Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

5 February 2018

Agenda Item: 4

REPORT OF DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH COMMISSIONING INTENTIONS 2019 ONWARDS

Purpose of the Report

1. To seek approval to Public Health commissioning intentions, along with approval to undertake consultation with key stakeholders, to align timescales by extending contracts where applicable, and to approve additional temporary staffing capacity to enable implementation.

Information

Context and Background

2. Since 1st April 2013, local authorities have been responsible for improving the health of their resident local population and for Public Health (PH) services including most sexual health services and services aimed at reducing drug and alcohol issues. This responsibility is reflected in the Council Plan 'Your Nottinghamshire, Your Future 2017-2021 and is explicit in ambition 6 'People are healthier'.

3. Contracts for current PH commissioned services will begin to expire from 30 September 2018. At the same time, future financial constraints include the end of the ring fence of Public Health grant March 2020 and the Council's own financial position as set out in the Medium Term Financial Strategy. Safely terminating these contracts, identifying options for how best to address future needs, and the letting of new contracts which deliver best value for money requires a planned approach.

4. Within this context an officer Task and Finish Group was set up to develop proposals for Public Health commissioning intentions. In developing these the following issues were considered:
   - Review of historical contract delivery and analysis of future need
   - Best service model (e.g. assessment of the relative merits of life course versus age-specific service models, and of service models which offer a more integrated approach to addressing the various needs of an individual versus separate services for addressing different types of need)
   - Capacity and competitiveness of the Public Health services provider market
   - Best procurement approach (e.g. options for securing increased influence in the market by "bundling up" services into a single tender)
   - The implications of the development of an Accountable Care System for PH commissioned services, and its potential as a means of commissioning for improved outcomes.

Commissioning Intentions

5. Table 1 below summarises the proposed commissioning intentions. The key proposed change is to move to an integrated "wellbeing" service that encompasses substance misuse, tobacco control, obesity prevention and weight management, wellbeing@work and public mental health within a single contract, in a life course approach. Such an approach would offer potential cost savings as well as achieving critical mass, effectively managing transition from children's to adults' services, and putting the service user at the centre of provision.

Table 1 Summary of Commissioning Intentions

Element	Approx value annual £	Proposal	Rationale and key assumptions	Compared to existing provision	Risks
Integrated "wellbeing" service	Currently £11,680,608 Proposed: £10,730,608 *The bundled service would need to achieve a saving of £950K against equivalent existing budgets from 2020/21*	Commission a bundled lifestyle / wellbeing service in a life course approach encompassing • Substance Misuse Services (SMS) • Tobacco Control • Obesity Prevention and weight management (OBPWM) • Wellbeing@work • Mental health	Rationale: Merger of services elsewhere has achieved critical mass in the context of budget constraints and some are judged effective. A life course service with a single provider has potential to manage transition from Children's to Adult services. Evidence base in OBPWM and SMS supports a family based approach. A co-ordinated approach across key lifestyle services would put the service user at the centre of provision, able to move seamlessly across different service provision. Mental health could be included with focus on	The bundled service would integrate a mental health approach with appropriate referrals. Currently public mental health provision is limited to a single year's funding for suicide prevention training.	Ability of market to support a bundled approach – presence of sufficient providers. May not be an attractive proposition to a non NHS provider not familiar with Nottinghamshire children's public health/NHS/NCC infrastructure thus limiting the market Ability of providers to manage a bundled service, manage sub-contractors appropriately, and manage high risk elements e.g. SMS. Concentration of risk into a single contract / single provider. The model may limit the ability of the provider to fully integrate

Element	Approx value annual £	Proposal	Rationale and key assumptions	Compared to existing provision	Risks
			supporting general service users with mental wellbeing and appropriate referrals to GPs or Pyschological Therapies. Demographic information in the Options Appraisal for mental health supports the integration. Assumptions: An integrated lifestyle service could potentially make referrals for NHS Health Checks for people in hard to reach groups. There would be the ability to specify which elements are most important to NCC as commissioner and to include pilot elements within the specification. Providers are willing to tender for this service.		with other Children & Young People and Adult services and partner organisations. Early evidence suggests that this model is less effective for some lifestyle change programmes particularly smoking cessation therefore performance could fall. Potential for some areas of activity to be squeezed in pursuit of those elements with easier outcomes.
Sexual Health (SH)	Current: £6,413,600 Proposed: £6,313,600 *Planned £100K budget saving from 2020/21*	Continue service on existing timeframe and recommission on expiry (currently 2021 with options for extensions to 2024). From 2020/21, vary contract to address planned budget saving, following	Rationale: Current integrated services commenced on 1 April 2016. Contract timeframes permit the opportunity to work with		Need to maintain open access as part of mandate Providers may not be willing to commit to a change in offer Changes may impact

Element	Approx value annual £	Proposal	Rationale and key assumptions	Compared to existing provision	Risks
		discussion with the current providers and taking into account the recommendations from the refresh of the SH JSNA in June 2019.	providers to agree where and how to make the required budget savings (with effect from April 2020) that have the lowest impact on SH outcomes and inequalities and which take account of the latest JSNA. Assumptions: Integrated Sexual Health Service providers are willing to negotiate on change to offer. Co-commissioner Nottingham City Council is willing for Notts CC to make adjustments.		Nottingham City provision which is part of the Framework agreement Reputational damage to the council if redundancies occur in Integrated Sexual Health Services as a result of budget reduction
NHS Health Checks	Current: £848,000 Proposed: £591,000 *Reduction to annual budget from £848K to £591K by 2020/21 (£257K reduction)*	Continue as annual direct award with PC Hubs or GPs. Achieve savings by removal of underspend, adjustment of payments made to GPs to better incentivise practices to deliver checks to those most at risk.	Rationale: GPs have access to patient data that enables them to identify the eligible population. No other provider is able to do this without the practices agreeing to put in place the relevant information sharing agreements. The GP-led service is cost effective and benchmarks well against market prices from other providers.		Risk of contract underperformance, managed by contract management mechanisms and additional performance management support from CCG leads. Maintain compliance with national mandate. The eligible population is increasing in size year on year, so there may be cost pressures if performance starts to improve.

Element	Approx value annual £	Proposal	Rationale and key assumptions	Compared to existing provision	Risks
			The new IT system reduces the administrative burden on practices and therefore is expected to increase the proportion of each practice population that is offered a check. Assumptions: Performance continues at its current level. The proportion of the population with high Cardio Vascular Disease risk (national figure) will not exceed 5% of the total (local) eligible population Delivery to GP registered population[1]		
Community Infection Prevention and Control service (CIPC)	Current: £91,000 Proposed: £60,000 *£31K budget reduction by 2020/21*	Work with CCGs to develop a co funded, CCG hosted CIPC service from April 2018 that provides a sustainable provision.	Rationale: Depends on integrated working with CCGs, joint funding and CCG agreement to host the CIPC service. Assumptions: CCGs commit to fund the CCG focused provision CCGs agree to host a co-funded CIPC service	Reduction to service with focus on residential and care home settings.	Management of outbreaks may absorb all available resource leaving no opportunity for proactive audit and prevention work. May not be able to respond to new community infection threats as they arise (e.g Anti Microbial resistance to antibiotics).

[1] GP registered population means individuals registered to a GP practice located within the County.

Element	Approx value annual £	Proposal	Rationale and key assumptions	Compared to existing provision	Risks
			Investment is sufficient to meet the outbreak management requirements within residential and care home settings		Staff attrition may result in loss of expert clinical knowledge and skills. Failure to address healthcare associated infections in services commissioned by the LA (and other commissioners) carries risk of avoidable disability and death of residents and/or loss of independence. Reputational risk if stakeholders consider the LA is not undertaking its duty to protect the public's health.
Domestic Violence and Abuse	Current: £1,007,438 Proposed: no change	Extend existing contract to March 2020 to align timeframes with other contracts (and with known PH grant) Recommission on expiry.	Rationale: No issues identified with current service.	None proposed.	No change.
Healthy Child Programme (HCP) 0-19	Current: £13,741,048 reducing over contract life *Proposed: increase by £35,000 from 2019/20 to*	Continue as is until contract expiry and recommission at that time. Expiry March 2020 with extension possible to 2024. From 2019, incorporate element	Rationale: Existing contract started only 1 April 2017 and is already designed to deliver annual savings in light of budget constraints.	None proposed.	No change.

Element	Approx value annual £	Proposal	Rationale and key assumptions	Compared to existing provision	Risks
	incorporate oral health activity	of children's oral health, see below.			
Oral health	Current: £83,000 Proposed: £35,000, to be transferred to HCP, see above. *Budget saving of £48K from 2019/20.*	Contract to be varied, March 2019. Statutory elements of service potentially to be subsumed into the 0-19 HCP contract after that.	Rationale: Budget constraints have already been considered and provisional agreement secured to terminate non-statutory elements, with view to incorporating statutory elements within alternative existing contract. Assumptions: 0-19 provider will be willing and able to incorporate oral health aspects.		Risk of reduction in service as end of contract approaches. Mitigation: planning for transfer of activities into 0-19 contract.

6. There is also potential to integrate Children's Centres within the Healthy Child Programme (HCP) 0-19. Further consideration could also be given to whether the HCP could also be included in the integrated wellbeing service, given that the first contract end date for HCP is 31 March 2020 (although extension options allow for continuation to 2024).

7. Outside of the integrated wellbeing service, some other Public Health services would continue to be commissioned separately, e.g. Sexual Health services, NHS Health Checks, Domestic Violence and Abuse.

8. The proposals in Table 1 relate to externally commissioned PH services only. Separate consideration will also need to be given in due course as to whether to continue the following in-house services:
   a. Tobacco control activities to tackle illicit tobacco – annual Service Level Agreements in place.
   b. ASSIST programme of smoking prevention in schools – delivered under licence by the Youth Service; expires March 2019 with no option to extend.

9. The intentions will require the extension of contracts on some existing commissioning services in order to align timeframes ready for potential integration. Specifically, the contracts for Substance Misuse (adults) and Domestic Violence and Abuse would need to be extended from September 2018 to March 2020, and the Obesity Prevention and Weight Management contract

would need to be extended from March 2019 to March 2020. These projected extensions are in line with extension provisions in existing contracts, but would be subject to agreement by the providers.

10. The overall timeframe for implementing the re-commissioning, should the intentions be agreed by Members, is as follows:

Time period	Action
May – November 2017	Needs analysis, options identification and assessment of outline proposals within Public Health staff team
Feb 2018	Formal Committee consideration of proposed intentions
Subject to authorisation	Extension of relevant contracts to March 2020
By end April 2018	Mitigation plan if providers do not agree to an extension
Subject to authorisation – by end March 2018	Initial consultation with stakeholders
Three months after consultation closes – by end June 2018	Development of detailed proposals
Six weeks after preparation of proposals – by end July 2018	Stakeholder engagement and consultation / soft market testing
From July 2018	Preparation of service specifications taking into account the results of consultation and testing
By end Dec 2018	Authorisation of procurement and award by Committee
By end March 2019	Tender period
By October 2019	Award of contract(s) for 1 April 2020 start
Oct 2019 – March 2020	Mobilisation phase
1 April 2020	Commencement of new service(s)

11. In line with the above timeframe, approval is sought to conduct initial consultation on the high-level commissioning intentions with key stakeholders – these include CCGs, Public Health England, and Health and Wellbeing Board partners. Initial consultation responses will be used to develop detailed proposals for more extensive stakeholder engagement, service user consultation and soft market testing.

Risk Analysis

12. Risks associated with each individual proposed intention are included in table 1. Risks will be exposed to soft market testing. Wider risks affecting the whole process include
    - Lack of clarity over future budget beyond 1 April 2020 – changes to Public Health grant and level of resources not yet known
    - Development of Accountable Care Systems - implications for coverage, alignment of services, and costs of commissioning
    - Potential perceptions / feedback from external stakeholders and partners
    - Extension of existing contracts is subject to agreement by contractor(s). If they decline, alternative services would have to be procured earlier.

Capacity

13. Recommissioning Public Health services requires an increase to current staffing on a temporary basis. Since the last round of service commissioning, addressing budgetary constraints has reduced the Public Health permanent staffing establishment by about 20%.

Even at its former level, during the last round of full service commissioning in 2015, the Public Health division was unable to accommodate the increased workload within its permanent establishment. To address this, additional resource was put in place through employment of two FTE staff members on temporary fixed term contracts. We have reviewed existing staff capacity in order to come to a conclusion that extra temporary capacity is required.

14. Options to increase capacity at the present time have been examined as follows:

Option	Cost estimate	Pros and Cons
1. Engage the Council's corporate Programmes and Projects Team, to work on project management aspects of the recommissioning process for a fixed term of 18 months.	Per FTE Band D Project Manager = £56,932 per year (top of scale; includes on costs, includes allowance for 2018 estimated pay award) 2 posts x 18 months = £170,796 (£113,864 per full year)	Would bring specialist project and programme management skills, plus familiarity with the Council's processes and ways of working. Potential to be faster to execute than formal recruitment. Availability would depend on competing priorities within the Programmes and Projects Team – needs further exploration of feasibility. May have limited ability to undertake mobilisation elements requiring specialist Public Health knowledge – hence costs assessed for 18 months only.
2. Recruit to temporary posts within Public Health to support the recommissioning process for a fixed term of up to 24 months.	1 x FTE Band E Health Improvement Principal (to lead a time-limited recommissioning team) plus one Band D Public Health and Commissioning manager. Band E max cost £63,372 per year (top of scale, includes on costs, estimate for 2018 pay award) Band D max costs at £56,932 Annual cost at £120,304; for two years £240,608.	Potential to attract staff with specialist Public Health skills and insight. Potential career development for staff within the authority – opportunity to gain PH experience, including at a more senior level. There can be difficulties in successfully recruiting to fixed-term posts, but this method was a successful approach previously at Band D. Lead-in time would be necessary to allow for recruitment processes. Training and induction overhead – could affect efficiency at initial stage. Would be able to undertake mobilisation elements requiring specialist Public Health knowledge – hence costs assessed for 24 months.

3. Seek secondments from NHS or health organisations with commissioning experience	To be explored, but likely to be more expensive than above options	Potential to bring in staff with specific skills and experience around health service commissioning. Likely to be unfamiliar with Council processes. Likely to be more expensive than other options.

15. Having considered these options in conclusion the preferred option is 2. Having explored option 1 there is insufficient existing capacity to undertake this work, and option 3 is expected to be more costly.

16. Two fixed term posts for a maximum period of two years, one at Hay Band E and one at Hay Band D, would cost a maximum of £120,304 per year (top of scale, including on costs) i.e. maximum total cost of £240,608. This can be met from within the Public Health reserves, where there remains just over £1M of unallocated funds.

Other Options Considered

17. All Public Health Services were reviewed by the Task and Finish Group to examine whether they could be included in an integrated approach. The reasons why other services were not included in the integrated wellbeing bundle are set out in Table 1.

18. With regard to time options for making the change, another option assessed was a 1 April 2019 start, which would entail termination of the smoking cessation contract a year early. This option was discounted as it would not leave sufficient time for soft market testing prior to detailed consultation and procurement, nor would it allow sufficient time for mobilisation.

19. Other options to increase staff capacity are set out at paragraph 14 above. Other options were either less cost-effective or would potentially not provide the range of skills needed.

Reason for Recommendations

20. The proposed commissioning intentions represent the optimum approach to address budget constraints whilst still maintaining sufficient Public Health commissioned services to be able to address health need in the population.

21. With regard to timeframes, a 2020 start for the new integrated service would:
    - Allow sufficient time for soft market testing prior to consultation and procurement process
    - Allow sufficient time for mobilisation
    - Permit greater certainty about budget – a year beyond the ring fence for the Public Health grant
    - Align with timeframes for ACS development and potential change to commissioning landscape

22. With regard to capacity, the establishment of temporary posts is an approach which worked successfully in the division to accommodate the last round of re-commissioning, and is affordable within the available Public Health reserves.

Statutory and Policy Implications

23. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

24. The financial envelopes indicated for the commissioning intentions would deliver £1.386M of savings to address known future budget reductions. However in the case of the worst case scenario being used for planning there would remain an additional cost pressure currently forecast at £3.485M in 2021/22.

25. With regard to the requirement for additional staff capacity, the cost of establishing two temporary posts for a maximum period of two years would be £240,608. This can be met from within the Public Health reserves, where there remain just over £1M of unallocated funds.

Human Resource Implications

26. The temporary posts will be recruited to and appointed on fixed term contracts.

Implications in relation to the NHS Constitution

27. Changing to an integrated wellbeing service for some elements of public health services is in line with the values of the NHS Constitution, because it will provide for a patient-centred approach (Value 4). At the same time, the NHS has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population (Value 1). The services to be included in the proposed integrated wellbeing service are those which disproportionately affect particular sections of society.

RECOMMENDATION/S

1) That Members approve the outline commissioning intentions for further development, as set out in Table 1.
2) That Members approve consultation with key stakeholders on the commissioning intentions.
3) That Members approve the outline timeframe for start of new integrated service at 1 April 2020 and approve extension of relevant existing contracts to 31 March 2020, in line with extension provisions in existing contracts.
4) That Members approve the establishment of two two-year fixed term posts, one Public Health Principal graded at Hay Band E and one Public Health and Commissioning Manager graded at Hay Band D, to support the recommissioning process, and also approve the funding for these posts from Public Health reserves.

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Constitutional Comments (LMC 4.1.18)

28. The Adult Social Care and Public Health Committee is the appropriate body to consider the contents of the report.

Financial Comments (DG 24.01.18)

29. The financial implications are contained within paragraphs 24 and 25.

HR Comments (SJJ 08/01/2018)

30. These are contained within paragraph 26

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Electoral Division(s) and Member(s) Affected

- All