London Borough of Enfield
Public Health Responsibilities

December 2012
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1. Overall Conclusions

Introduction and Context

As part of our 2011/12 audit plan we have undertaken a review of the London Borough of Enfield’s (the Council) arrangements to deliver their new public health responsibilities.

Equity and Excellence: Liberating the NHS, the White Paper published by the Government in July 2010, set out a vision for the NHS which will change the way the NHS works. The White Paper proposed that everyone should have services tailored for them, at the right times in their life from the professionals closest to them. This will require joint commissioning and integration between health, public health and social services with local government being given the power and responsibility to lead on public health. Health and wellbeing boards are proposed to be the vehicle used for local government to work in partnership with commissioning groups to achieve the objectives of the White Paper. Local authorities are expected to lead on public health as so many of the services provided by local authorities (e.g. housing, leisure) play a role in improving public health.

Current responsibility for public health lies with Primary Care Trusts (PCTs), who are due to be abolished on 1 April 2013. Responsibility for public health will be split between the NHS Commissioning Board (due to be established in shadow form in October 2011), local authorities and a new public health overview body (Public Health England) from this date.

We have reviewed the plans and the arrangements the Council has in place to take on the new responsibilities. Specifically we have considered the following:

- the extent to which the Council understands its public health responsibilities
- the extent to which the Council understands who the key partners are in delivering the Council's public health responsibilities and how these relationships will be developed
- consideration of how the health and wellbeing board will interact within the Council and with external stakeholders to achieve health improvement, promotion and prevention and for tackling health inequalities
- how the Council proposes to meet their new public health responsibilities and maintain budgetary control

Overall Conclusion

The Council clearly understands its public health responsibilities and has put sound processes in place to support the change in arrangements. This is reflected in the early appointment of the Joint Director of Public Health, the early relocation of the public health team to Council offices and the way
it has fostered engagement with key stakeholders and partners to support the transfer of functions. Through the development of a shadow Health and Wellbeing Board and a Transition Board, the Council has put in place appropriate structures to support the transition and the work of these boards demonstrate that it understands its role and is considering the issues currently impacting on public health.

The Council recognises, however, that it faces a major challenge in ensuring that it is discharging its duties as effectively as possible if anticipated funding pressures are realised. The Council understands that not all of the public health functions are mandatory and will want to focus on the activities that will bring the biggest health gains to the population. It will also need to look at how it can work with partner organisations to develop new ways of working to deliver programmes and projects by alternative means and/or funding pathways.

**Key recommendations**

Through the course of our work we have made a number of recommendations, for improvements in processes and arrangements these are detailed with agreed management responses in Appendix A of this report.
2. Health and Well-being Board

The Health and Social Care Act 2012 (the Act) required that every unitary local authority established a Health and Well-being Board (the Board) as a committee.

The Act gave boards specific functions and powers:
• A duty to encourage integrated working between commissioners of NHS, public health and social care services, including arrangements under Section 75 of the NHS Act 2006.
• Powers to bring together commissioners of any services that impact on the wider determinants of health to work with the Board and other commissioners of health and social care
• There is the power for the local authority to delegate any of its powers to the Board, except health scrutiny
• A duty to discharge the functions of CCGs and local authorities to prepare Joint Strategic Needs Assessments (JSNA) and joint health and wellbeing strategies. To discharge this, Boards will need to have arrangements in place to review CCG commissioning plans each year against the priorities in the joint health and wellbeing strategy.
• A duty to prepare and publish local pharmaceutical needs assessments
• Powers to request information from the local authority and any person or organisation represented on the Board.

The Council has a shadow Health and Wellbeing Board in place with an agreed terms of reference. The Terms of Reference states that it will hold partner agencies to account for delivering improvements in public health through the use of three delivery groups composed of partner agencies:
• Health Improvement Partnership Board
• Joint Commissioning Partnership
• Improving GP Quality and Access.

These delivery groups will report through to the Health and Well-being Board and each have their own specific terms of reference and membership that is drawn from across different organisations, for instance, the Council, the voluntary sector and the NHS.

Membership of the Board must include the Director of Public Health, the Director of adult social care and Director of children's services as well as at least one councillor and representatives of their Local Healthwatch (LC), CCGs and others as required. The membership of the Council's shadow Board is per the requirements of the Act.

The Department of Health sees self-regulation and improvement as being an important part of health and well-being boards' own governance systems and operational culture. Boards will need to adopt a learning approach to evaluate how well they operate, their collective impact on improving outcomes and a process for identifying the most effective ways of shared learning. Both the Council and the Board should ensure that there is a process in place for reviewing the effectiveness of the Board and where improvements can be made.
2. Health and Well-being Board

The first review should be undertaken in the final quarter of 2012/13. This should evaluate the performance of the shadow Board and the outcomes of this review used to refine and enhance the remit and performance of the Board from 1 April 2013. A self assessment and annual review should be part of the Board's annual workplan.

The shadow Board has been active throughout 2012/13. Regular meetings have been held and agendas have covered transition matters, CCG development and updates from working groups. From review of Board papers and minutes it is evident that there is engagement from all stakeholders and partners involved in the delivery of public health.

Joint Strategic Needs Assessment
One of the key functions of the Health and Well-being Board is to oversee the development of a Joint Strategic Needs Assessment (JSNA) with the aim of identifying current and future health and well-being needs of the local population and to inform on relevant priorities and targets to be set. In Enfield, this process was managed by a steering group set up by the Enfield Health Improvement Partnership with a steering group chaired by the Director of Public Health.

The JSNA details plans for further strengthening partnership working in public health. This involves increased engagement with the voluntary, community and faith sectors.

The JSNA action plan is overseen by the Board and will be reported on to the Strategic Partnership Board to ensure that progress against key deliverables to improve health and tackle inequalities are met.
3. Supporting the transition

**Shadow working**

The Council took early action to support it taking on responsibility for public health duties from 1 April 2013. This is evidenced by the relocation of the NHS public health team to Council offices during 2011/12. The Enfield team was the first public health team in the country to physically relocate. In doing so, the Council considers it has already benefitted from the public health team being available to feed into current and planned Council initiatives in the area of public health, supporting and advising on some proposals. This is also important as it reduces the risk of potential cultural impact that the changes to where and how staff work from April 2013. This will help to enable a smooth transition with continuity of services and working arrangements 'hitting the ground running'.

A joint Director of Public Health was appointed in March 2010 and has joint reporting lines to both NHS North Central London (NHS NCL) Joint Boards and the Council Cabinet Member for Community Wellbeing and Public Health.

As part of the project planning a Memorandum of Understanding (MoU) has been put in place to support shadow working through 2012/13. This was developed alongside the London Public Health Transition Delivery Board.

The Council has established a Public Health Transition Board (Transition Board). The Transition Board reports to the NCL Joint Board, the Health and Well-Being Board and Enfield Clinical Commissioning Group (ECCG). The Transition Board has four workstreams covering finance, HR, the future operating model and infrastructure. Each workstream has its own terms of reference and membership from the Council and the NHS. There are 'action trackers' in place to support the workstream. These show actions necessary to support transition and responsible officers for ensuring actions are implemented. Progress against actions and plans are reported through to the Transition Board. The Council has therefore put in place good project management arrangements which have been agreed and signed up to by both major stakeholders.

There is a project team in place to support the transition process. There is a project lead from both the Council and the NHS on the project team and a detailed project plan.
3. Supporting the transition (cont.)

The Council has worked closely alongside NHS NCL throughout the transition process and has engaged in joint working with Enfield Clinical Commissioning Group (ECCG) and there are clear links between the CCG and the Transition Board: the Chair of the Enfield CCG is on the Public Health Transition Board. There is also good evidence that the Council is ensuring that the public health implications of decisions are taken into consideration. It is now a requirement of all papers being submitted to the Executive that they demonstrate that these have been taken into account before decisions have are made.

From previous reviews undertaken by Grant Thornton, such as the Diagnostic Health Check on Collaboration, it has been noted that the Council has good arrangements in place to support collaborative and partnership working. This review reported on in April 2012 noted that the Council has 'a strategic and operational commitment to partnership and collaboration'.

This provides assurance that the Council has appropriate frameworks and processes in place to support successful partnership working. If these principles are fully applied to the transfer of public health responsibilities this should help to ensure a successful transition and effective partnership working post-1 April 2013.

Risk Management Arrangements

The Transition Board meets on a quarterly basis and is responsible for identifying, assessing and mitigating risks and dependencies. An update report on transition produced in April 2012 identified the following as key issues:

- Having sufficient resources available at both the Council and the PCT to support the transition process. Actions to mitigate against this risk include having a programme manager to manage and drive the planning work.

- Effective transition planning is reliant to a certain extent on guidance and information being made available from the Department of Health and NHS London, for instance, detail on what public health functions will be transferred to Public Health England and the NCB. If this information is not available, the Council will need to make assumptions until there is clarification. The Council, therefore, needs to ensure any plans that it makes prior to final determinations being received from the DH and/or NHS London are flexible and that it can respond to sudden changes.

The Council is also liaising with NHS London to understand how other clusters are dealing with this issue.

- Ensuring continuity and standards of services are maintained after the transfer of public health responsibilities takes place. It is important, therefore, that the Council has considered what feedback loops it will have in place on service delivery and what arrangements it has with its commissioners where underperformance is identified.
3. Supporting the transition (cont.)

- The completeness of information available from NCL in relation to public health responsibilities including contract information. From discussions with the Council, it is noted that there have been improvements in the flow of information; however, the 'unpicking' of some of the larger contracts such as the sexual health contract has been problematic.

As well as risks being managed by the Transition Board, given the scale of change involved and the financial impact of the transfer of responsibilities, the Council needs to ensure that it is properly managing the risks from transition through its own risk management processes.

The Council has recently identified a new risk for inclusion on its strategic risk register in relation to the transfer of public health responsibilities. This is specifically linked to financial impact of contract liabilities not identified where the current provision is part of a block contract and was quantified as potentially £0.5m, however, this amount is seen by the Council to be a 'moving feast'. Whilst it is recognised that the Transition Board has identified risks to delivery through its own processes, the Council should ensure that its corporate risk registers reflect the risks that the transfer of public health responsibilities brings with it, for instance, ensuring the continuity and standard of services is maintained from April 2013.

The Council's Medium Term Financial Plan includes the transfer of PCT responsibilities as a key risk. The Plan states that financial resources have been identified and allocated by the government to support the transfer. The assumptions are that the responsibilities transferred will be met from the proposed allocations, but there is the risk that unforeseen pressures may emerge.

The Council has concerns over its proposed allocation for public health and has identified the risk that current block contracts may include elements of expenditure that relate to public health duties. It is, therefore, important that this risk continues to be monitored as the MTFP and the 2013/14 budget is reviewed, revised and finalised.
4. Managing and measuring the delivery of public health responsibilities

Financial Management

Enfield Primary Care Trust has faced significant financial difficulties over recent years, at one point being the most financially challenged PCT in the country. Whilst its financial performance has improved over the last two years, it remains in a deficit position.

The Department of Health published first estimates of baseline spending in February 2012 and was based on returns from PCTs actual spend in 2010/11. The proposed public health budget for Enfield has been set at £16.18m, of which approximately £10m will be allocated to the Council to enable it to meet its responsibilities. The deficit position of the PCT has impacted on the budget it has had available for public health and this has had an impact on the Council's proposed allocation. Enfield received one of the lower allocations in London. The Council has reviewed the proposed allocations and considers that there are boroughs with similar levels of deprivation that have larger shadow allocations. Concerns have been raised by the Council that the current proposed allocation will be insufficient to meet the public health needs of the community. These concerns have been raised with the Member of Parliament for Enfield and the then Secretary of State for Health. It is noted elsewhere in this report that insufficient funding has been identified as a potential risk and pressure on medium term planning.

There are a number of mandatory services that the Council has to deliver as part of its public health responsibilities. However, other services are non-mandatory. The Council has concerns over the level of funding it is to receive to support its activity and is therefore, currently considering what non-mandatory services it will look to deliver or exploring alternative delivery methods or accessing funding from alternative sources. The Council is working with its CCG and needs to ensure that there is agreement over plans and budgets.

For instance, the Council has already started to deliver some programmes that would fall under the remit of public health, for instance, a smoking cessation programme and health checks. This has been partly funded from grant funding, however, there is no guarantee that this funding will be received in future periods and the Council is not factoring in this funding in future year budgets.

The Council needs to apply the same disciplines and methodology to managing this budget as it does with other service area budgets. There needs to be regular monitoring and reporting of spend. It is key that this is done from month one to inform budget planning for future reporting periods. This will help to identify pressure points by programme (if there are any) and for proactive action to be taken. Year one is likely to be a learning year in terms of the real cost of delivering public health and how manageable this is within the Council's allocation of funding. It is important therefore, that the senior management team responsible for the delivery of public health receives accurate information on a timely basis so that any issues are quickly identified and can be acted on promptly.
4. Managing and measuring the delivery of public health responsibilities (cont.)

Contract Management

The Council will need to ensure that it has appropriate structures in place to manage its commissioning role. The Council has a commissioning function in place and it will be important to ensure that it works closely with the Public Health team.

One of the key risks identified by the Transition Board relates to the commissioning and management of service and ensuring that the continuity and standards of services are maintained. The Council needs to ensure that there are appropriate performance standards included in all of its contracts and that there are systems in place to ensure that performance against these is measured and any under-performance identified can be appropriately and effectively managed (on a timely basis). Performance measures should be linked to the objectives in the Public Health Outcomes Framework.

There remain uncertainties over how current contracts will be managed. Options being considered include novating all current contracts or allowing contracts to continue without novation so that there is no impact on the current services being delivered. It is important that this is clarified and enough time is allowed to let new contracts if this approach is taken. The Council needs to ensure that contracts let in respect of public health function are managed and monitored in line with the arrangements for other Council contracts and that they are included on a contract register which details the terms and conditions of the contract.

The Council needs to continue to work with NHS NCL to understand current contracts, particularly any block contracts currently in place with commissioners that include public health elements so that these elements can be appropriately costed and performance managed along with all other commissioned public health services.

Performance Reporting

The Department of Health published its Public Health Outcomes Framework (the Framework) in January 2012. The Framework sets out the desired outcomes for public health and how these will be measured. The Framework concentrates on the two high level outcomes of increasing healthy life expectancy and reducing differences in life expectancy and healthy life expectancy between communities. The Framework includes a set of performance indicators the Council will be required to monitor its performance against and provide an indication of the impact the Council's work is having on the public health of the community. There are a large number of indicators included in the Framework and collecting and collating these indicators will be a significant task. There is detailed guidance on how indicators should be calculated and reporting requirements. The Transition Board has gone through a process of identifying which of the indicators relate to a priority in the Joint Strategic Needs Assessment (JSNA).
4. Managing and measuring the impact of delivery of public health responsibilities (cont.)

The Council needs to ensure that it has appropriate processes and systems in place to collect data and collate the specified performance indicators and any local performance indicators the Council wishes to use to monitor its performance. It needs to put in place data assurance processes, for instance, spot-checking of performance information prior to reporting to the Health and Well-being Board so that assurance can be taken over reported performance.

It is important that systems are established in place by 1 April 2013 to enable accurate monitoring and reporting of performance. This may involve ensuring that there are systems in place to collate the required information, understanding how the information can be extracted from the Council’s systems and also, where the information is to be provided by a third party, that there are clear requirements and an agreed timeline for providing performance information.

The Council should document the indicator preparation processes. To be effective this should cover the whole of the process from data capture to information being reported to the Department of Health. Audit trails should be maintained to support reported performance information. All members of staff involved in collecting data for, and calculating, each indicator should be made aware of their role in ensuring data quality. Their responsibility for this should be reflected in job descriptions and performance appraisals.

For the Health and Well-Being Board to gain assurance over data quality, it should also receive reports on and scrutinise how officers providing the indicators get their assurance. This should include formal reporting on the accuracy of data supporting performance measures, and the appropriateness of the procedures in place.
Appendix A: Recommendations

The key recommendations arising from work are detailed in this Appendix, along with management responses to the recommendations and agreed action plans.

Key to priority ratings

<table>
<thead>
<tr>
<th>Priority</th>
<th>Effect on control system</th>
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<tbody>
<tr>
<td>High</td>
<td>Significant effect on control system</td>
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<tr>
<td>Medium</td>
<td>Effect on control system</td>
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<tr>
<td>Low</td>
<td>Best practice</td>
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<tr>
<th>Item</th>
<th>Matter arising</th>
<th>Recommendation</th>
<th>Priority</th>
<th>Council response</th>
<th>Lead responsibility</th>
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<tbody>
<tr>
<td>1</td>
<td>The Public Health Transition Board has identified a number of significant risks relating to the transition of public health responsibilities to the Council. If realised, these will impact on the Council.</td>
<td>The Council should ensure that its corporate risk registers reflect the risks that the transfer of public health responsibilities brings with it. Risks relating to the transfer should be managed in line with the Council's risk management strategy.</td>
<td>High</td>
<td>High risk items included in the Public Health Transition risk register have been included in the Corporate risk register from November 2012</td>
<td>Completed</td>
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<tr>
<td>2</td>
<td>The Council has concerns over its proposed allocation for public health and has identified the risk that current block contracts may include elements of public health expenditure that are not reflected in the proposed funding allocation.</td>
<td>The Council should continue to work with NHS NCL to review current contracts for public health elements. It should also continue to monitor this risk and review and revise its MTFP and 2013/14 budget accordingly.</td>
<td>Medium</td>
<td>Ongoing</td>
<td>Olu Ayodele, Business Partner, Health, Adult Social Care and Environment</td>
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<td>3</td>
<td>The Department of Health see self-regulation and improvement as an important part of health and wellbeing boards own governance systems.</td>
<td>A process should be put in place for reviewing the effectiveness of the Board. The first review should evaluate the performance of the Shadow Board and the outcomes of this review be used to refine and enhance the remit and performance of the Board. A self-assessment and annual review should be part of the Board’s annual workplan.</td>
<td>Low</td>
<td>Agreed – to be in place from 1 April 2013</td>
<td>Shahed Ahmad, Director of Public Health</td>
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## Appendix A: Recommendations (cont.)

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<thead>
<tr>
<th>Item</th>
<th>Matter</th>
<th>Recommendation</th>
<th>Priority</th>
<th>Council response</th>
<th>Lead responsibility</th>
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<td>4</td>
<td>It is important that the Council has arrangements in place by 1 April 2013 to enable accurate monitoring and reporting of performance against both national and locally defined performance indicators.</td>
<td>The Council should document the indicator preparation processes. To be effective this should cover the whole of the process from data capture to information being reported to the Department of Health.</td>
<td>High</td>
<td>Agreed – to be in place by 30 April 2013</td>
<td>Suzanne Hutchinson, Performance Manager</td>
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<td>5</td>
<td>The Health and Well-being Board needs to be able to take assurance over the quality of data being reported to it.</td>
<td>The Boards should receive reports on how officers providing performance information get their assurance. This should include formal reporting on the accuracy of data supporting performance measures and the appropriateness of the procedures in place.</td>
<td>Medium</td>
<td>On-going, demonstrated through Health and Well-being Board papers.</td>
<td>All</td>
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<td>6</td>
<td>To maintain and safeguard standards of service delivery, the Council needs to ensure that proper contract management processes are in place with commissioners for the delivery of public health services.</td>
<td>The Council needs to ensure that contracts let in respect of public health functions are managed and monitored in line with the arrangements for other Council contracts and that they are included on a contract register which details the terms and conditions of the contract. The Council needs to ensure that appropriate performance standards are included in all of its contracts. There should be systems in place to ensure that performance against these is measured regularly and any identified under-performance is addressed.</td>
<td>Agreed – to be implemented by 1 April 2013</td>
<td>Christine Williams</td>
<td></td>
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Appendix B: Reference Sources

The following documents informed this review:

- Operating principles for health and wellbeing boards
- Healthy Lives, Healthy People: Update on Public Health Funding
- Public Health Transition Board Terms of Reference
- Draft Future Operating Model Discussion Paper
- Public Health Transition highlight report – July 2012
- Update on Public Health Transition - July 2012
- Public Health Outcomes Framework

NHS Confederation and partners
Department of Health
London Borough of Enfield
London Borough of Enfield
London Borough of Enfield
Department of Health