWB • Provide support through agreeing agenda, delivering papers and presentations • Agree mechanism to monitor HWB strategy • Review annually HWB strategy and adjust	Well functioning HWB HWB strategy delivered as per plan	DPH with HWB support officer – Clarissa Larsen	
Ensure Joint Strategic Needs Assessment is updated regularly	Update JSNA	JSNA provides most up-to-date analysis of health needs	Consultant in PH PH Intelligence Specialist	
Provide local assurance for NHS England and Public Health England	• Assure robust plans for immunisations, for example • Support health protection work, as required	Robust local delivery of NHS England and Public Health England work	DPH with PH team	

Public Health Team Structure Chart - Actual




Legend: Existing Post
Proposed Post
Public Health Team Structure Chart - Proposed
Health & Wellbeing Partnership Manager
0.4 WTE
Director of Public Health
1WTE
P.A & Business Support
1 WTE
AD/Consultant in Public Health
Adults
1WTE
AD/Consultant in Public Health
PH Intelligence & Prevention
1WTE
AD/Consultant in Public Health
Children
0.6 WTE
Public Health Specialist - MG C
Adult
1WTE shared with MCCG
Public Health Commissioning Manager (MG C equiv)
1WTE
Public Health Data Manager
1WTE
Public Health Specialist – MG C
Children
1WTE shared with MCCG
Sexual Health Commissioning Manager
1WTE shared with Sutton
1
Public Health Programme Manager
1 WTE
Public Health Information Analyst
1WTE shared with MCCG
Sexual Health Commissioning Officer
1WTE shared with Sutton

16