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Cabinet
16 July 2015

7. Public Health Ring-Fenced Grant

Relevant Cabinet Member	Mr M H Hart
Relevant Officer	Dr Richard Harling, Director of Adult Services and Health
Recommendation	**1. The Cabinet Member with Responsibility for Health and Well-being recommends that Cabinet:** **(a) Notes the conditions and current expenditure of the public health ring-fenced grant;** **(b) Notes the anticipated reduction to the public health ring-fenced grant in 2015/16;** **(c) Approves the initial proposals for savings in the public health ring-fenced grant as set out at paragraphs 29 to 54;** **(d) Requests that on this basis the Director of Adult Services and Health initiate discussions with partners and providers of services, and undertake consultations and Equality Impact Screenings or full Equality Impact assessments as necessary;** **(e) Note that a detailed review of all prevention spend will be undertaken, so as to prioritise future spend on those areas where effectiveness can be best evidenced; and** **(f) Delegate a final decision for each service to the Cabinet Member for Health and Well-being in discussion with the Director of Adult Services and Health, and in the context of the discussions and review highlighted above.**
Introduction	2. This paper provides details about the public health ring fenced grant (PHRFG), and initial proposals for savings in the wake of the Treasury announcement on 11 June 2015 that the government intended to reduce the national PHRFG by £200m in 2015/16.

Background information: the public health ring-fenced grant

3. The Health and Social Care Act 2012 made fundamental changes to the public health system from April 2013. Unitary and upper tier Local Authorities were given new duties, which had formerly sat with the NHS, for improving the health and well-being of the local population.

4. This change aimed to meet key demand pressures including:

- Dramatic increases in the number of years people living with disability and long-term conditions, often into extreme old age;
- A significant and continuing rise in the proportion of disease which is caused by avoidable lifestyle factors, in particular smoking, being physically inactive, drinking too much alcohol, and eating too much food which is high in fat, salt and sugar;
- A continued gap in health outcomes between those living in more and less deprived areas with the avoidable disease burden being higher in more deprived areas.

5. Local Authorities were given new public health duties and leadership powers to tackle these pressures, because of their:

- Place based experience and knowledge about the local population, including the hard to reach communities;
- Community leadership roles; and
- Influence over the determinants of health, such as education, housing, employment, and the built and green environment.

6. To support the new duties, the Department of Health created a national PHRFG, which is allocated by Public Health England to Local Authorities annually. Details of how the PHRFG is calculated are available in Appendix 1.

7. The Department of Health specifies conditions for the PHRFG annually. For 2015/16, these are to:

- Significantly improve the health and well-being of local populations;
- Carry out health protection and health improvement functions delegated from the Secretary of State for Health;
- Reduce health inequalities across the life course, including hard-to-reach groups;
- Ensure the provision of population healthcare advice; and
- Have regard to the need to improve the take up of, and outcomes from, drug and alcohol misuse treatment services.

8. In order to make sure that the PHRFG is spent in line with these conditions, the Department of Health has specified seven mandatory areas of spend, and a further 20 discretionary areas of spend as listed in Appendix 2. Local

Authorities must also have regard to the need to reduce health inequalities between people in their areas in determining expenditure. Local Authorities are required to complete an annual return detailing how the PHRFG has been spent.

9. In addition to this, Local Authorities must:
    - Appoint a specialist Director of Public health;
    - Produce a Joint Strategic Needs Assessment (JSNA) to describe local need and priorities;
    - Establish and support a Health and Well-being Board to oversee the local health and social care system;
    - Produce a Health and Well-being Strategy to shape commissioning priorities (including public health commissioning) across the health and social care system.

Worcestershire's public health ring-fenced grant

10. In Worcestershire, our initial allocation in 2015/16 was £26.5m. In addition to this, in October 2015 a further £3.3m will be transferred from NHS England to fund 0-5 Years public health services for the remaining six months of the financial year. A further small amount of funding may be available under the PHRFG Health Premium Incentive scheme.

11. The PHRFG is committed in line with:

- The Council's **corporate plan** 2013-17 and its ambitions to:
    - ✓ Create a vibrant economy supported by a healthy population;
    - ✓ Promote healthy lifestyles
    - ✓ Help people to stay healthy and active and independent for as long as possible
    - ✓ Give due regard to vulnerable and disadvantaged groups and work to advance equality of opportunity; and
    - ✓ Invest in prevention in order to reduce demand.

- The **Joint Health and Well-being Strategy** with its:
    - ✓ Vision to place a greater emphasis on prevention, early intervention and early help to preserve people's health and independence;
    - ✓ Four priorities: older people and management of long term conditions, mental health, obesity and alcohol; and
    - ✓ Three groups for particular focus: **c**hildren and young people, communities and groups with poor health outcomes, people with learning disabilities.

- The Council's **Care Act prevention policy,** which describes our approach to preventing, reducing and delaying needs in the long, medium and short

term in line with Section 2 of the Care Act and through a combination of:
- ✓ Supporting healthy policy making;
- ✓ Providing information and advice;
- ✓ Encouraging and enabling communities;
- ✓ Investment in services - for which the PHRFG is the major source of funding; and
- ✓ Effective gatekeeping.

- **Nationally mandated** areas of spend – see Appendix 2.

- The **evidence base** for interventions that have proven successful in improving health and well-being and reducing health and social care demand. This is with a particular emphasis on interventions in childhood that influence the life course and reduce the risk of health and social problems arising, and in adulthood to prevent, reduce or delay entry into adult social care by addressing the major causes of entry into care: stroke, falls, incontinence and dementia.

12. Measuring the effectiveness of spend on prevention is complex and does not fit well with simple cost benefit calculations. The return on investment may often be medium to long term. Also some of the benefit may accrue to other organisations – notably the local NHS and West Mercia Police. However the Council is committed to testing all services for effectiveness and value for money. In the coming months, a detailed review of all prevention spend will be undertaken, so as to prioritise future spend on those areas where effectiveness can be best evidenced.

13. Specific areas of PHRFG commitment are summarised below with full details in Appendix 3.

Older people's recovery services

14. This is a contribution from the PHRFG to services that help older people remain independent at home, avoid admission to hospital or care homes, and/or speed up hospital discharge.

Targeted prevention services for adults

15. These are services targeted at high risk adults (and some younger people), designed to reduce and delay the development of longer term needs. They include community safety projects, drug and alcohol services for adults and young people, funding for a social impact bond to reduce social isolation in older people, and falls prevention services for older people.

16. They also include a range of services for adults that the Council decided to fund from the PHRFG in March 2014. These are domestic abuse services, homeless

services, adults' housing related support, re-ablement services for people with a learning disability and people with mental health problems, housing adaptations and repairs, support to access information and advice including advocacy, dedicated support for carers, and support for people with a sensory impairment. In addition they include a contribution via the CCGs to the integrated mental health team for NHS primary care services, funding for which was included in the PHRFG at baseline.

17. In addition there is funding to support implementation of the digital inclusion strategy which will introduce measures to support people to use the internet, including to access advice and information about keeping well and about local services. Note that this funding is required as a one off only in 2015/16.

Universal prevention services for adults

18. These are services open to all adults (and some younger people) designed to prevent, reduce and delay the development of health problems. They include:

- Sexual health services for adults and young people including prevention, diagnosis and treatment of sexually transmitted infections and contraceptive services provided at genitourinary medicine clinic and in GP surgeries, as well as outreach services to schools.
- The national Health Checks programme.
- Services to promote heathier lifestyles, including smoking cessation and the Living Well service.

19. There is also funding earmarked for health improvement projects to support implementation of the Health and Well-being Board's four priorities: Alcohol, Obesity, Mental Health and Well-being, and Older people and management of long term conditions.

Prevention services for children

20. These include targeted services in the form of housing related support for young people, which the Council decided to fund from the PHRFG in March 2014.

21. They also include universal services such as school nursing, services to support expectant and new mothers, and from October 2015 Health Visiting and the Family Nurse partnership. In addition they include NHS Child Development Services, as well as the NHS contribution to the Children's Safeguarding Board, funding for both of which was included in the PHRFG at baseline.

22. Note that many of the services for adults also benefit children. Contracts for services such as drug and alcohol include a requirement to consider the needs of the whole family as well as the adult directly affected. Services such

as smoking cessation reduce the harm caused to children from conception onwards.

Strategic functions

23. This includes funding for the specialist Public Health team as well as the Emergency Planning team, a contribution to the Directorate of Adult Services and Health Quality Assurance function, and corporate recharges.

Anticipated reduction in the public health ring-fenced grant

24. The Treasury announced on 11 June 2015 that the government intended to reduce the national PHRFG by £200m, just under 7.5% of the total, in 2015/16, with this reduction passed on to Local Authorities. The Department of Health has indicated that there may be a consultation about this. Should this be the case, the Council has prepared a response, which is set out in Appendix 4. It is likely that this reduction will be recurrent and there may be further reductions in future years.

25. However, our response not withstanding we must expect that Worcestershire's PHRFG will be reduced. We must also expect that PHRFG reductions are likely to be greatest in those local authorities who are funded above their target position. The responsible course of action is to prepare for a reduction of at least £3.3m, around 12.5% of our initial allocation, in 2015/16. This gives an opportunity to consider how this reduction can be managed and how any risks can be mitigated.

Proposals for managing the reduction in Worcestershire's public health ring-fenced grant

26. Making a saving of £3.3m in 2015/16 would be extremely difficult and disruptive: the majority of the PHRFG is committed through contracts that require 3, 6 or in some cases 12 months' notice, and ending or reducing contracts at short notice is likely to destabilise services and providers.

27. The proposed financial strategy is therefore:

i. To continue to prioritise commitments in line with the strategic framework set out in paragraph 10.

ii. To make savings in 2015/16 if possible where the PHFRG is uncommitted through contracts;

iii. To meet the resulting overspend in 2015/16 from public health reserves;

iv. To make additional savings from 2016/17 to a minimum of £3.3m. Then to make further additional savings in year to allow reserves to be replenished;

v. To make additional savings from 2017/18 to complete repayment of reserves to the value of the overspend in 2015/16. These reserves are currently committed to one-off investments to improve health

and well-being and/or transform health and social care services. These include investments in new technologies to improve and reduce the costs of care.

vi. To create a revenue underspend position that would allow:
- Reinvestment in priority services; or
- A contingency to be held against the risk of a further reduction in the PHRFG or further reductions in other central government funding.

vii. To work with partners to explore additional and alternative sources of funding, especially the local NHS who are the principal beneficiaries of investment and who are expected to receive a share of the £8bn increase in budget allocated by the government over the next five 5 years.

28. Initial proposals for savings are summarised below. These proposals will be modified in light of emerging information, which means that the **final savings to some services may be greater and to others less, and that the timescales may change**. The information that will be used in reaching a final decision includes:
- Confirmation of the government's decision about the scale and timing of reductions to the PHRFG;
- Discussions with partners and providers of services and any consultations where necessary, as well as the outcomes of Equality Impact screening and Equality Impact Assessments as required; and
- The findings of our detailed review of prevention spend.

Older people's recovery services

29. The PHRFG contribution to the Integrated Equipment Service would be maintained. These contribute directly to reducing and delaying the need for adult social care and a reduction is likely to lead to an increase in costs.

30. The PHRFG contribution to the discharge liaison nurses would be maintained but note that the base budget contribution to this team will be phased out as part of the Council's wider Future Fit programme.

Targeted prevention services for adults

31. Funding for community safety projects would be phased out by 75% in 2015/16 and the remaining 25% in 2016/17. These are not a core duty of the Council and do not prevent, reduce or delay the demand for adult social care or significantly improve health outcomes. We would work with West Mercia Police and the District Councils to consider the impact on people and communities and identify whether any alternative sources of funding might

be available.

32. Funding for drug and alcohol services would be reduced by 10% from October 2016. This would allow priority services to be sustained. We would work with the provider to redesign services to prioritise the most important elements and achieve greater efficiency so as to minimise the impact on users. We would work with West Mercia Police and the Clinical Commissioning Groups (CCGs) to consider any impact on people and communities and identify any additional sources of funding. Any funding earned under the PHRFG Health Premium Incentive scheme for performance on successful completion of drug treatment will be ring-fenced to the service. Note that excessive alcohol use is a risk factor for stroke and dementia, major causes of entry into adult social care.

33. Funding for the Social Impact Bond would be maintained. This is a new investment whereby the Council pays on the basis of outcomes achieved in terms of reducing older people's social isolation.

34. Funding for falls prevention services for older people would be maintained as they have demonstrated a direct effect in reducing acute hospital admissions due to falls, one of the major causes of entry into adult social care.

35. Funding for domestic abuse services would be reduced by 10% from April 2016. This would allow priority services to be sustained. We would work with providers to redesign services to prioritise the most important elements and achieve greater efficiency so as to minimise the impact on users. We would work with West Mercia Police and the Clinical Commissioning Groups (CCGs) to consider any impact on people and communities and identify any additional sources of funding.

36. We are looking to phase out funding for homeless services from April 2016 as current contracts come to an end. These are not a core duty of the Council and their contribution to preventing, reducing or delaying demand or improving health outcomes is limited. Any recommissioning of these services would be at a considerably reduced level of funding. We would work with the District Councils and providers to consider any impact on people and communities and identify any alternative sources of funding.

37. We are looking to phase out funding for adults' housing related support from April 2016 as current contracts come to an end. These are not a core duty of the Council and their contribution to preventing, reducing or delaying demand or improving health outcomes is limited. Any recommissioning of these services would be at a considerably reduced level of funding. We would work with the District Councils and social housing providers to consider any impact on people and communities and

identify any alternative sources of funding.

38. Funding for re-ablement services for people with a learning disability and people with mental health problems would be maintained. These contribute to reducing and delaying the need for adult social care and a reduction might lead to an increase in costs.

39. Funding for housing adaptations and repairs would be maintained. These contribute to reducing falls, one of the major causes of entry into adult social care.

40. Funding for support to access information and advice including advocacy, would be reduced by 10%. These services are currently undergoing commissioning and the savings will be achieved through service redesign, prioritisation and greater efficiency. The reduction in funding would be built into the tenders to take effect from April 2016.

41. Funding for dedicated support for carers, and support for people with a sensory impairment would be maintained. These contribute to reducing and delaying the need for adult social care and a reduction might lead to an increase in costs.

42. The PHRFG contribution to the integrated mental health team of £960k in respect of primary care mental health services would be discontinued from October 2016. These are NHS services for which the responsibility for funding lies with the CCGs. Now that the PHRFG is being reduced we can no longer afford for this additional funding to come out of the PHRFG. The Council would work with the CCGs and the provider to identity alternative funding arrangements. Half year savings would be realised in 2016/17 with the remainder deferred until 2017/18.

Universal prevention services for adults

43. Funding for sexual health services would be reduced by 10% from October 2016. These services are mandated and this would allow them to be sustained. They are currently undergoing commissioning and the savings will be achieved through service redesign, prioritisation and greater efficiency. Half year savings would be realised in 2016/17 with the remainder deferred until 2017/18.

44. Funding for Health Checks will be maintained. This is a mandated programme commissioned through a payment by results arrangement.

45. Smoking cessation services would be targeted on communities and groups with poor health outcomes. This means that their impact on reducing health inequalities would be preserved, along with their impact on reducing the risk of stroke in people who are most likely to require

Council funding for adult social care. These are commissioned through a payment by results arrangement and the Council would work with providers to agree a variation in the tariff so that payment would be made in respect of people living in areas with the poorest health as well as people with certain protected characteristics.

46. Funding for the Living Well service would be maintained. This service contributes to tackling obesity, excessive alcohol use and smoking in communities with poor health outcomes, and therefore addresses risk factors for stroke and dementia in people who are most likely to require Council funding for adult social care.

47. Funding for health improvement projects to support the Health and Well-being Board's four priorities would be reduced by £1m in 2015/16. This is a pragmatic proposal as this funding has not yet been committed through contracts. Funding would be reduced by a further £200k in 2016/17 through early cessation of some of the projects currently ongoing. We would work with partners through the Health Improvement Group to identify priorities for the remaining PHRFG and any potential additional sources of funding.

Prevention services for children

48. We are looking to phase out funding for housing related support for young people from April 2016 as current contracts come to an end. These are not a core duty of the Council and their contribution to preventing, reducing or delaying demand or improving health outcomes is limited. Any recommissioning of these services would be at a considerably reduced level of funding. We would work with the District Councils and social housing providers to consider any impact on people and communities and identify any alternative sources of funding.

49. Funding for school nursing would be reduced by 10%. This would allow the service to be sustained. In particular this service delivers the mandated function of the National Child Measurement Programme, and this would be preserved. We would work with the provider to redesign services to prioritise the most important elements and achieve greater efficiency so as to minimise the impact on users. The reduction in funding would be agreed through a contract variation to take effect from October 2016. Therefore half year savings would be realised in 2016/17 with the remainder deferred until 2017/18.

50. Funding for services to support expectant and new mothers, as well as Health Visiting and the Family Nurse partnership would be reduced by 10% from October 2016. The services would be recommissioned along with children's Early Help as a single 0-5 service. Health Visiting and the Family Nurse partnership are mandated elements. Half year savings would be realised in 2016/17 with the remainder deferred until 2017/18.

51. Funding from the PHRFG would be identified to support children's Early Help: £250k for the second half of 2015/16 and first half of 2016/17. A further £1m would be identified from October 2016 to support recommissioning of a single 0-5 service as noted in paragraph 49. This would allow a reduction in the Council's base budget and expenditure on Early Help in order to compensate for the budgetary pressures in children's social care. The specification for the new service would be founded on the evidence base for interventions that have proven successful in improving health and well-being and reducing health and social care demand. The savings would therefore be achieved through service redesign, integration, prioritisation and greater efficiency.

52. Funding for Child Development Services would be discontinued from October 2016. These are predominantly NHS services for which the responsibility for funding lies with the CCGs. Now that the PHRFG is being reduced we can no longer afford for this additional funding to come out of the PHRFG. The Council would work with the CCGs and the provider to identity alternative funding arrangements. Half year savings will be realised in 2016/17 with the remainder deferred until 2017/18.

53. Funding in respect of the NHS contribution to the Children's Safeguarding Board would be discontinued in 2015/16. This is the responsibility of the CCGs. Now that the PHRFG is being reduced we can no longer afford for this additional funding to come out of the PHRFG. The Council would work with the CCGs and the Children's Safeguarding Board to identify alternative funding arrangements. Additional funding of £86k from the PHRFG to support children's Early Help would be made available in 2015/16 only so that so that if alternative funding arrangements cannot be established in-year this would not result in a net cost pressure on Children's Services.

Strategic functions

54. Funding for the specialist Public Health team, health intelligence and medicines management would be reduced 10% from 2016/17. Funding for the Emergency Planning team will be reduced by £50k in 2015/16. These teams deliver the mandated functions of the Council's responsibilities for health protection and public health advice to NHS CCG commissioning, and these would be preserved.

Next steps

55. If approved by Cabinet these initial proposals would be discussed with partners and providers to ensure an understanding of the impact on people and other agencies, identify any additional or alternative sources of funding and identify any further mitigation required. Consultations with current and prospective users will be undertaken where

necessary. Equality Impact screening and full Equality Impact Assessments will be undertaken as required. The findings of these enquiries as well as the detailed review of prevention spend will be summarised and reported to the Cabinet Member for Health and Well-being who will make a final decision for each service in discussion with the Director of Adult Services and Health, with an update to the Health and Well-being Board if required.

Risks

56. The reduction in the PHRFG and the consequent savings required from services generate four risks.

i. That ongoing improvement in health and reductions in health inequalities might be jeopardised. This would be mitigated by strengthening our other approaches at prevention: supporting healthy policy making, providing information and advice, encouraging and enabling communities, and effective gatekeeping. Also by ensuring that the remaining investment is targeted on those groups whose health is poorest.

ii. That reduced investment in prevention might lead to a rise in demand for health, social care and other public services. This is particularly a risk for the local NHS, as well as for the Council and other partners such as West Mercia Police, District Councils and housing associations. This would be mitigated by:

- Deferring the majority of savings until 2016/17 to give other partners the opportunity to consider additional and alternative sources of funding and work with us on service redesign.
- Discussions with providers to agree appropriate contract variations that allow the most important elements of services to be maintained.
- The creation of a contingency against the risk that a reduction in funding for housing related support leads to an increase in demand for social care.

iii. That a reduction in income might destabilise providers. This would be mitigated by deferring the majority of savings until 2016/17 to give time for discussions with providers about contract variations that allow services to be maintained within the reduced funding available.

iv. That the savings required by the Council might damage relationships with partners, particularly with the local NHS, and that this compromises further integration of services. This would be mitigated by discussions with partners to try and agree a common approach, with an update to the Health and Well-being Board if required.

Legal, Financial, HR and Equality Implications

Legal

57. These initial proposals will allow the Council to continue to meet its legal duties for prevention under Section 2 of the Care Act. The Care Act prevention policy (published on the Council's website) describes how these will be met.

58. These initial proposals will allow the Council to continue to meet its legal duties under the Health and Social Care Act 2012. In addition all planned expenditure will be within the conditions of the PHRFG.

59. Those initial proposals that require consultation with current and prospective users will be identified and consultation carried out as necessary. These will tend to relate to those services where the initial proposal is that funding will be withdrawn.

Financial

60. These proposals would generate savings of around:

- £0.9m in 2015/16 – leading to a projected overspend of £2.4m in year that would require use of public health reserves;
- A further £3.2m in 2016/17 – leading to a projected in-year underspend of £0.7m that would allow reserves to be repaid;
- A further £1.3m in 2017/18 – leading to a projected revenue underspend of £2.0m, of which £1.6m would be used in year to complete repayment of reserves. The revenue underspend would be used either for reinvestment in priority public health services, or to offset a further reduction in the PHRFG or further reductions in other central government funding.

61. The final savings figure will be calculated in the light of the final decision, which will be based on

- Confirmation of the government's decision about the scale and timing of reductions to the PHRFG;
- Discussions with partners and providers of services and any consultations where necessary, as well as the outcomes of Equality Impact screening and Equality Impact Assessments as required; and
- The findings of our detailed review of prevention spend.

HR

62. The Public Health team will explore ways to make the required savings. In line with HR policy this will be done in a way that minimises any need for compulsory redundancies. The Emergency Planning team will make the required

savings by deleting a vacant post.

Equality

63. The Equality Act 2010 requires the Council to have "Due Regard" to the three aims of the Equality Duty in designing policies and planning/delivering services. These aims are to:

- Eliminate unlawful discrimination. Harassment and victimisation
- Advance equality of opportunity
- Foster good community relations between people who share any of the defined Protected Characteristics and those who do not.

64. The Act lists nine Protected Characteristics, but, clearly, it is highly unlikely that they will all be of relevance in all circumstances. The level of regard which is "due" in respect of the Duty aims should always be proportionate and is dependent on the potential of the proposed policy/action to contribute to or detract from the aims of the Duty.

65. An initial analysis has been undertaken in order to identify those proposals where further Equality Impact screening and full Equality Impact Assessments will be required. These will be undertaken alongside discussions with partners and providers and consultation where necessary in order to identify the impact of the initial proposals on service users.

Supporting Information

- Appendix 1: Details of how the public health ring-fenced grant is calculated
- Appendix 2: Mandatory and discretionary areas of spend for the public health ring-fenced grant
- Appendix 3: Public health ring-fenced grant commitments
- Appendix 4: Worcestershire County Council response to consultation on the national reduction in the public health ring-fenced

Contact Points

County Council Contact Points

Worcester (01905) 763763, Kidderminster (01562) 822511 or Minicom: Worcester (01905) 766399

Specific Contact Points for this report

Dr Richard Harling, Director of Adult Services and Health (01905) 766307
Email: rharling@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Director of Adult Services and Health) the following are the

background papers relating to the subject matter of this report:

- Prevention, Early Help and other Support for Adults Young People: Outcome of Consultation and Final Recommendations. Cabinet. 6 March 2014.
- Care Act Prevention Policy.