HEALTH SELECT COMMISSION

Venue: **Town Hall, Moorgate Street, Rotherham S60 2TH**

Date: **Thursday, 19th April, 2012**

Time: **9.30 a.m.**

A G E N D A

1. To determine whether the following items should be considered under the categories suggested in accordance with Part 1 of Schedule 12A (as amended March 2006) to the Local Government Act 1972

2. To determine any item the Chairman is of the opinion should be considered later in the agenda as a matter of urgency

3. Apologies for Absence

4. Declarations of Interest

5. Questions from members of the public and the press

6. Communications

7. Minutes of previous meeting (Pages 1 - 7)

8. Health and Wellbeing Board (Pages 8 - 38)
   - minutes of meeting held on 29th February, 2012
   Presentation by Councillor Wyatt, Cabinet Member for Health and Wellbeing

9. Public Health Transition (Pages 39 - 76)
   - Nagpal Hoysal, NHSR

10. Rotherham Clinical Commissioning Group Update (Pages 77 - 81)
    - presentation by Sarah Whittle, NHSR

11. Implications of the Health and Social Care Bill on the Foundation Trust (Pages 82 - 91)
    - presentation by Peter Lee, RFT

12. Achieving an Effective Health and Wellbeing Structure in Rotherham

13. Date and Time of Future Meeting:-
- Thursday, 31st May, 2012 at 9.30 a.m.

HEALTH SELECT COMMISSION
8th March, 2012

Present:- Councillor Jack (in the Chair); Councillors Barron, Beaumont, Beck, Blair, Dalton, Goulty, Hodgkiss, Kirk and Steele and co-opted members P. Scholey and V Farnsworth.

Apologies for absence had been received from:- Councillors Doyle, Burton, Wootton and co-opted members J. Evans, J. Richardson and R. Wells.

49. DECLARATIONS OF INTEREST

There were no declarations of interest made at the meeting.

50. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS

There were no members of the public or the press present at the meeting.

51. COMMUNICATIONS

There was nothing to report under this item.

52. MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 26th January, 2012, were noted.

53. HEALTH AND WELLBEING BOARD

Councillor Jack noted that the Health Select Commission work programme had been presented for information to the Health and Wellbeing Board at their last meeting on 29 February. It was flagged up that the Continuing Healthcare Scrutiny Review was currently taking place and that the next meeting of the Commission would have a themed session on the Health and Wellbeing Board and that members of the Board had been invited to attend. If Health Select Commission members had any questions they wished to raise with Board members at that meeting they were welcome to do so and could send questions in advance to Kate Green.

Resolved:- That the minutes of the Health and Wellbeing Board held on 18th January, 2012, be noted.

54. RDASH QUALITY ACCOUNT

Lynsey Blackshaw, Senior Business and Performance Manager, and Tracey Clark, Commercial Development Director, RDaSH, NHS Foundation Trust, gave the following powerpoint presentation in relation to the submitted report on 'Quality Matters' in relation to the Service's annual Quality Account:-

What is a Quality Account:-

- Coalition Government White Papers set out the vision of putting Quality at the heart of everything the NHS did
- Key component of the Quality Framework was the continuing requirement for all providers of NHS Services to publish Quality Accounts
- This was the opportunity to enable the OSC to review and supply a

statement as to whether "the report is a fair reflection" of RDaSH services
- 2011/12 was the 4th Quality Account produced by RDaSH

2011/12 Performance monitoring suggested that: -
- Governance – Amber/Red (at Quarter 3)
- Finance – 4 (Good) (at Quarter 3)
- Care Quality Commission - registered with no conditions
- Commissioning for Quality Indicators were achieving 9 of 9 indicators (at Quarter 3)

Review of Quality Markers 2011/12:-
- 3 domains of Quality:
    1. Patient Safety
    2. Clinical Effectiveness
    3. Patient Experience

Process for 2012:-
- Consultation with OSC – presentation/draft Quality Account for comment
- Engagement with Trust User Carer Partnership Council – regular agenda item/draft Quality Account for comment/development of Quality Markers for 2012/13
- Engagement with Trust Council of Governors – regular agenda item/draft Quality Account for comment/development of Quality Markers for 2012/13
- Draft Quality Account to Trust Clinical Governance Group

Quality Priorities for 2012/13:-
Developed by:-
- User Carer Partnership Council
- Council of Governors
- Business Divisions
- Board of Directors

Board of Directors Quality Priorities:-
3 quality improvement priorities identified by the Board of Directors:-
- Personalised Care Planning
- Record Keeping
- Clinical leadership roles and responsibilities

Council of Governors (CoG) Quality Priorities:-
CoG had identified the following priorities for 2012/13:-
- Personalised care
- Effective, knowledgeable, personalised communication from all of the staff
- Continuously improve communication with, and feedback from, people who used the service through a wide range of methods

User Carer Partnership Council (UCPC) Quality Priorities:-
- Attitudes shown by staff towards people who were diagnosed with a personality disorder
- Service user carer involvement in staff selection and recruitment
- 7 day follow up from discharge, support on discharge from Wards

- Embedding WRAP, mapping what there was and where it was. Connecting discharge and community WRAP Groups
- Access to services (maintaining progress on accessibility and responsiveness)
- Provide information to UCPC on analysis of complaints, trends and lessons learned
- Increase meaningful activities on the Wards

Comments were expected from the OSC in relation to the RDaSH 2011/12 Quality Account- 8 during March, 2012. The document would be disseminated to the full range of RDaSH stakeholders for comment in the coming months. It was noted that this document would be circulated to the Health Select Commission for comment in due course.

Discussion ensued with the following issues raised/highlighted;-

- The content of 'meaningful activities' undertaken by patients on wards
- Identification and separation of the Rotherham element of the RDaSH Quality Account
- Implementation of good practice and lessons learned across all RDaSH settings.

Resolved:- (1) That Lynsey Blackshaw and Tracey Clark be thanked for their presentation to the Health Select Commission and the information shared be noted.

(2) That the Health Select Commission receives the OSC's comments in relation to the RDaSH Quality Account 8 in order to comment on the document when it was available.

55. HEALTH INEQUALITIES SCRUTINY REVIEW BMI>50

Further to Minute No. 46 of 26th January, 2012, the finalised report was presented for approval prior to submission to the Overview and Scrutiny Management Board.

A range of activity took place to gather data and information from various organisations in terms of service provision and costs, as well as gathering the views and experiences of a range of professionals working in the field and individuals out in the community.

The key findings from the review were summarised as follows:-

- As of 30th March, 2011, 5,909 people had been identified on GP practice registers in Rotherham with a BMI over 40 and 793 people had been recorded as having a BMI over 50
- There were likely to be additional cases with no recorded BMI, making the total numbers in Rotherham not entirely known
- It was not necessarily known where all the people were; there may be small numbers of people known to each organisation, but not all organisations knew all the people – if information was shared this could benefit organisations by increasing their knowledge of the issue within the community

- There was an issue around sharing data and information between organisations and data protection issues which could prevent relevant information being shared
- There was inconsistency in the policies and procedures within all organisations in relation to this group of people; although there may be protocols in place these were not always joined up between services
- Although some services did have a system in place, there was uncertainty around who co-ordinated this and how
- Assessments were generally only completed when there was a problem, meaning patients were often not identified until there was an emergency
- There needed to be a way of identifying and supporting people before they became isolated and their weight increased to this level
- The obesogenic environment needed to be considered, particularly for certain groups such as people who were physically disabled or those with learning difficulties
- It was important to raise awareness of the healthy weight services available to people in Rotherham, particularly with professionals who may come into contact with individuals on a day to day basis – to encourage use of services
- Being unable to get out of the house unaided greatly affected a person's quality of life; always needing assistance could leave them isolated and unable to be spontaneous
- Being properly assessed and having the appropriate assistive equipment in a person's home could really improve a person's quality of life and independence

Full details of the activity that that had taken place, findings and recommendations were set out in the report.

Resolved:- (1) That the Scrutiny Review report be noted.

(2) That the report be submitted to the Overview and Scrutiny Management Board prior to submission to Cabinet and/or the Health and Wellbeing Board.

56. TOBACCO CONTROL UPDATE

Alison Iliff, Public Health Consultant, reported that as from April, 2013, the Council would have responsibility for delivering a comprehensive Tobacco Control Strategy as part of the transfer of Public Health under the Health and Social Care Act. A presentation that gave an update on the current key tobacco control issues in Rotherham and performance of the NHS Stop Smoking Services was shared, alongside the submitted report and the Rotherham NHS Stop Smoking Service Annual Report, 2010-11.

It was noted that, as in all other areas, smoking was Rotherham's greatest single cause of preventable illness and early death. Smoking had caused 487 preventable deaths in Rotherham in 2010.

In 2011, the Department for Health published a new national Tobacco Control Strategy that was aimed at reducing the number of deaths from smoking related diseases and substantially reducing healthcare costs associated with smoking. The

Strategy included three inspirational targets and six key actions: -

The inspirational targets were: -

1. Reduce smoking prevalence among adults in England
2. Reducing smoking prevalence among young people
3. Reduce smoking during pregnancy in England

The six key actions were: -

1. Stopping the promotion of tobacco
2. Making tobacco less affordable
3. Effective regulation of tobacco products
4. Helping tobacco users to quit
5. Reducing exposure to second-hand smoke
6. Effective communications for tobacco control

Pertinent statistics were considered in relation to smoking issues:-

- There was a static incidence of smoking in Rotherham at 24%, compared to around 21% England average, and 22% Yorkshire and Humber average.
- Around 8% of children aged 11-15 smoked in Rotherham, compared to an England average of around 5%.
- The prevalence of smoking in pregnant women up until delivery was around 20%, compared to an England average of around 13%.
    - All pregnant women in Rotherham who were smokers had at least one consultation with the Stop Smoking Midwife during their pregnancy.
- The financial costs in relation to smoking were considered, including the costs to the individual smoker, costs to the community and costs to the NHS.
    - Whilst smoking in Rotherham brought an estimated £62.1millions into the Exchequer each year, it was estimated that it cost £71.9millions to the community (including the NHS). This left a shortfall of £9.8millions.
- 83% of smokers had started smoking before the age of 19.
- Children were three-times more likely to start smoking if their parents smoked.
- Smoking was one of the greatest contributors to health inequalities.

Other issues in relation to the availability and consumption were: -

- Branding and promotion of tobacco, including packaging and celebrity /media promotion.
- Tackling cheap and illicit tobacco – removing the supply in local communities ('fag houses', under the counter sales, car boot sales, ice cream vans).
- Regulatory activity, including, removal of vending machines, age of sale and point of sale display issues.
- Smoke free homes and cars.

Simon Lister, Service Manager, Rotherham Stop Smoking Service, detailed the stop smoking interventions available in Rotherham: -

- Cost effectiveness of specialist smoking cessation support against costly medical intervention.
- Facilities within Rotherham provided through the Rotherham NHS Stop Smoking Service: -
    - Quit Stop (Bridgegate);
    - Stop Smoking Centre (Rotherham Hospital);
    - Dedicated service for pregnant women;
    - Dedicated telephone service;
    - Delivered one to one and group sessions across Rotherham (including out of hours);
    - Trained and supported a network of LES advisors;
    - Supported others to deliver stop smoking interventions;
    - Promotional activities;
    - Reporting function.
- Client satisfaction was high amongst those who had used the Bridgegate facility.

Local Authorities had significant and growing roles in relation to enforcement of: -

- Age of sale;
- Smoke free places;
- Smuggled and counterfeit tobacco;
- Advertising ban.

From 2013, Local Authorities would take on responsibility to commission services to motivate and support smokers to quit their habit. Joint working, and working across local authority boundaries, was already being considered to achieve economies of scale in relation to data collection and analysis, provide clear and consistent media messages and combat organised crime.

Discussion ensued, and the following issues were raised by members of the Health Select Commission: -

- Statistical consideration of the many individuals who would frequently start and stop smoking.
- 'Silent Salesman' consultation that was expected.
- Ban on shop displays in April 2012 for large retailers and April 2015 for smaller retailers.
- Proactive work of the Rotherham Stop Smoking Service.
- Facilities for Rotherham's communities that were further away from the town centre facilities.
- Role of community leaders in promotion of the Rotherham Stop Smoking Service and drives to tackle the use of cheap and illicit tobacco.

Resolved:- (1) That Alison Iliff and Simon Lister be thanked for their presentation to the Health Select Commission and the information shared be noted.

(2) That the Health Select Commission take part in the consultation on 'plain packaging' when it is launched.

(3) That members of the Health Select Commission play an exemplar role in the implementation of tobacco control programmes, and communicate this

message to colleagues, communities and partner organisations to take forward the Tobacco Control agenda.

57. DATE AND TIME OF FUTURE MEETING:-

Resolved:- That meetings be held during 2011/12 on the following dates commencing at 9.30 a.m. in the Town Hall:-

27th October
8th December
26th January, 2012
8th March
19th April

HEALTH AND WELLBEING BOARD
29th February, 2012

Present:-

Members:-	
Councillor Wyatt	**In the Chair**
Karl Battersby	Strategic Director, Environment and Development Services
Christine Boswell	RDaSH
Brian James	Rotherham Foundation Trust
Martin Kimber	Chief Executive, RMBC
Dr. David Polkinghorn	CCG
Dr. John Radford	Director of Public Health
Janet Wheatley	VAR
Sarah Whittle	NHSR/CCG
Officers:-	
Rebecca Achinson	NHS Rotherham
Laura Brown	RMBC
Miles Crompton	RMBC
Kate Green	RMBC
Tracy Holmes	RMBC
Simon Lister	Stop Smoking Service
Shona McFarlane	Director of Health and Wellbeing
Chrissy Wright	Strategic Commissioning Manager
Dawn Mitchell	Democratic Services, RMBC
Councillor Jack	Observer

Apologies for absence were received from Councillors Doyle and Lakin, Tom Cray, Joyce Thacker, Matt Gladstone, Dr. David Tooth, Alan Tolhurst and Chris Edwards.

S48. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

S49. JOINT HEALTH AND WELLBEING STRATEGY

Kate Green, Policy Officer, reported that the Department of Health had recently published draft guidance on developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

The report submitted set out a timetable for developing the Strategy which hopefully would be produced by May, 2012 in advance of the national timeline of April, 2013 when Boards were due to take on their statutory responsibilities. Draft guidance had been published to enable local authorities and Clinical Commissioning Groups to incorporate jointly agreed actions based on identified need into their planning.

The work programme approved at the previous meeting set out the timeline for completion of specific tasks and decisions for the next 12 months. This also

provided milestones for self-assessment against specific criteria so that the Board could improve its effectiveness.

The JSNA would be the means by which local leaders worked together to understand and agree the needs, as well as 'assets', of local people and communities. Data, information and intelligence underpinned them as well as being an analysis and narrative of the evidence, presenting a picture of the local community and its health and social care needs.

Dr. Polkinghorn stressed the importance of agreeing and publishing a Strategy by May, 2012, or the Clinical Commissioning Group would not receive "signing off" of their Plan.

It was suggested that a special workshop style meeting be held in March to further discuss and agree priorities for the Strategy and Joint Strategic Needs Assessment to enable community engagement to take place before April.

Resolved:- (1) That a special meeting of the Board be held in March to agree the further work being undertaken on the JSNA and consider priorities for the Joint Health and Wellbeing Strategy.

(2) That a small working group comprising of officers from the local authority, Public Health and Clinical Commissioning Group meet regularly to align the different activities required.

S50. JOINT STRATEGIC NEEDS AASSESSMENT

Miles Crompton, Corporate Policy Team, gave the following powerpoint presentation:-

What is a Joint Strategic Needs Assessment (JSNA)?
- Statutory assessment of current and future needs
- Partnership between Council and NHSR
- Evidence base to guide:-
  Commissioning of Health and Social Care Services
  Health and Wellbeing Strategy
  Health and Wellbeing Board priorities
- 2008: First Rotherham JSNA
- 2010: Health White Paper confirmed duty
- 2010/11: Refresh of JSNA
- 2013: Central role and equal partnership – Council and CCG

Rotherham's Population
- Total population 254,600 (+2.6%)
  51% female 49% male
  Projected increase of 13,000 by 2020
- 22% children aged 0-17 (-9%)
- 23% older people aged 60+ (+14%)
- 16% on disability benefits (+17%)
- 7.5% BME (+86%)
- Life expectancy – Male 76.6/Female 80.7 years

Ageing Population: Implications for 2020

– Limiting long term illness	+5,580	+22%
– Mobility Impairment	+1,990	+26%
– Hearing Impairment (18+)	+5,120	+21%
– Obesity	+2,270	+20%
– Dementia	+860	+30%
– Depression	+800	+21%
– Incontinence	+1,660	+24%
– Diabetes	+1,200	+22%
– Falls	+2,730	+24%

Care Needs and Carers

- 17,400 need help with domestic tasks
- 14,200 need help with personal care
- 25% increase projected in both by 2020
- Estimated 35,000 carers, most aged 45-64 but 5,300 aged 65+ (+19% by 2020)
- Care gap increasing
  Adult children and non-relatives less inclined to provide informal care and fewer children
  Rising demand in care from spouses and the formal care sector

Ageing Households

- Household increase 2006-2031 (25 years)
- All ages +27,000
- One person +17,000 (+55%)
- 65+ +18,000 (8,000 living alone)
- 75+ +11,000 (6,000 living alone)
- Lone pensioners projected for 2031
  24,000 pensioners living alone (+51%)
  16,000 aged over 75 (+66%)
  11,000 over 75 with long term illness (+75%)

Children and Young People: Indicators relative to England
Rotherham was:-

- Average on Obesity and Tooth Decay
- Worse on Child Poverty, GCSE A*-C Maths and English, Smoking in Pregnancy, Breast Feeding Initiation, Physical Activity, Teenage Pregnancy, Key Stage 2 Level 4, Infant Mortality, A & E Admissions

Deprivation: Indices of Deprivation 2010

- Commissioned by Government
- 6 District Measures – 354 districts in 2007, 326 in 2010
- "Average of SOA Scores" – increased from 68th most deprived 2007 to 53rd 2010
- "Local Concentration" – increased from 60th in 2007 to 48th in 2010
- % of Rotherham in most deprived 10% of England up from 12% (2007) to 17% (2010)

Poverty

Child Poverty
- 2009: 13,665 children in poverty (23.3%)
- 2011 (est.): 13,800 in poverty (23.6%)
- 2012: 20% eligible for Free School Meals
  15.6% increase since 2009
- Most polarised form of deprivation

Pensioner Poverty
- 18,080 pensioners in Pension Credit households (35%)
- 11,238 pensioners in Guarantee Credit Households (22%)
- Low take-up – est. 21,000 households (60%) low income pensioners (13,000 or 37% Guarantee)

Health Indicators relative to England
Rotherham was:-
- Better on Hospital re. Self-Harm, new cases of TB, Road Injuries and Deaths
- Average on higher risk drinking
- Worse on Breast Feeding, Physical Activity, Obesity, Emergency Admissions, Teenage Conceptions, Smoking, Poor Diet, Drug Misuse, Hip Fracture 65+, Excess Winter Deaths, Life Expectancy, Cancer

Key Issues
- The impact of an ageing population
- Promoting healthy living – physical activity, diet and risk awareness (smoking and alcohol)
- Reducing the gap between healthy and actual life expectancy
- Increasing independence for people with long term conditions
- Increasing independence, choice and control for people suffering with dementia and new service development
- Preventative health and care strategies to save future care costs
- Reflecting the diversity of the learning disability population in services

Discussion ensued on the priorities for Rotherham:-

- Access to a good quality advice service in respect of poverty issues, Welfare Reform Act, mental health
- Influence of housing
- JSNA was agreement of the priorities – where should funding be invested to create the biggest impact
- The majority of health problems and inequalities stemmed from employment opportunities and wealth

Resolved:- That further work on the JSNA take place forming the basis for discussion at the special meeting to be held in March.

S51. HEALTH INEQUALITIES SUMMIT

John Radford, Director of Public Health, gave the following powerpoint presentation:-

Action and Next Steps

Session Plan
- Discussion on proposed actions
- Opportunity to develop the action plan

Aspiration
- Communities
- Look and Feel of Rotherham
- Health
- Skills for Life
- Cost of Living

Raising Aspirations
- Recognise what Rotherham had to offer and use the media to promote e.g. Clifton Park, Rotherham Shown, green spaces, play sites, walks etc.
- Refresh and extend the "Rotherham Ambassadors" Scheme – broaden involvement with communities

Look and Feel of Rotherham
- Planning to consider the health impact of all new applications and developments e.g. takeaways
- Develop a commercially viable, innovative and imaginative "Town Centre offer" e.g. early evening activities, café culture
- Develop a scheme to regulate private landlords

Rotherham Communities
- Develop an asset, skills and knowledge framework to fully utilise local potential in the 11 most deprived areas

Cost of Living
- Promote help with cost of living including credit unions, fuel/food co-operatives, housing and travel

Health
- CCG to make accessibility to services a priority for 2013

Skills for Life
- Develop and promote a skills training register identifying the "trigger points" for skills for life training linking to schools, colleges and job centres
- Increase the volunteering and apprenticeship programme/opportunities across Rotherham

Summary
- Actions need to make a difference
- Recurring theme of reducing short termism needs to be addressed
- Consultations need to result in action – "You said, We did"
- Energise communities – communities to be an active partner in service development and delivery e.g. Kimberworth Park

Discussion ensued on the presentation with the following issues raised/highlighted;-

- Should form part of the JSNA
- Hard to reach communities – how to raise their aspirations
- Health and Wellbeing Strategy wider than health
- Commissioning strategies would not be aimed at just health but delivering the whole health and wellbeing agenda
- Work on documents that linked together to ensure co-ordination

Resolved:- (1) That the presentation be noted

(2) That learning from the summit activity be built into the development of the JSNA and joint Health and Wellbeing Strategy.

S52. HEALTH AND WELLBEING BOARDS - LEARNING FROM EARLY IMPLEMENTERS

Kate Green, Policy and Scrutiny Officer, reported that the Local Government Improvement Development (LGID) had published a document, 'New Partnerships, New Opportunities', which pulled together 9 case studies of Health and Wellbeing Board Early Implementer areas where preparations were generally well advanced. The report submitted summarised the work undertaken by the case study areas and where it had been used to develop Rotherham's Board.

There were 5 stages outlined for developing a good Health and Wellbeing Board:-

Stage 1 Preparing for the Board
Rotherham had now agreed joint leads – Strategic Director for Neighbourhoods and Adult Services and the Chief Operating Officer of the Clinical Commissioning Group. A multi-agency working group was also being established to support the Board in developing the key areas of work required including the JSNA and Joint Strategy.

Stage 2 Forming the Board
Early Implementers reflected 2 main approaches in relation to Board membership – commissioner focused or mixed-membership approach.

Many had agreed to opt for the core statutory members in the first instance until the Board took on its statutory duties and then review membership. It may be that Rotherham wished to take this approach.

Stage 3 Work Programmes, Priorities and Commissioning
Rotherham had agreed a Board work programme based on a good practice toolkit and was to be implemented to inform agendas over the next 12 months.

The Board may wish to consider how it would manage the other business items alongside the more strategic items required.

Stage 4 Developing Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies
A proposed timetable for further development of the local JSNA and JHWS had been put in place for the Board to consider.

Stage 5 Review, Performance and Looking Forward
The work programme included milestones for self-assessment against set criteria ensuring the Board's continued effectiveness and achievement.

The report also set out further development areas which the Board may wish to adopt or explore further.

Discussion ensued on the possibility of holding a stakeholder event as part of the JSNA and Health and Wellbeing Strategy. The importance of asset mapping was also stressed due to diminishing resources.

The Centre for Public Scrutiny had produced a paper on Achieving an Effective Health and Wellbeing Board. It was suggested that a meeting be held with them to discuss good practice.

It was reported that, in light of the delayed HealthWatch, the contract with LiNKS had been extended to carry out consultation on the JSNA.

Resolved:- (1) That the learning from the Early Implementer case studies and where it had been applied to the development of the Rotherham Board be noted.

(2) That a session at the May meeting of the Board take place to review the future directions of the Board and to consider best practice guidelines that were becoming available.

S53. HEALTH SCRUTINY WORK PROGRAMME

Kate Green, Scrutiny and Policy Officer, submitted, for information, the Health Select Commission work programme for January to July, 2012.

There were 2 items in the programme which the Commission wished to raise:-

- Scrutiny Review of Continuing Healthcare – there would be a requirement for NHS partners to be involved. The scope of the review was submitted for approval
- 19th April Health Select Commission meeting focussing on the Health and Wellbeing Board

The Chair and Vice-Chair of the Commission would like to invite Board representatives to attend the April meeting to discuss how they could complement the Board's work programme as well as building relationships between the Commission and Clinical Commissioning Group.

Resolved:- (1) That the Health Select Commission work programme be noted.

(2) That the areas of work which would require partner involvement and co-operation be noted, including the review of Continuing Healthcare.

(4) That the meeting of the Health Select Commission on 19th April be themed around the Health and Wellbeing Board and members of the Board be invited to attend.

S54. ROTHERHAM NHS STOP SMOKING SERVICE ANNUAL REPORT 2010-11

Simon Lister, Service Manager, Rotherham NHS Stop Smoking Service, presented the 2010-11 annual report.

RSSS was a specialist service that provided support for anyone who lived or worked in Rotherham. It provided one-to-one, drop-in, group and telephone support. Sessions were delivered in a number of venues across Rotherham during the day, evenings and Saturday mornings.

RSSS was commissioned by NHS Rotherham. The Service specification contained a number of very challenging objectives including:-

- Meet the specific 4 week quitter target (1,850 per annum)
- Meet the specific pregnant women 4 week quitter target (160 per annum)
- Achieve an average of 50% conversion rate
- Achieve 85% CO verification rate of clients who quit
- Support the achievement of the LES target (1,000 per annum)
- Contribute to the reduction of health inequalities by targeting specific groups

The Service specification had contained significant financial penalties should the Service not meet the 4 week quitter, pregnancy women 4 week quitter and conversion rate targets. The penalties had subsequently been removed.

The annual report contained detailed information on:-

- Service Objectives
- Performance Data
- Pregnant Women
- Primary Care and the Locally Enhanced Service
- Quit Shop
- Community Sessions
- Rotherham Hospital
- Telephone Service
- Patient and Public Engagement
- Staff Training and Development
- Challenges and Aspirations
- Aspirations

Discussion ensued with the following issues raised/highlighted;-

- Close work had taken place with the Midwifery Service and had undertaken flexible service delivery. They operated an opt-in service rather than opt-out service with all pregnant women receiving, as part of their clinical care, stop smoking advice
- Rotherham was the only area in the region that had a dedicated out of hours telephone service
- Although the number of pregnant women quitters had increased, Rotherham still had a very high percentage of smokers compared to the national average

Resolved:- That the report be noted.

S55. PREMIUM PHONE LINES IN GP PRACTICES

Dr. John Radford, Director of Public Health, reported on the use of 084 telephone numbers in Rotherham General Practices.

In December, 2009, the Secretary of State issued the "Directions to NHS bodies concerning the cost of telephone calls 2009". These mandated that, regardless of the telephone number being called, people should not pay more to call a NHS body than they would to make an equivalent call to a local telephone number. The directions did not expressly disallow the use of any particular telephone number ranges.

A recent review of Rotherham General Practice telephone numbers had been carried out and identified that many were using 0845 and 0844 telephone numbers. Calls to the numbers from a fixed line were charged at no more than a call to a local number. However, all calls, irrespective of the caller's provider or call plan, should be at the local rate and as such the continued use of 084 telephone numbers disadvantaged some patients who could not afford land lines and should be withdrawn.

Dr. Polkinghorn reported that, at a meeting held earlier in the week, there had been an undertaken given by all Rotherham GPs to migrate away from the 08 numbers. There would be a problem for some practices with large contracts.

Resolved:- That the report and decision by Rotherham GPs to migrate away from the 08 numbers be noted.

S56. ROTHERHAM'S OLYMPIC LEGACY PROJECT

Laura Brown, Corporate Improvement Officer, reported that working with Members and partners, the Council would deliver a programme of Olympic associated events and activities that would encourage people to live healthier lives, see more of Rotherham residents join clubs, volunteering and learning to coach and becoming more involved in social and cultural events.

The report highlighted progress to date in forging an Olympic partnership with the London Borough of Barking and Dagenham and the planning and initiating of a wide range of Olympic focussed events during 2012 as well as the Queen's Golden Jubilee.

Informal partnership working arrangements had been in place enabling the development of a joint events calendar. A draft Memorandum of Understanding had been drawn up which formalised the arrangements and focussed on aims, shared responsibilities and the partnerships structures. This was currently with Barking and Dagenham for review prior to final sign off by both authorities.

It was extremely important to encourage healthy lifestyles and cultural experiences, not only for 2012, but for years to come.

Any organisations that had planned events that could be linked to the

programme should notify Laura so they could be included in the promotional activities. It was hoped to have an Olympic page on the Council's website which would not only publicise events but also be a gateway to partners and their activities.

Rotherham's approach to the Olympics had been recognised by London 2012's Inspire programme. A revised application had been submitted in mid-January with confirmation received that the Council had been awarded the coveted Inspire Mark. This enabled the Inspire Mark to be included on marketing, subject to licence.

Resolved:- (1) That the report be noted

(2) That members of the Board consider areas of work/initiatives which could be linked to this wider project

S57. COMMUNICATIONS

The Chairman circulated, for information, a booklet produced by the LGA offering considerable support and resources to Health and Wellbeing Boards.

S58. DATE OF NEXT MEETING

Resolved:- (1) That a special meeting of the Board be held in March, 2012.

(2) That a further ordinary meeting be held on Wednesday, 11th April, 2012, commencing at 1.00 p.m.

ROTHERHAM BOROUGH COUNCIL - REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**19th April, 2012**
3.	**Title:**	**Rotherham Health and Wellbeing Board Update**
4.	**Directorate:**	**Resources**

5. Summary

The Health and Social Care Bill (2011) set out proposals for all local authorities to have statutory Health and Wellbeing Boards (HWBB) up and running by April 2013 at the same time as Clinical Commissioning Groups take on responsibility for NHS commissioning. Many local authorities have already begun to put measures in place to establish these Boards early, including Rotherham.

The Rotherham HWBB met for the first time in September 2011. Terms of Reference have now been agreed along with a work programme, and work is now well under way to developing a joint health and wellbeing strategy for Rotherham. This report sets out the terms of reference and work programme for scrutiny to consider and to begin discussions as to how Rotherham is working towards achieving an effective board and health and wellbeing structure for Rotherham.

6. Recommendations

That the Health Select commission:

- **Note the activity currently taking place in relation to health and wellbeing in Rotherham**
- **Note the Terms of Reference and work plan for the Health and wellbeing Board**
- **Discuss and Consider the ways in which Rotherham is working towards achieving an effective health and wellbeing structure**

7. Proposals and Details

7.1 Operation of Health and Wellbeing Boards

The Health and Wellbeing Board is a statutory board as set out in the Health and Social Care Bill 2011. The Board is a sub-committee of the Council and brings together key decision makers from Social Care, Public Health, NHS and GPs, to address issues of local significance and to seek solutions through integrated and collaborative working.

The Rotherham Board is chaired by the Cabinet Member for Health and Wellbeing and is a high-level strategic Board made up of senior officers who are able to make key decisions in relation to their organisations and budgets. The Board will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population. The Board will advocate for and act as ambassador for Rotherham collectively on local, regional, national and international forums.

To ensure that the board is able to engage effectively with local people and neighbourhoods local HealthWatch, once established, will also have a place on the board.

7.2 Functions of Health and Wellbeing Boards

The primary aim of the HWBB is to promote integration and partnership working between the NHS, social care, public health and other local services and improve democratic accountability. The main functions of the HWBB include:

- to assess the needs of the local population and lead the statutory joint strategic needs assessment (JSNA);
- to use the intelligence gathered through the JSNA to develop a joint Health and Wellbeing Strategy for Rotherham
- to promote integration and partnership across areas, including through promoting joined up commissioning plans across the NHS, social care and public health;
- to support joint commissioning and pooled budget arrangements, where all parties agree this makes sense

There is a statutory obligation for the local authority and commissioners to participate as members of the Board and act in partnership on these functions. The HWBB gives local authorities influence over NHS commissioning, and corresponding influence for NHS commissioners in relation to health improvement, reducing health inequalities, and social care. The HWBB is also a vehicle for taking forward joint commissioning and pooled budgets, where parties agree this makes most sense and it is in line with the financial controls set by the NHS Commissioning Board.

7.3 Rotherham Health and Wellbeing Board: Key Roles and Responsibilities

Terms of reference have been agreed by the board, including the membership, roles and responsibilities and operating principles. The full terms of reference are set out in Appendix A.

7.4 Governance and Reporting Structures

The Health and Wellbeing Board will be accountable to the council, but also has a reporting link to the over-arching Rotherham Partnership Board, which is through the Chair of the HWBB being allocated a place on the Partnership Board.

The Clinical Commissioning Group (CCG) which has now been established; supported by NHS Rotherham, has two places on the HWBB. The Chair of the HWBB Board has also been allocated a place on the CCG Board.

7.5 Work Programme

To ensure that the local HWBB is able to structure its work appropriately to achieve an improvement in health inequalities and drive the change needed to meet demographic and financial challenges locally, a work programme has been developed. This has been based on the Good Governance Institute's Board Assurance Prompt self assessment toolkit, which sets out a path from basic level to becoming an exemplar HWBB. The plan sets out how the board can move up each progress level to becoming an exemplar, with a series of actions identified on a quarterly basis which need to be tasked to accountable lead managers to be delivered and outcomes reported through to the Board.

The work plan is attached as appendix B to this report.

7.6 Health and Wellbeing Strategy

One of the key roles of the HWBB will be to develop and sign-off a joint Health and Wellbeing Strategy. This strategy will be the overarching document for delivering health and wellbeing services locally and will be a crucial document for informing all related commissioning plans, both within the authority as well as partner organisations, including the clinical commissioning group.

The Health and Wellbeing Strategy will include high-level priorities and actions needed, taken directly from the joint strategic needs assessment and will therefore need to inform and have a direct relationship with other key plans and strategies.

The board's main priority currently is to develop this strategy, which is requirement for the Clinical Commissioning Group in seeking authorisation from July 2012. The Board have held two workshop sessions to date where they have set the strategic priorities and considered an intelligent response to how we tackle these priority areas locally. Scrutiny members have been involved in these sessions.

7.7 Overview and Scrutiny Function (OSC)

An original proposal for the HWBB to take on the role of health scrutiny within local authorities was revoked. The Bill confirms the continuance of Local Authority scrutiny function on the NHS, with the power to call in and scrutinise any provider of NHS services.

Scrutiny will have an important role alongside the HWBB, to ensure that commissioning arrangements are in line with the agreed priorities set out in the joint Health and wellbeing Strategy and that appropriate outcomes are seen locally for the people of Rotherham.

8. Finance

Health Secretary Andrew Lansley has allocated funds of almost £1 million to support the development of Health and Wellbeing Boards. The funds are being used to:

- create a learning programme to develop solutions on key challenges around joint working between local government and the NHS;
- develop an interactive online forum, tools and events to show-case and share this learning; and
- support councillors working on Health and Wellbeing Boards

Rotherham has been involved in the various work streams and learning networks.

From April 2013, Public Health England will allocate ring-fenced budgets, weighted for inequalities, to upper-tier and unitary authorities in local government. Shadow allocations will be issued to local authorities (LAs) in 2012/13, providing an opportunity for planning.

9. Risks and Uncertainties

The health reform agenda will continue to be a changing environment for some time, whilst plans are put in place relating to GP commissioning, the abolishment of PCTs and other NHS bodies being changed or re-shaped.

Those involved in the Health and Wellbeing Board locally will need to be mindful of this changing environment and the terms of reference will need to continually be reviewed to ensure all the changes are taken into account. This is particularly in relation to the membership or the Board and relationships with other Boards and external bodies.

10. Policy and Performance Agenda Implications

Work is currently being undertaken in relation to the development of a local Health and Wellbeing Strategy, which will be shared with the Commission at a later date.

11. Background Papers and Consultation

Health and Social Care Bill 2011

Equity and Excellence: liberating the NHS white paper 2010

The Good Governance Institute's Board Assurance Prompt Toolkit:
http://www.good-governance.org.uk/Product%20Menus/Health_wellbeing_board.htm

Appendix A Health and Wellbeing Board Terms of Reference

Appendix B HWBB work programme

12 Contacts

Cllr Ken Wyatt
Chair of the Health and Wellbeing Board

Kate Green
Policy and Scrutiny Officer
Commissioning, Policy and Performance
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Health and Wellbeing Board

Terms of Reference

1. Context

These terms of reference set out how the Health and Wellbeing Board will operate in Rotherham during the transition to formal establishment of the proposed statutory board. These will need to be kept under continual review taking into account any changes made by the government as the new Health and Social Care Bill is debated through Parliament.

The terms of reference aim to build upon the collaborative working between NHS Rotherham, Rotherham MBC and other key partners. Importantly the focus of the Health and Wellbeing Board will be wide ranging looking at the health, social, environmental and economic issues which all impact on the health and wellbeing of people in Rotherham. The scope will also include the new responsibilities for local government in terms of public health.

2. Function

The Health and Wellbeing Board will be the single strategic forum to ensure coordinated commissioning and delivery across the NHS, social care, public health and other services directly related to health and wellbeing in order to secure better health and wellbeing outcomes for the whole Rotherham population, better quality of care for all patients and care users and better value for the taxpayer.

The Health and Wellbeing Board is a statutory board (The Health and Social Care Bill 2011) set up by the local authority and brings together key decision makers to address issues of local significance and to seek solutions through integrated and collaborative working.

The Health and Wellbeing Board advocates and acts as ambassador for Rotherham collectively on local, regional, national and international forums.

The Health and Wellbeing Board gives guidance and support, offers challenge, and adds value to both the collective partnership working, and the work of individual partners where appropriate.

2.1 Key responsibilities of the Board

- To reduce health inequalities and close the gap in life expectancy by targeting services to those who need it the most
- To develop a shared understanding of the needs of the local community and approve the statutory joint strategic needs assessment (JSNA).
- To ensure public engagement and involvement in the development of the JSNA so that the experiences of local people influence policy development and service provision.
- To promote the development and delivery of services which support and empower the citizen taking control and ownership for their own health
- To ensure all services delivered in Rotherham ensure the safeguarding of vulnerable adults and children
- To develop a joint Health and Wellbeing Strategy to provide the overarching framework for commissioning plans for the NHS, social care, public health and other services that the Board agrees to consider.
- To assess whether the commissioning arrangements for social care, public health and the NHS are sufficiently in line with the joint Health and Wellbeing Strategy.
- To prioritise services (through the development of the Health and Wellbeing Strategy) that are focused on prevention and early intervention to deliver reductions in demand for health and social care services.
- To promote integration and partnership working across areas, including promoting joined up commissioning plans and pooled budget arrangements across the NHS, social care and public health where all parties agree this makes sense
- To advocate for Rotherham nationally and regionally to maximise resource opportunities.
- To oversee at strategic level the relevant joint communications, marketing/social marketing and public relations programmes and campaigns required to support the delivery of health and wellbeing objectives in the borough and ensure that local people have a voice in shaping and designing programmes for change.
- To ensure that the people of Rotherham are aware of the Health and Wellbeing Board, have access to the relevant information and resources around the different work streams and can contribute where appropriate.

- To ensure that communications across the members' host organisations are consistent and appropriate to the intended audience.

2.2 Operating principles

It will be important for the Board to have some agreed business principles to aid decision making and discussion on key issues. The following principles are:

a) Working in collaboration with partners to ensure people get the support and services they need as early as possible
b) Ensuring best interest for the Rotherham community
c) Involving the right people early on to make sure we get it right first time, reducing bureaucracy and getting better value for money
d) Having the right people with the right skills in the right place
e) Supporting and enabling our communities to help themselves whilst safeguarding the most vulnerable
f) Focussing on prevention and early intervention
g) Talking and listening to all Rotherham people and treating everyone fairly and with respect
h) Working to a set of agreed communications standards, including openness and transparency; clarity and use of plain English; consistency, co-ordination and timeliness
i) Setting clear strategic objectives and priorities
j) Seeking opportunities to increase efficiency across Service Providers
k) Holding partners to account

3. Membership, representation and conduct

The membership of the Health and Wellbeing Board is made up of leaders from across the NHS, social care, public health and other services directly related to the health and wellbeing agenda (as defined in The Health and Social Care Bill 2011).

The membership of the Health and Wellbeing Board may be reviewed periodically to ensure that the membership is representative of the identified priorities. The membership may be subject to change in the early months as a result of structural changes within the NHS.

The membership of the Health and Wellbeing Board is outlined in Appendix A.

The Board will be chaired by the Cabinet Member for Health and Wellbeing. The Board is a statutory sub-committee of the Council; therefore in the absence of the official Chair, meetings will be chaired by either of the two other nominated Cabinet Members.

Members of the Board should be of sufficient seniority to be able to make key decisions in relation to their relevant organisations and budgets. In the event of the nominated representative being unavailable, a deputy should be provided, who is equally at a suitable level for decision making.

The Health and Wellbeing Board is a strategic leadership body and members will be in attendance first and foremost as 'commissioners'. However, members may also have a provider role and should therefore identify themselves as providers and declare any conflict interest as and when appropriate.

3.1 The responsibilities of a Health and Wellbeing Board member include:

a) To attend meetings as required and to fully and positively contribute to meetings
b) To act in the interests of the Rotherham population, leaving aside organisational, personal, or sectoral interests
c) To fully and effectively communicate outcomes and key decisions of the Health and Wellbeing Board to their own organisations
d) To contribute to the development of the Joint Strategic Needs Assessment
e) To ensure that commissioning is in line with the requirements of the joint Health and Wellbeing Strategy
f) To deliver improvements in performance against the indicators within the public health, NHS and Adult Social Care outcomes frameworks
g) To declare any conflict of interest, particularly in the event of a vote being required and in relation to the providing of services
h) To act in a respectful, inclusive and open manor with all colleagues to encourage debate and challenge
i) To read and digest any documents and information provided prior to meetings to ensure the Board is not a forum for receipt of information
j) To act as ambassadors for the work of the Health and Wellbeing Board
k) To participate where appropriate in communications/marketing and stakeholder engagement activity to support the objectives of the Board, including working with the media.

4. Meetings

The Health and Wellbeing Board will meet six-weekly. The schedule of meetings will be reviewed annually by the Board.

The meetings of the Health and Wellbeing Board are public meetings, however, the Board will retain the ability to exclude representatives of the press and other members of the public from a defined section of the meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest (Section 1 (2) Public Bodies (Admission to meetings) Act 1960).

Papers for the Health and Wellbeing Board will be distributed one week in advance of the meeting. Additional items may be tabled at the meeting in exceptional circumstances at the discretion of the Chair.

All agenda items brought to the Health and Wellbeing Board need to clearly demonstrate their contribution to the delivery of the Board's priorities.

Non-members of the Health and Wellbeing Board may attend the meeting with the agreement of the Chair.

Decisions are to be taken by consensus. Where it is not possible to reach consensus, a decision will be reached by a simple majority of those present at the meeting.

The following should be taken into account by Board members when taking decisions:

(a) The priorities and objectives contained within the Health and Wellbeing Strategy.
(b) Any recommendations made by other Boards/groups.
(c) The business case (strong and robust)

Decisions of the Health and Wellbeing Board will not override organisational decisions, but are intended to influence partners to work for the benefit of the borough as a whole.

Minutes of the Health and Wellbeing Board will be circulated in advance of the next meeting and approved at the meeting.

4.1 Support to the Health and Wellbeing Board

Administrative and organisational support for the Health and Wellbeing Board will be provided by Rotherham Metropolitan Borough Council.

Rotherham MBC and NHS Rotherham will be the lead partners for communications, marketing and public engagement, but operational delivery of activity will be shared across Board partners, as appropriate.

5. Governance and Reporting Structures

The Health and Wellbeing Board has a direct reporting link to the over-arching Rotherham Partnership Board. The Chair of the Health and Wellbeing Board is also allocated a place on the Rotherham Partnership Board.

Minutes of Board meetings will be forwarded to the LSP Board, Full Council, the Health Select Commission (Scrutiny) and the South Yorkshire and Bassetlaw NHS Cluster Board for information.

The governance and reporting lines are illustrated at Appendix B.

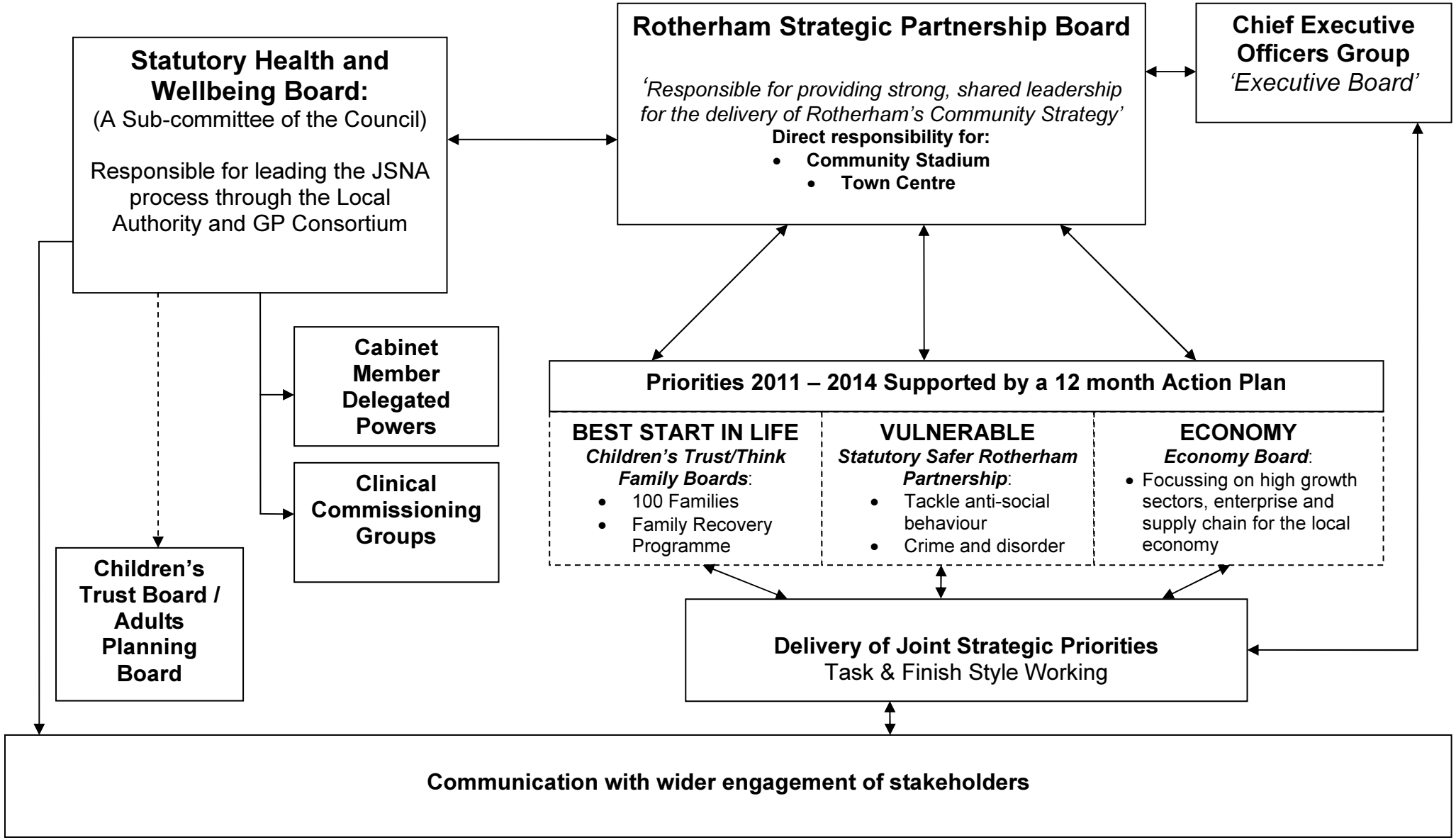
Appendix A

Membership of the Health and Wellbeing Board

Core Members
Cabinet Member for Health and Wellbeing (Chair) Cabinet Member with responsibility for Adult Services Cabinet Member with responsibility for Children's Services Director of Public Health Chief Executive, RMBC Strategic Director of Neighbourhoods and Adult Services Strategic Director of Children and Young People's Services Strategic Director of Environment and Development Services Chief Operating Officer, NHS Rotherham and CCG Chair of Clinical Commissioning Group (CCG) Chair of PCT Cluster Board (until April 2013, when position will be reviewed) Chief Executive, Rotherham Foundation Trust HealthWatch Representative (to be reviewed once body is in place) Chief Executive, Voluntary Action Rotherham

In attendance
Director of Policy, Performance and Commissioning, RMBC Director of Health and wellbeing (Adult Services) Chief Executive, RDaSH Head of Communications RMBC/NHSR/TRFT or other

In addition to the core members outlined above, the following may be required by invitation
NHS Commissioning Board South Yorkshire Ambulance Service South Yorkshire Fire and Rescue Clinicians South Yorkshire Police Rotherham Force Commander Representatives from the Adults and Children's Safeguarding Boards Chair of Rotherham School Improvement Partnership Executive Medical Directors and Chief Nurses Coroner Chief Emergency Planning Officer Environment Agency Voluntary/Community Sector Representatives Other provider organisations as required Private Sector Representation as required i.e. workplace health issues


Rotherham Strategic Partnership Board
'Responsible for providing strong, shared leadership for the delivery of Rotherham's Community Strategy'
Direct responsibility for:
Community Stadium
Town Centre
Chief Executive Officers Group
'Executive Board'
Statutory Health and Wellbeing Board:
(A Sub-committee of the Council)
Responsible for leading the JSNA process through the Local Authority and GP Consortium
Cabinet Member Delegated Powers
Clinical Commissioning Groups
Children's Trust Board / Adults Planning Board
Priorities 2011 – 2014 Supported by a 12 month Action Plan
BEST START IN LIFE
Children's Trust/Think Family Boards:
100 Families
Family Recovery Programme
VULNERABLE
Statutory Safer Rotherham Partnership:
Tackle anti-social behaviour
Crime and disorder
ECONOMY
Economy Board:
Focussing on high growth sectors, enterprise and supply chain for the local economy
Delivery of Joint Strategic Priorities
Task & Finish Style Working
Communication with wider engagement of stakeholders

Rotherham Health and Wellbeing Board
Work Programme - Year 1 (October 2011 – September 2012)

No.	Key Action	Lead Agency / Lead Officer	Completion Date	Excellence Plan Ref.
1	Agree Terms of Reference, Roles and Responsibility of the Board		**Complete December 2011**	1.1, 1.2, 1.3, 1.4, 4.1 and 6.1
2	Hold a Health Summit to define priorities for all stakeholders		**Complete December 2011**	1.5
3	Undertake a review of HWBB pilots and feed learning into Board work programme and improvement plan	Kate Green	February 2012	4.2
4	Agree the Joint Strategic Needs Assessment	Chrissy Wright	March 2012	2.3
5	Agree HWBB Priorities across all stakeholders	Tom Cray	April 2012	1.2, 1.3, 1.5, 1.6 and 2.4
6	Put in place a Joint Commissioning Model	Chrissy Wright/ Sarah Whittle	May 2012	2.5
7	Develop a Performance Management Framework based on the outcomes framework and the priorities of the board	Dave Roddis	April 2012	5.1, 5.2 and 5.3
8	Publish Rotherham's Health and Wellbeing Strategy	Matt Gladstone	May 2012	1,8, 2.1, 2.2, 2.4 and 2.6
9	Complete a review of health complaints ahead of the transition	Dave Roddis/Sarah Whittle	June 2012	5.5
10	Develop effective HealthWatch arrangements in Rotherham	Zafar Saleem	September 2012	4.7

Rotherham Health and Wellbeing Board - Board Development Excellence Plan				
Basic Level Oct 11 – Dec 11	Early Progress Jan 12 – Mar 12	Results Apr 12 – June 12	Maturity Jul 12 – Sept 12	Exemplar Oct 11 – Dec 12

1. PURPOSE AND VISION

No.	Key Action	Who?	Timeline
1	Agree purpose of the Board	COMPLETE	October 11
2.	Publish values and board priorities to public and in key stakeholder documents	COMPLETE	November 11
3.	Ensure all HWBB members understand the boards role	COMPLETE	December 11
4.	Hold a Health Summit to identify priorities with all stakeholders.	COMPLETE	December 11
5.	Agree values, board priorities and work programme	COMPLETE	January 2012
6.	Agree priorities and stretch goals with all stakeholders	Matt Gladstone	April 12
7.	Agree ethical values combined with a robust mechanism for adding and removing services and/or care settings against these	Shona McFarlane	April 12
8.	Ensure all plans are rooted in local population needs (Public Health Annual Report)	John Radford	April 12
9.	Undertake public engagement and public accountability testing on purpose and vision	Zafar Saleem	June 12
10.	Ensure the work of relevant existing local partnership groups eg. The Local Strategic Partnership has been considered	Carole Haywood	June 12
11.	Hold an annual HWBB debate on organisational purpose, and how in-year achievements or issues impact on this.	Tom Cray	August 12

Purpose & Vision - Annual Self Assessment

1	Ensure we systematically match how purpose dovetails with population needs
2.	Demonstrate we are achieving our purpose and vision as we are benefiting population health in accordance with our plans
3.	Influence both local health and local authority commissioners

2. STRATEGY			
No.	**Key Action**	**Who?**	**Timeline**
1	Undertake a review of all relevant strategies	Kate Green	April 2012
2	Set out a timetable for developing HWB Strategy	Kate Green	Complete
3	Agree the Joint Strategic Needs Assessment and make sure the JSNA is the base for all strategic decisions	Chrissy Wright	March 2012
4.	Ensure the HWBB Strategy is underway	Kate Green	February 12
5.	Put in place a joint commissioning model and an agreement is in place for areas of joint commissioning.	Chrissy Wright	April 12
6.	Publish the HWB Strategy, which includes improvement milestones and how these will be measured	Matt Gladstone	April 12
7.	Put in place a framework for ensuring the HWBB strategy has been reviewed and refined in the light of successful achievement of milestones, and new intelligence and aspirations	Tom Cray	September 12

Strategy - Annual Self Assessment

1.	The HWBB strategy has benefited other healthcare economies to our own, as well as influencing the strategic direction of all local partner organisation

3. LEADERSHIP OF THE LOCAL HEALTHCARE ECONOMY			
No.	**Key Action**	**Who?**	**Timeline**
1	Communicate the leadership of the HWBB and their contact details to key stakeholders	Tracy Holmes / Helen Watts	January 2012
2	Identify relevant stakeholders and invite to participate	COMPLETE	January 2012
3.	Make sure Leadership development for HWBB discussed and agreed and development plans initiated	COMPLETE	February 12
4.	All stakeholders understand leadership issues for HWBB	Shona McFarlane	March 12
5.	Relevant stakeholders regularly attend and provide input into work programme	Matt Gladstone	March 12
6.	Results of partnership working systematically reviewed by HWBB.	Matt Gladstone	April 12
7.	Public health voice is evident in commissioning and contracting decisions	John Radford	June 12
8.	Make sure ongoing succession plans are in place	Matt Gladstone	September 12

Leadership of the Local Healthcare Economy – Annual Self Assessment

1	Make sure that local health and social care resources are understood
2.	Evidence that relationships with CCG's are positive and there is ongoing dialogue about commissioning and contracting decisions
3.	Review success of leadership approach.
4.	Demonstrate benefits of partnership working have enabled the majority of stakeholders to meet their improvement trajectories and resource allocation
5.	Demonstrate benefits of partnership working have enabled the majority of stakeholders to exceed their improvement trajectories.
6,	Outcomes have been improved and this is traceable back to initiatives from the HWBB

4. GOVERNANCE			
No.	Key Action	Who?	Timeline
1	Membership and terms of reference for the HWBB have been drafted, shared and are fully agreed	COMPLETE	December 11
2	Examine the work of the pilot HWBB's to inform how we work	Kate Green	Complete
3	The HWBB has been fully set up and first annual cycle of business agreed.	Tom Cray/Chris Edwards	January 12
4.	Develop effective HealthWatch arrangements in Rotherham and make sure that they are embedded into the HWBB governance.	Zafar Saleem	September 12

Governance – Annual Self Assessment

1.	Good governance benefits to HWBB identified and we know how our better governance practice has influenced local partner organisation.
2.	Develop relationships with relevant local organisations
3.	Local stakeholders have clearly incorporated HWBB accountabilities into their own governance arrangements.
4.	Carry out a structured annual review of the HWBB and make improvements to structure and organisation

5. INFORMATION AND INTELLIGENCE			
No.	**Key Action**	**Who?**	**Timeline**
1	**Identify information requirements and agree format for initial performance management framework.**	**COMPLETE**	**January 2012**
2	**A dashboard of key information and performance management framework has been developed based on the outcomes framework and priorities and discussions on how to improve our information are underway.**	**Dave Roddis**	**March 12**
3	**KPI's reflect shared performance objectives across health and social care**	**Dave Roddis**	**April 12**
4.	**The HWBB has current published strategy, which includes improvement milestones and how these will be measured**	**Dave Roddis**	**May12**
5,	**Complete a review of health complaints to ensure that customer experience is captured and feeds into the HWBB**	**Dave Roddis**	**June 12**

Information and Intelligence – Annual Self Assessment

1.	**HWBB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care**
2.	**Outcomes and performance benchmark against the best performers**

6. EXPERTISE AND SKILLS			
No.	**Key Action**	**Who?**	**Timeline**
1	**Skills and expertise for HWBB members have been identified and agreed**	**Tom Cray/ Chris Edwards**	**March 2012**
2	**Induction and development plans for the HWBB are up and running**	**Tom Cray/ Chris Edwards**	**March 2012**

Expertise and Skills – Annual Self Assessment

1	**HWBB influencing skills are evident by success in positive change to local contracts and the pattern of local provision.**
2.	**The HWBB supports CCG's and local authority by valuing key commissioning skills.**
3.	**The HWBB acts as a forum to bring specialist skills and expertise to support commissioning e.g. clinical advice from local providers**
4.	**The HWBB is influencing the organisation development of partner organisations.**
5.	**The local health and social care economy is recognised as being a good career choice for commissioning professionals.**

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**Health Select Commission**
2.	**Date:**	**19th April, 2012**
3.	**Title:**	**Public Health Transition**
4.	**Directorate:**	**Public Health**

5. Summary:

As part of the Government's changes to the NHS set out in the Health and Social Care Bill, Public Health responsibilities are moving to Local Authorities from April 2013. This paper describes these changes, statutory responsibilities and a transition plan to support this move. The Government is aiming to establish a new Public Health service through Public Health England (PHE) and Local Authority Public Health departments. Its aim is to embed Public Health as a core responsibility throughout Local Government. The budgetary implications of this are not yet fully clear but it is anticipated that the service will be fully funded by the ring-fenced Public Health grant from the Department of Health to Local Authorities and will be at no cost to the local rate payer.

The transfer of responsibility from Public Health from the NHS to Councils will lead to a greater impact being had on the root causes of ill health, and so improve health for the people of Rotherham. At the same time it will be important to ensure that strong links remain between specialist public health functions and the commissioning of health services, so as to ensure they best fit the needs of Rotherham people.

The biggest public health gain to be obtained from the new arrangements will be realised if Public Health influences everything the Council does, so that the whole organisation becomes a public health driven organisation, and every contact that the Council has with the people of Rotherham helps to promote health and wellbeing. Transition will be in two phases: shadow form from April 2012 to full transition in April 2013.

Following these proposals being approved by Cabinet in March, the Health Select Commission are being presented the information to ensure scrutiny members feel assured the appropriate activity is taking place to ensure an effective public health system is in place for Rotherham.

6. Recommendations

That the Health Select Commission:

- **Notes the proposed new powers and statutory responsibilities with respect to the Health and Social Care Bill detailed in Appendix 1**

- **Considers the Public Health transition plan (Appendix 2) which sets out assurances that RMBC will meet these new powers and responsibilities**

7. Proposals and Details:

Background

In planning for this transition of Public Health leadership from the NHS to the Council, we are building on existing strong local joint working. The current joint appointment between the NHS Rotherham and RMBC of the Director of Public Health has and will continue to strengthen joint working on local health priorities. We also have the advantage of having a unitary authority and co-terminosity between the Council and the Primary Care Trust (and the CCG). A Public Health Transition Steering Group will be established, chaired by the Director of Public Health, to take forward the transition plan (Appendix 2) and detailed planning of the transfer in order to ensure an efficient transfer process.

Timescales

Although formal transfer (phase 2) will not occur until April 2013, it is recommended that financial year 2012-13 is a 'transition year' (phase 1) during which shadow arrangements will be in place and we will be working as though the new arrangements were in place. In anticipation of this, a restructuring of the existing Public Health team within NHS Rotherham is taking place, so as to align the team appropriately with the planned future arrangements in the Council and most importantly in order to address the statutory responsibilities and to ensure that there is appropriate management and delivery of the key priorities and Public Health outcomes.

Public Health in RMBC

The statutory Public Health responsibilities, commissioning responsibilities and health protection and resilience functions that are proposed to transfer to RMBC subject to passage of new legislation are set out in Appendix 1. There are two types of commissioning responsibility. Mandatory responsibilities include access to sexual health services, health protection, ensuring NHS commissioners receive advice and the provision of NHS health checks. Additionally, Local Authorities will be responsible for a range of discretionary Public Health services such as those for drug and alcohol misuse, obesity prevention and stop smoking.

The transfer of Public Health functions into RMBC is a once in a generation change and opportunity for a new way of working for Public Health in Rotherham. There is still much to be done in terms of improving the health and wellbeing of the people of Rotherham and driving down inequalities. Having Public Health leadership and resources for a local area led from RMBC should make it easier to address some of the root causes of ill health which are more easily influenced by Local Authorities than the NHS. These include, among other things, housing, the environment, education and employment, transport, benefits and poverty measures and special planning.

Although the underlying Public Health problems for the population in Rotherham are not changing significantly, with the transfer to new arrangements, the options available for addressing them will. The new priorities for Public Health need to influence the new Health and Wellbeing Strategy for Rotherham and have already influenced the RMBC Corporate Plan.

NHS commissioning support

In addition to maximising opportunities within RMBC, it is vital and a proposed statutory arrangement that Public Health will continue to support the NHS commissioning of health service provision. The RMBC Public Health team will have to work closely with both Public Health England (PHE) and the local CCG.

It is proposed that PHE will have responsibility for screening, vaccination and immunisation programmes, commissioning health visitors and maternity services and some aspects of emergency planning; however, the detail of these responsibilities is not yet clarified. For all responsibilities there will need to be close liaison between PHE and Public Health to ensure a local fit and because the Director of Public Health will retain responsibility for them at a local level. We do not yet know the local arrangements for PHE, so planning this joint working is not yet possible.

It will also be important to have close working with the NHS Rotherham CCG to influence their commissioning of health services, as well as with individual GP practices in their role as providers of health services locally. 'Healthcare Public Health and preventing premature mortality' remains a core domain in the Public Health Outcomes framework (see below). A 'core offer' between Public Health and NHS Commissioners has been published by the Department of Health and this has been used to set out a 'Memorandum of Understanding' between RMBC Public Health and NHS Rotherham CCG for the provision of Public Health advice to NHS commissioning in Rotherham (Appendix 3).

Shared responsibility for NHS emergency planning will go to the NHS Commissioning Board and a lead Director of Public Health. Responsibility for Public Health emergency planning and health protection (including on-call arrangements for out-of-hours work) will transfer to RMBC. This will need to be effectively integrated with existing Local Authority emergency planning functions and is noted in the Public Health transition plan (Appendix 2).

8. Finance:

The Public Health budget will be taken from the NHS and allocated to Local Authorities. The final details of the financial allocations for local areas has been delayed nationally and is now not expected until June 2012. The Public Health function within the Council will be funded from this and at no cost to the local rate payer.

9. Risks and Uncertainties:

Legal Implications

The report contains a summary of the relevant provisions of the Bill. The Bill is still being debated and may be subject to change. The implementation date for the provisions is also subject to change. Regulations and guidance may be issued when the Bill becomes an Act, which will need to be considered before arrangements are finalised.

'Health premium' and funding allocation

The Rotherham Public Health budget is currently fully committed, so that whilst the Council will wish to review the detail of the spend, it will not be possible to commission any additional public health activity without decommissioning existing activity.

The Public Health White Paper describes a 'health premium.' This is an incentive payment to award Local Authorities that make significant progress in addressing health inequalities. It will be funded from the Public Health grant by holding back money from the grant and allocating it in subsequent years on the basis of performance. Concerns about this have been expressed as part of the consultation process, so it is now not known how the Department of Health will now implement this.

10. Policy and Performance Agenda Implications:

Public Health Outcomes Framework

It will be for Local Authorities in partnership with Health and Wellbeing Boards to demonstrate improvements in Public Health outcomes through achieving progress against those indicators that best reflect local health need. This need should be set out in the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy. The use of data within the Public Health Outcomes Framework for benchmarking will also be an essential tool alongside the NHS, Adult Social Care and other sectors' frameworks for driving local improvements to health and wellbeing. Subject to the passage of the Health and Social Care Bill, Local Authorities will have a statutory duty to have regard to the Public Health Outcomes Framework document.

11. Background Papers and Consultation:

- Appendix 1: Public Health responsibilities and functions
- Appendix 2: Public Health Transition Plan
- Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.
- Appendix 4: Public Health Outcomes Framework – Overview of outcomes and indicators

Background papers:

- Health and Social Care Bill draft: http://www.publications.parliament.uk/pa/bills/lbill/2010-2012/0119/2012119.pdf
- Public Health White paper: Update and way forward: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128120
- Department of Health Public Health in Local Government guidance fact sheets: http://healthandcare.dh.gov.uk/public-health-system/
- Local Government Association Public Health workforce issues: Local government transition guidance: http://www.dh.gov.uk/health/2012/01/public-health-workforce/
- Director of Public Health job description: http://www.fph.org.uk/job_descriptions
- Public Health Outcomes Framework: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

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Appendix 1: Public Health responsibilities and functions

Public Health responsibilities and functions

1.0 Statutory Public Health Responsibilities

Statutory guidance on the responsibilities of the Directors of Public Health will be issued subject to Royal Assent of the Health and Social Care Bill. Subject to Parliament, Directors of Public Health will be added to the list of statutory chief officers in the Local Government and Housing Act 1989.

The Director of Public Health as a public health specialist will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. The Health and Social Care Bill will in addition make it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. Directors of Public Health will also be statutory members of health and wellbeing boards, and will wish to use the boards as the key formal mechanism for promoting integrated, effective delivery of services.
(Source: Public Health in Local Government, December 2011)

The public health duties below are those which are described within current statutory instruments. *(Source: East Midlands DPHs)*

1.1 Health Protection

- DPH is responsible individually and severally with the HPA for all infection issues outside of hospital.
- Section 47 of the National Assistance Act 1948/1951 (compulsory admission of patients to hospital with non psychiatric chronic conditions).
- All Health Impact Assessments of local environmental programmes such as IPPC applications (Integrated Pollution Prevention and Control).
- Health protection cover out of hours on call rota.
- Proper Officer role for the Local Authorities.
- Emergency Planning category 1 responder (Civil Contingencies Act 2004).
- Vaccination and Immunisation targets – overall programme management (e.g. childhood, swine flu, seasonal flu, pneumococcal Hep B – all at population level), the duty is to ensure vaccination is offered in line with JCVI recommendations.

1.2 Health Improvement

- DPH post is joint with the local authority; DPH responsible for effective NHS partnership working with council.
- Duty to cooperate with other NHS bodies and local authorities in the development of health improvement plans (e.g. 5 year Strategic Plan).
- Support for Children's Partnerships (e.g. Children's Trust).
- Community Safety Partnerships – the PCT is a "responsible authority" under the Crime and Disorder Act 1998, and the Criminal Justice Act 2003, and has a duty to cooperate on all aspects of the crime and disorder agenda e.g. implementation of national drugs and alcohol strategies, improving the health of prisoners (including prison death reviews), youth offending, and violent or sexual offenders.

Appendix 1: Public Health responsibilities and functions

- Production of the Joint Strategic Needs Assessment (JSNA) (joint statutory duty with Director for Children's Services and Director of Adult Social Services).
- The SHA hold the DPH responsible for all population health outcome targets that are formally performance managed (life expectancy, teenage pregnancy, cancer rates, suicide rates, smoking, exercise, obesity, breast feeding, Vaccination and Immunisation, Screening QA and incidents etc).
- Support for the statutory Overview and Scrutiny function of local authorities.
- Periodic Provision of information in relation to HIV / AIDS (AIDS Control Act 1987).

1.3 Healthcare commissioning

- Responsible officer role for Controlled Drugs (post Shipman Enquiry)
- Public Health representation on child death review processes (part of Children's Trust process).
- Clinical effectiveness – assurance that mandatory NICE Technology appraisals are implemented (via Area Prescribing Committee).
- National clinical audits e.g. diabetes.
- Public Health reports – the DPH has a duty to ensure the PCT Board is aware of the health needs of the population, and that strategies are in place to meet those needs within resources available.
- Pharmaceutical Needs assessment.

2.0 Public Health Commissioning Responsibilities

(Source: Public Health in Local Government, December 2011)

2.1 Mandatory

The mandatory services and steps that were identified in '*Healthy Lives, Healthy People: update and way forward'* included:

- Appropriate access to sexual health services;
- Steps to be taken to protect the health of the population, in particular, giving the Local Authority a duty to ensure there are plans in place to protect the health of the population;
- Ensuring NHS commissioners receive the public health advice they need;
- The National Child Measurement Programme;
- NHS Health Check assessment.

2.2 Discretionary

Local Authorities will also be responsible for:

- Tobacco control and smoking cessation services;
- Alcohol and drug misuse services;
- Public Health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all Public Health services for children and young people);
- Interventions to tackle obesity such as community lifestyle and weight management services;

Appendix 1: Public Health responsibilities and functions

- Locally-led nutrition initiatives;
- Increasing levels of physical activity in the local population;
- Public mental health services;
- Dental public health services;
- Accidental injury prevention;
- Population level interventions to reduce and prevent birth defects;
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions;
- Local initiatives on workplace health;
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes;
- Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention);
- Local initiatives to reduce excess deaths as a result of seasonal mortality;
- Public Health aspects of promotion of community safety, violence prevention and response;
- Public Health aspects of local initiatives to tackle social exclusion;
- Local initiatives that reduce public health impacts of environmental risks.

The commissioning of these services will be discretionary, guided by the Public Health Outcomes Framework, the local Joint Strategic Needs Assessment (JSNA) and the joint Health and Wellbeing Strategy.

The list of commissioning responsibilities above is not exclusive. Local Authorities may choose to commission a wide variety of services under their health improvement duty, and indeed we would hope to see much innovation as local authorities embrace their new duties. This freedom is deliberately wide, to encourage the kind of locally-driven solutions that lie at the core of localism, underpinned by a robust analysis of the needs and assets of the local population.

Public Health England (PHE) will promote this local innovation through encouraging peer sharing of best practice and learning experiences, and through supporting rigorous evaluation of new approaches to improving and protecting public health.

3.0 Health Protection and Resilience Functions

(Source: DPH Job Description, Faculty of Public Health 2011)

Broadly, to lead a team within the Local Authority responsible for the development of a strategic needs assessment for the local population and for the delivery of:

- Dealing with infectious disease threats including food and water borne disease supported by local Public Health England;
- Preparing for emergencies including pandemic influenza;
- Advising on environmental threats including pollution, noise and contaminated land.

Appendix 1: Public Health responsibilities and functions

Defined competency areas:

- To take responsibility for safeguarding the health of the population in relation to communicable disease, infection control and environmental health, including delivery of immunisation targets.
- To ensure that effective local arrangements exist for covering the on call rota for the effective control of communicable disease, environmental hazards to health and emergency planning, as detailed in local health protection agreements.
- To communicate effectively and diplomatically with a wide audience including the media and the public to change practice in highly challenging circumstances such as communicable disease outbreaks, chemical incidents, immunisation and screening.

More work will take place in the coming months to develop operational guidance for the system-wide emergency preparedness, resilience and response model, including exploring how Public Health England and Local Government will work together to protect the health of local populations.

4.0 Public Health Advice to Local Government

(Source: Public Health in Local Government, December 2011)

The Director of Public Health acting as the lead officer in a Local Authority for health and championing health across the whole of the authority's business. Thus the Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services.

Often the Director of Public Health will not be personally responsible for the problem, but he/she will know how to resolve it through engaging with the right people in the new system.

He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities.

And he/she will engage with wider civil society to enlist them in fostering health and wellbeing.

In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality.

With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the Local Authority, but we would expect day-to-day responsibility for the grant to be delegated

Appendix 1: Public Health responsibilities and functions

The Director of Public Health's new role offers a great opportunity to build healthier communities. But to make the most of this Directors of Public Health will need to:

- Be fully engaged in the redesign of services that address the coming challenges;
- Influence and support colleagues who have a key role in creating better health, such as planning officers and housing officers;
- Facilitate innovation and new approaches to promoting and protecting health, while bringing a rigorous approach to evaluating what works, using the resources of Public Health England;
- Contribute to the work of NHS commissioners, thus ensuring a whole public sector approach.

5.0 Public Health Advice to NHS Commissioners

(Source: Public Health in Local Government, December 2011)

Public Health Advice to NHS Commissioners	Examples
Strategic Planning: assessing needs	
Supporting clinical commissioning groups to make inputs into the joint strategic needs assessment and to use it in their commissioning plans	Joint strategic needs assessment and joint health and wellbeing strategy with clear links to clinical commissioning group commissioning plans
Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with the clinical commissioning group and local authorities	neighbourhood/locality/practice health profiles with commissioning recommendations
Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality	Clinical commissioners support to use health related datasets to inform commissioning
Health needs assessment for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures	Health needs assessments for condition/disease group with intervention/commissioning recommendations
Strategic Planning: reviewing service provision	
Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and	Vulnerable and target populations clearly identified; public health recommendations on commissioning to meet health needs and address inequalities

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utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the equality duty	
Support to clinical commissioning groups on interpreting and understanding data on clinical variation in both primary and secondary care. Includes public health support to discussions with primary and secondary care clinicians if requested	Public health recommendations on reducing inappropriate variation
Public health support and advise to clinical commissioning groups on appropriate service review methodology	Public health advice as appropriate
Strategic Planning: deciding priorities	
Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence base for the setting of priorities	Review of programme budget data Review of local spend/outcome profile
Advising clinical commissioning groups on prioritisation processes – governance and best practice	Agreed clinical commissioning group prioritisation process
Work with clinical commissioners to identify areas for disinvestment and enable the relative value of competing demands to be assured	Clear outcomes from clinical commissioning group prioritisation
Critically appraising the evidence to support development of clinical prioritisation policies for populations and individuals	Clinical prioritisation policies based on appraised evidence
Horizon scanning: identify likely impact of new National Institute for Health and Clinical Excellence guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	Public health advise to clinical commissioners on likely impacts of new technologies and innovations
Procuring Services: designing shape and structure of supply	
Providing public health advice on the effectiveness of interventions , including clinical and cost-effectiveness (for both commissioning and de-commissioning)	Public health advice on focusing commissioning on effective/cost-effective services
Providing public health specialist advice	

Appendix 1: Public Health responsibilities and functions

on appropriate service review methodology	
Providing public health specialist advice to the medicines management function of the clinical commissioning group	Public health advice to medicines management, for example ensuring appropriate prescribing policies.
Procuring Services: planning capacity and managing demand	
Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes	Public health advice on development of care pathways/specifications/quality indicators
Public health advice on modelling the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	Public health advice on relevant aspects of modelling/capacity planning
Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views	
Public health advice on design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance	Clear monitoring and evaluation framework for new intervention/service public health recommendations to improve quality, outcomes and best use of resource
Working clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes	
Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out health equity audits and to advise on health impact assessments	Health equity audits Public health advice on health impact assessments and meeting the public sector equality duty
Interpreting service data outputs, including clinical outputs	Public health advice on use of service data outputs

ROTHERHAM PUBLIC HEALTH TRANSITION PLAN

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ROTHERHAM PUBLIC HEALTH TRANSITION PLAN

RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
	WORKSTREAM 1: MODEL						
G	John Radford/ Matt Gladstone	1.1 Agree statement of scope/function for Public Health in Rotherham for Transition Phase to April 2013	Feb-12	Paper for NHSR OE, Cluster Board and SLT/Cabinet to be produced	Martin Kimber	Requires agreement to be reached on high level staffing structure. Discussions are continuing.	PH budget may be less than anticipated.
G		1.2 Agree statement of scope/function for Public Health in Rotherham from April 2013 as an RMBC service	Apr-13	To follow on from transition discussions.	Martin Kimber	Need to dovetail together structure/functions of PH and existing RMBC services.	RMBC finance pressures. Potential impact on achievement of public health outcomes.
G		1.3 Design of new Public Health staff structures in RMBC to support transition function.	Apr-12	In progress.	Staff consultation and HR leads.	Maintaining staff morale and focus on outcomes during transition.	PH budget may be less than anticipated. Alignment of structure and function needed.
G		1.4 Director of Public Health accountability arrangements.	April-12	Regular priority setting meetings with RMBC CE. Regular Cluster Meetings with Cluster CE.	Maintain and develop further schemes of delegation.	None.	Non alignment of priorities
G		1.5 Director of Public Health accountability arrangements.	Apr-13	In progress.	Appointment arrangements.	DPH accountable to Chief Executive at the moment, needs formal agreement.	Agreement of accountability arrangements between partners.
G		1.6 Cabinet Members briefed.	Ongoing	Cabinet lead(s) briefed on a regular basis	Continue.	Complex system and new arrangements in constant flux.	Meet development needs of Councillors in understanding system.
G		1.7 Discussion with other internal and external stakeholders.	Ongoing	Consultation with CCG, and LSP members.	Joanna Saunders to take forward.	Need to secure a date.	Developing understanding and ownership of public health issues.

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RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
G		1.8 Agree work programme for PH with Cabinet.	Ongoing	Paper written for Cabinet detailing statutory responsibilities and transition plan.	John Radford to take forward.	None foreseen.	Developing understanding and ownership of public health issues.
G		1.9 Lead DPH for Emergency Planning	Ongoing	Agreed DPH Sheffield.	Awaiting further national guidance.	None.	Awaiting further national guidance.
A		1.10 Arrangements for emergency preparedness included in design of new system.	To be confirmed – national guidance expected shortly.	PH responsibilities incorporated into JD of replacement for head of combined Rotherham/Sheffield LA EP team.	Awaiting national guidance.	Need clarity about the role of PHE, and exact nature of PH EP responsibilities within the LA.	PHE operating framework may be delayed or insufficiently detailed.
G		1.11 Restructure Public Health Directorate to deliver running cost savings and in preparation for transfer to RMBC.	Ongoing	Running cost savings released. NHSR VR scheme 3rd round initiated.	VR submissions.	Cluster-led VR scheme.	PH budget still unknown. Need to maintain sufficient skills and capacity to deliver outcomes.
A		1.12 Deliver agreed efficiency and cost savings for 2012/13.	Apr-12	In progress.	Progress monitored.	Cluster-led cost saving requirement.	Need to maintain sufficient skills and capacity to deliver outcomes.
A		1.13 Review existing Directorate to identify functions that will transfer to RMBC, those that will go to CCGs/CSU/PHE, those that will go to external providers.	Ongoing	Largely done, though to be finalised as part of 'alignment' exercise within NHSR. Final responsibility is not clear for some staff.	Some more work needed on (small number of) posts/ functions that may transfer to external providers.	Has implications, in some cases significant, for some individuals in post. Will require significant HR input and careful management of personnel issues.	Mismatch between alignment and budgets.

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RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
A		1.14 Ensure all staff are properly supported to continue to do their jobs properly, and offer appropriate training for future roles.	Ongoing	Transition interviews to be completed by the end of January 2012.	Support within NHSR continues, through regular staff briefings.	Need to retain staff and maintain motivation.	Continuing lack of certainty about details, especially with regard to HR issues.
	WORKSTREAM 2: HEALTH AND WELLBEING BOARD						
G	RMBC CE	2.1 Health and Wellbeing Cabinet member appointed	Sept-11	Health and Wellbeing Board is meeting regularly.	Develop Health Watch representation on the Board.	Awaiting national guidance on Health Watch.	National funding for Health Watch undetermined.
G	Members of Health and Wellbeing Board	2.2 Agreed work programme for Board.	Jan-12	Agreed by Board 18-01-12.	Implementation	None.	None implementation.
G		2.3 Joint Strategic Needs Assessment and Health and Wellbeing Strategy	Jan-12	Part of work programme agreed by Board 18-01-12.	Revision of JSNA	Alignment of JSNA and prioritisation of 11 most deprived areas in Rotherham.	Matching local priorities with outcomes frameworks.
	WORKSTREAM 3: HUMAN RESOURCES						
A*	Peter Smith/ Phil Howe/ Cluster (Debbie Hillditch)	3.1 Work through HR implications of design of new Public Health function within RMBC, including TUPE arrangements, line management arrangements, specialist register status etc in line with PH HR Concordat.	Ongoing	Initial bilateral HR discussion January 2012, awaiting further national guidance.	To schedule a meeting to discuss the recently updated training needs analysis for PH, and any actions necessary to support this.	Need to clarify funding stream for professional development (Masters level linked to 'learning beyond registration') - agreed national issue to be picked up at regional level in the first instance - any risks associated with transfer to be highlighted.	* Terms of transfer determine RAG status - need further clarity. Non-compliance with PH Human Resources Concordat.

Appendix 2: Public Health Transition Plan

RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
G		3.2 Formal consultation with staff and unions (both within NHSR and RMBC) relating to transfer arrangements	Ongoing	Work already commenced.	Awaiting publication of further guidance nationally but informal consultation on-going.	Awaiting further details from national guidance.	Delayed publication of national guidance. Disagreement with unions may delay process.
A		3.3 Relocation to Riverside House	TBC - Dependent on negotiation of release from Oak House	Formal consultation with staff.	Agree terms of transfer between Cluster and RMBC.	Staff concerns about new building and arrangements.	3 months notice needed for staff consultation of move could delay process.
A		3.4 Implement employment transfers, including formal consultation period on TUPE transfers as required.	TBC	Not able to progress until further guidance received.	Awaiting national guidance.	Awaiting further details from national guidance.	Delayed publication of national guidance. Disagreement with unions may delay process.
A*		3.5 Induction process for staff moving from NHSR to RMBC.	TBC	To be agreed – including Riverside induction.	Timescales for relocation to be confirmed.	Disagreement with unions may delay process.	* Transfer time will dictate timescales
G		3.6 Ensure staff are kept well informed, including communication with RMBC staff and members.	Ongoing	Communications plan to be drafted by Alison Iliff in partnership with Tracy Holmes.	Begin communication plan with RMBC staff.	Awareness of RMBC staff around new roles and responsibilities being transferred.	RMBC staff concerns related to RMBC finance arrangements whilst undergoing transfer.

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RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
G	Phil Howe/ John Radford	**3.7 Induction:** Induction timetable and programme to be agreed including Worksmart.	Ongoing	Discussion held at PH all staff meetings.	Programme to be agreed.	Programme to be developed for Council staff (i.e. what you can do for Public Health).	Capacity for induction programme whilst focussed on achieving outcomes.
	WORKSTREAM 4: FINANCE						
A	John Doherty and Andrew Bedford	4.1 Clarify NHSR expenditure on different identified elements of Public Health as per the funding consultation document.	Feb-12	Revised DH submission was sent in September 2011. The information was shared between NHSR and RMBC SLT. Awaiting national formula.	More work and discussion is to take place around the apportionment of overheads.	Link in with the Corporate workstream to gain an understanding of Public Health IT systems and running costs etc.	Inconsistencies on a national level may have a knock on effect in terms of delay to Shadow Budgets for April 2012.
A		4.2 Clarify likely amount of ring fenced Public Health budget to come through Public Health England.	TBC 2012	As above. The re-submission was intended to eliminate any variances nationally. We are now waiting for feedback from the DH.	Awaiting further guidance from the DH.	Delay in publication of national guidance is hindering planning process.	If the DH uses a percentage of recurrent resource limit to allocate resources to LA's rather than agreed value.
A		4.3 Consider mechanisms for shadow management of Public Health funds directly from NHSR to RMBC prior to establishment of 'ring fenced' budget above.	Apr to Oct-12	Await national guidance following re-submission exercise.	Await national guidance following re-submission exercise.	Potential tension between Cluster and RMBC due to misalignment between legal and functional responsibilities during shadow period.	Further delay in the passing of the Bill. Slippage in the allocation of shadow budgets and the final list of services to transfer to LA's.

Appendix 2: Public Health Transition Plan

RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
	WORKSTREAM 5: CORPORATE						
A	Richard Waller/ John Radford / Cluster (Andy Buck)/ John Doherty	**5.1 Legal Services**: Including scope of service, legal documentation to transfer, resources (staff/budgets).	Ongoing	Awaiting further clarity from national guidance.	Establish Project Group Terms of Reference to be agreed	Need clarity of expected national 'People Transitions' paper in respect of associated support personnel and if they are part of the transfer.	A lack of national guidance may hinder process clarity.
A		**5.2 Procurement/Contract Management**: Including scope of service, current contract register and contract documentation, current spend analysis, procurement forward plans, resources (staff /budgets)	Ongoing	Contract stock-take being undertaken.	Develop new Operating Model for service delivery through RMBC.	Need new Operating Model within RMBC to finalise new service delivery arrangements.	Services may need to be 'seen' as NHS service by the public. Procurement systems may not be aligned.
A		**5.3 Estates & Facilities**: Including any potential property transferring, scope of service, resources (staff & budgets), accommodation requirements	Ongoing	Current 'weeding' of paperwork ongoing.	Worksmart arrangements to be led by RMBC.	Need storage capacity for legal document storage. Current storage available for public publications / leaflets etc.	Risk of lack of storage capacity for legal document storage or time for electronic storage of current paperwork.
A		**5.4 ICT**: to be discussed as part of Riverside transfer.	Ongoing	Data-sharing agreement being reviewed.	Data-sharing review led by John Radford.	Need to ensure access to NHS and patient data as RMBC staff. Need for emergency phone systems to remain in use.	Different legal status and systems may hinder current access to data.

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RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
		5.4a Documents and records management (Nagpal Hoysal)	Ongoing	Draft records management top tips issued to PH staff. Training provided by RMBC to 4 members of PH staff.	Identify PH records currently held on PCT systems and plan for transfer to RMBC systems. Develop file plan and security model.	Need to implement electronic documents and records management. Some teams maintain bespoke databases on the PCT 'MyPortal.'	Loss of Public Health corporate knowledge.
A		**5.5 Governance**: Including governance links with Health & Wellbeing Board.	Ongoing	Health and Wellbeing Board established.	Governance arrangements to be clarified.	Public Health accountabilities shared between RMBC, H&WB Board, PHE.	Lack of clarity or mismatch in priorities of accountable organisations.
A		**5.6 Communication Services**: Includes providing specialist support in terms of producing, specifying etc, communications programmes using a range of external channels and promotional documentation.	Ongoing	Discussions taken place between RMBC Communications team and NHSR Comms and CMS.	Continue discussions.	Not transfer of all Comms capacity to RMBC therefore requirement to use existing RMBC Comms team.	Public Health requires specialist comms skills around supporting behaviour change.
A		**5.7 Complaints Handling**: Includes the provision of a corporate external complaints handling and reporting service/ system.	Ongoing	To be initiated.	Agreement needed on complaints system and process during and post-transition.	New service provision commissioned through PH transferred into RMBC, therefore subject to complaints process.	Stakeholders need to be clear on new complaints processes.

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RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
	WORKSTREAM 6: PUBLIC HEALTH INTELLIGENCE						
A	John Radford/ Robin Carlisle	6.1 Full description of current delivery model (including budget/resources schedule).	Ongoing	Member of staff identified for transfer into PH.	Incorporation into PH staff structure for transition.	Further PH Financial Return has clarified some of the budget issues but need further clarity on what is/isn't included in support costs.	Underestimate the level of resource/nature of dependencies - working with Finance and IT colleagues to mitigate.
A		6.2 Arrangements for access to NHS data.	Ongoing	More national guidance may be produced to support this.	SLA to be agreed.	Legal and access implications mean this may be complex process.	Hindered access to NHs data will impact on ability to deliver service and outcomes.
	WORKSTREAM 7: MANDATORY COMMISSIONING ARRANGEMENTS						
G	Nagpal Hoysal/ David Tooth/ Andy Buck	**7.1 RMBC Public Health Offer to Rotherham CCG / SY Cluster/ CSU**	Apr to Oct-12	Full description of model of public health advice to NHS Commissioners.	SLAs in place.	Will need to include the cooperation arrangement that will be in place to enable PH to provide advice to commissioners.	Agreement over details of provision arrangements.
G	Jo Abbott	**7.2 Appropriate access to sexual health services**	Ongoing	SLA developed for CASH and GUM services. CASH/GUM services redesigned to be more responsive to public needs.	Awaiting national guidance on Sexual Health Strategy.	Awaiting national guidance on Sexual Health Strategy.	Clarification over budget to be transferred for all sexual health services (acute, primary care, community, and voluntary e.g. SHIELD) Clarification over who is to commission LES e.g. Chlamydia /LARC.

Appendix 2: Public Health Transition Plan

RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
G	Kathy Wakefield	**7.3 Plans in place to protect the health of the population (including infection control and prevention)**	Ongoing	Comprehensive outbreak control plans in place agreed with RMBC. Joint surveillance with HPA. Out of hours rota fully operational. HAI control plans in place at Rotherham Hospital.	Continue.	Linking emergency response between local and Cluster-led provision.	Continuing system required to work during transition phase.
G	Joanna Saunders / Carol Weir	**7.4 National Child Measurement Programme**	Ongoing	Programme delivered by School Nursing Service as part of existing contract. Specified within the SLA.	Unclear whether SN service will move out of NHS commissioning, therefore need to monitor as SLA or service is reviewed.	No funding identified within the SN contract or PH budgets.	If NCMP is taken out of SN contract and PH expected to fund – there is no identified funding.
A	Jo Abbott	**7.5 NHS Health Check assessment**	Oct-12	Existing programme funding secure until October 2012. Transition plan in progress towards meeting national targets.	Continue.	The Rotherham programme is well established with good uptake. It is anticipated the national programme will commence 2012/13.	Future funding of the programme. Despite plans for it to become a National programme, it will be funded locally.
	WORKSTREAM 8: KEY DISCRETIONARY PROGRAMMES						
G	Nagpal Hoysal	**8.1 Screening programmes**	Ongoing	National programme for transition of responsibility for screening programmes to PHE. 2012/13 commissioning intentions for programmes published, currently being implemented locally.	Continue.	Some of the commissioning intentions are un-funded.	Need to ensure safe and secure operation during transition year. Continued uncertainty over destination of staff currently responsible for screening programmes.

Appendix 2: Public Health Transition Plan

RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
G	Kathy Wakefield	**8.2 Immunisation programmes**	Ongoing	Vaccination and Immunisation steering group, SY Immunisation group and designated member of staff to support vaccination programme oversight and performance management.	Continue.	Communication to stakeholders of transition to ensure awareness of responsibilities within RMBC.	Patient information systems required.
A	Anne Charles-worth	**8.3 Drug Services**	Year end position , and quarterly	Improve performance on treatment exits.	Improvement in last quarter.	High levels of long term methadone maintenance patients and low social capital make full recovery a challenge.	20% minimum of budget performance related. Budget reductions still to take full effect.
A	Anne Charles-worth	**8.4 Alcohol Prevention and Services**	Aug-11	Complete national PBR pilot.	On target.	Begin analysis of data.	That tariff makes clear lack of adequate investment in this area.
A	Alison Iliff	**8.5 Tobacco Control**	Mar-13	South Yorkshire PBMA work to determine best spread of commissioned activity to deliver prevalence reduction underway and due to report by Sept 2012.	Continue PBMA work. Review service spec for stop smoking services for 2012/2013.	SY work may suggest joint commissioning of some services across region. Clarity on medicines budget and what does/does not get transferred.	Focus on quitters not reducing prevalence but national targets remain 4-week quits. This leads to increasing medication bills that could easily overspend.
A	John Radford	8.6 Secure arrangements for delivery of Rotherham Occupational Health Service (ROHAS) and Health Trainer programme.	Oct-12	Core funding for ROHAS agreed. Health Trainer programme funding agreed until Oct-12.	Allocation of funding from public health grant or CCG.	Provider service.	Funding.

Appendix 2: Public Health Transition Plan

RAG	Leads	Deliverables	Timescale	Progress	Next key Steps	Issues	Risks
	WORKSTREAM 9: PUBLIC HEALTH FUNCTIONS AND COMMISSIONING ARRANGEMENTS MIGRATING TO NCB AND PHE						
G	Andy Buck	9.1 Commissioning functions transferred.	Apr-13	DPH regular meetings with Cluster CE.	Identification of funding streams as part of finance and contract reviews.	Complex disentanglement of contracts according to new accountability arrangements.	Maintain service during transition.
	WORKSTREAM 10: PERFORMANCE MANAGEMENT						
A	John Radford	**10.1 Public Health Outcome Indicators:** Oversight of performance	Ongoing	JSNA and data repository system to be established to monitor performance.	Develop profiles in line with PH outcomes.	Data transfer between different organisations to be negotiated.	Capacity pressures on RMBC research team or new responsibilities.

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

MEMORANDUM OF UNDERSTANDING

THE PROVISION OF PUBLIC HEALTH ADVICE TO NHS COMMISSIONING IN ROTHERHAM

1. Parties to the agreement:

Rotherham Metropolitan Borough Council ("the Council")	NHS Rotherham Clinical Commissioning Group ("the CCG") NHS South Yorkshire and Bassetlaw ("the Cluster/NCB") collectively known as "the NHS Commissioners"

2. Date of agreement:
3. Term of agreement:
    a. The agreement will commence from 1 April 2012
    b. The agreement is indefinite; however, the agreement will be subject to annual review.
    c. The agreement will be reviewed in March 2013.
    d. The parties will honour agreed commitments either via the accepted arrangements or suitable alternatives negotiated at that point.
4. Acknowledgements:
    a. With thanks to NHS Doncaster, NHS Nottingham and NHS Nottingham City, NHS Worcestershire, NHS Lincolnshire and NHS Bradford and Airedale public health directorates who developed previous versions of this document.
5. Compensation details:
    a. Subject to the passage of the Health and Social Care Bill, Local Authorities will be mandated to provide Public Health advice to NHS Commissioners.
    b. The costs associated with the responsibilities of the Council for providing public health advice will be borne fully by the Council from the Department of Health, Public Health grant at no cost to rate payers in Rotherham.
    c. The costs associated with the responsibilities of the NHS Commissioners for cooperation will be borne fully by the NHS Commissioners.

d. Any support to NHS Commissioners outside the scope of this MoU (such as commissioning support) will be subject to separate negotiation and agreement.

6. This Memorandum of Understanding establishes a framework for the provision of Public Health advice to NHS commissioners (the CCG and the Cluster/NCB) in relation to the population resident within the boundaries of the borough of Rotherham. The framework sets out the responsibilities of all that are party to this agreement and the expected level of service.
7. The aim of this agreement is to facilitate the efficient and effective commissioning of NHS, PHE and Council services within Rotherham in order to improve and maintain the health and well-being of people living within the borough and hence deliver the Public Health, NHS and Social Care outcomes frameworks.
8. Responsibilities of the Council:
    a. The overall responsibility for the provision of advice rests with the Director of Public Health.
    b. The Council will ensure that an appropriately skilled, qualified, experienced and credible specialist public health workforce (Advisors) will be maintained and supported to allow delivery of the technical and leadership skills required of the function. This will include:
        i. The entire specialist staff will be subject to all existing NHS clinical governance rules, including those for continued professional development
        ii. The entire specialist staff will, as necessary, contribute to the developing Commissioning Support arrangements and link geographically to support functions at different population levels which may be wider than a local CCG / LA base, including working with PHE and the NHS CB as required as part of the overall support function for the CCG and health community
        iii. Public health consultants within the specialist workforce will be appointed according to AAC rules including a rigorous assessment centre process for all candidates to run in parallel and inform that process. In addition, they will be required to be on the GMC Specialist Register/GDC Specialist List/UK Voluntary Register (UKPHR) for Public Health Specialists.

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

c. The Council will provide the NHS Commissioners with contact details for the Advisors and their sub-specialist lead areas.

d. The Council agrees to provide and/or facilitate access to public health data sets aggregated by Lower Layer SOA, GP Practice and/or borough.

e. The Council will ensure that the Advisors have freedom to provide impartial and professional advice and recommendations to NHS Commissioners based on the available evidence and in good faith.

f. Some public health tasks are delivered most effectively and efficiently at larger geographical level than one CCG e.g. screening or emergency planning, and as such will be delivered by teams that may work across existing boundaries. Public Health will deliver the following for the CCG

   i. Coordination of Health Protection planning and response,
   ii. Implementation of Health Improvement initiatives, and
   iii. Healthcare public health encompassing provision of Public Health intelligence, rigorous framework for clinical effectiveness, and sustainable approach to prioritisation

g. The Council will provide advice within the scope of the core offer from Public Health to the NHS Commissioners detailed in Appendix 1.

h. The Council will provide Public Health advice whenever it has been reasonably sought and accepted except where there is mutual agreement with the NHS Commissioners that it is not required.

i. Acceptance of requests for advice, prioritisation and timelines for completion of work will normally be left to the discretion of Advisors to negotiate; where there is a dispute, the Director of Public Health will retain the overriding responsibility and right to prioritise the workload of Advisors and decide whether advice is required for a particular issue.

9. Responsibilities of the NHS Commissioners:

a. The NHS Commissioners agree to cooperate with the Council so that it can be provided with effective public health advice as detailed in the core offer from NHS Commissioners to Public Health at Appendix 2.

b. The NHS Commissioners will provide and/or facilitate access to intelligence and capacity to the analysis of health related data sets such as (but not restricted to) that from SUS, QOF, PbR, local surveys, performance data and data held on GP systems aggregated by Lower Layer SOA, GP Practice,

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

Secondary/Tertiary care and Mental Health service providers and/or NHS Commissioners (as appropriate).

c. NHS Commissioners will obtain Public Health advice in relation to any commissioning, redesign or decommissioning decisions it intends to make.
d. NHS Commissioners will obtain Public Health advice on an ongoing basis in the management of existing services.
e. The level and quantum of Public Health advice will be determined through negotiation subject to paragraph 8.i above.
f. For issues where Public Health advice has been sought, the NHS Commissioners agree to engage with the Advisors in an open and transparent manner so that the advice received is impartial.
g. The NHS Commissioners agree to uphold the rights of the Advisor in relation to the protection of whistleblowers as if the Advisor was their own employee.

10. Administrative arrangements:

a. Public Health advice to NHS Commissioners will normally be available Monday – Friday, 0900 – 1700.
b. Out of hours provision will normally provide response to public health emergencies only.

Mr Martin Kimber Chief Executive RMBC	Mr Chris Edwards Chief Operating Officer NHS Rotherham	Mr Andy Buck Chief Executive NHS South Yorkshire and Bassetlaw

Dr John Radford Director of Public Health RMBC/NHS Rotherham	Dr David Tooth Chair of the CCG NHS Rotherham

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

Abbreviations in use within this document:

SUS – Secondary Uses Service

QOF – Quality and Outcomes Framework

PbR – Payment by Results

SOA – Super Output Area

CCG – Clinical Commissioning Group

NCB – NHS Commissioning Board

NHS – National Health Service

PHE – Public Health England

AAC – Appointments Advisory Committee

LA – Local Authority

GMC – General Medical Council

GDC – General Dental Council

UKPHR – United Kingdom Public Health Register

GP – General Practice

JSNA – Joint Strategic Needs Assessment

Appendix 1 – the Core Offer from Public Health to NHS Commissioners

1. Health improvement
    a. Refresh delivery and lead role in current health improvement strategies and action plans to improve health and reduce health inequalities, with input from the CCG
    b. Maintain and refresh as necessary metrics to allow the progress and outcomes of 'preventive' measures to be monitored, particularly as they relate to delivery of key NHS and LA strategies
    c. Support primary care with health improvement tasks appropriate to its provider healthcare responsibilities - for example by offering training opportunities for staff, targeted behaviour health change programmes and services
    d. Lead health improvement partnership working between the CCG, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

e. Embed public health work programmes around improving lifestyles into frontline services towards improving outcomes and reducing demand on treatment services

2. Health Protection
    a. Lead on and ensure that local strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, major incidents and provide assurance to PHE regarding the arrangements
    b. Ensure that these plans are adequately tested
    c. Ensure that the CCG has access to these plans and an opportunity to be involved in any exercises
    d. Ensure that any preparation required – for example training, access to resources - has been completed
    e. Ensure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements
    f. Ensure adequate advice is available to the clinical community via Public Health England and any other necessary route on health protection and infection control issues
3. Strategic planning: assessing needs
    a. Supporting clinical commissioning groups to make inputs to the joint strategic needs assessment and to use it in their commissioning plans
        i. Developing a JSNA and Health and Well-being Strategy
    b. Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with the clinical commissioning groups and local authorities
        i. Support the compilation, assimilation and synthesis of multiple sources of knowledge in order to translate knowledge into action
        ii. Local knowledge of health inequalities, their drivers and effective interventions
    c. Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality
    d. Health needs assessments for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

4. Strategic planning: reviewing service provision
    a. Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered by the equality duty
    b. Support to clinical commissioning groups on interpreting and understanding data on clinical variation in both primary and secondary care. Includes public health support to discussions with primary and secondary care clinicians if requested
    c. Public health support and advice to clinical commissioning groups on appropriate service review methodology
5. Strategic planning: deciding priorities
    a. Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence base for the setting of priorities
    b. Advising clinical commissioning groups on prioritisation processes – governance and best practice
    c. Work with clinical commissioners to identify areas for disinvestment and enable the relative value of competing demands to be assessed
    d. Critically appraising the evidence to support development of clinical prioritisation policies for populations and individuals
    e. Horizon scanning: identifying likely impact of new National Institute for Health and Clinical Excellence guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation
6. Procuring services: designing shape and structure of supply
    a. Providing public health specialist advice on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning)
    b. Providing public health specialist advice on appropriate service review methodology
    c. Providing public health specialist advice to the medicines management function of the clinical commissioning group
7. Procuring services: planning capacity and managing demand

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

a. Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes
b. Public health advice on modelling the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs

8. Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views
    a. Public health advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance
    b. Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes:
        i. Leadership and advice on the management of Quality within contracted healthcare services including chairing/participating in routine contract quality meetings.
        ii.
    c. Providing the necessary skills and knowledge, and population relevant health service intelligence to carry out health equity audits and to advise on health impact assessments
    d. Interpreting service data outputs, including clinical outputs.

Appendix 2 – the Core Offer from NHS Commissioners to Public Health

1. Health Improvement:
    a. Contribute to strategies and action plans to improve health and reduce health inequalities
    b. Ensure that constituent practices maximise their contribution to disease prevention – for example by taking every opportunity to address smoking, alcohol, and obesity in their patients and by optimising management of long term conditions
        i. Ensure primary and secondary prevention is incorporated within commissioning practice

Appendix 3: Memorandum of Understanding – The provision of Public Health advice to commissioning in Rotherham.

ii. Commission to reduce health inequalities and inequity of access to services

iii. Support and contribute to locally driven public health campaigns

2. Health protection:
    a. Contribute to and support the borough health protection plan
    b. Familiarise themselves with strategic plans for responding to emergencies
    c. Participate in exercises when requested to do so
    d. Ensure that provider contracts include appropriate business continuity arrangements
    e. Ensure that constituent practices have business continuity plans in place to cover action in the event of the most likely emergencies
    f. Ensure that providers have and test business continuity plans and emergency response plans covering a range of contingencies
    g. Assist with co-ordination of the response to emergencies, through local command and control arrangements
    h. Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and through action by constituent practices
3. Healthcare public health
    a. Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.
    b. The CCG to publish its commissioning intentions in line with PH priorities including the areas outlined in Healthy Lives Healthy People Update and way forward (DH 2011)
    c. Utilise specialist public health skills to target services at greatest population need and towards a reduction of health inequalities
    d. Contribute intelligence and capacity to the production of the JSNA

Appendix 4: Public Health Outcomes Framework – Overview of outcomes and indicators

Public Health Outcomes Framework – Overview of Outcomes and Indicators

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Department of Health

The new public health system: summary

What we are trying to achieve

We face significant challenges to the public's health and wellbeing. Rising levels of obesity, misuse of drugs and alcohol, high levels of sexually transmitted infections and continuing threats from infectious disease have a heavy cost in health, life expectancy and a large economic burden through costs to the NHS and lost productivity. Improving public health and wellbeing and developing sustainable services will be a key contribution to meeting the challenges to the public finances.

The Government has an ambitious programme to improve public health through strengthening local action, supporting self-esteem and behavioural changes, promoting healthy choices and changing the environment to support healthier lives. This document provides an overview of these changes and links to more detailed material to support implementation of the reforms.

In summary the reforms will see:

- local authorities taking the lead for improving health and coordinating local efforts to protect the public's health and wellbeing, and ensuring health services effectively promote population health. Local political leadership will be central to making this work
- a new executive agency, Public Health England will:
  - deliver services (health protection, public health information and intelligence, and services for the public through social marketing and behavioural insight activities)
  - lead for public health (by encouraging transparency and accountability, building the evidence base, building relationships promoting public health)
  - support the development of the specialist and wider public health workforce (appointing Directors of Public Health with local authorities, supporting excellence in public health practice and bringing together the wider range of public health professionals)
- the NHS will continue to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts
- the Government's Chief Medical Officer will continue to provide independent advice to the Secretary of State for Health and the Government on the population's health
- within Government, the Department of Health will set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities.

The focus will be on outcomes. A new Public Health Outcomes Framework will set out key indicators of public health from the wider determinants of health through to effectiveness in reducing premature mortality. Our overall goals will be to increase healthy life expectancy and reduce health inequalities.

The Public Health Outcomes Framework will be published in January 2012 and will be aligned with the NHS Outcomes Framework and the Adult Social Care Outcomes Framework.

Local responsibilities

Local authorities will have a new duty to promote the health of their population. They will also take on key functions in ensuring that robust plans are in place to protect the local population and in providing public health advice to NHS commissioners.

Through the health and wellbeing board they will lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public's health and wellbeing.

Giving local authorities this key role allows action to build on local knowledge and experience and aligns public health responsibility with many of the levers to tackle the wider determinants of health and health inequalities.

To enable them to deliver these new public health functions local authorities will employ Directors of Public Health, who will occupy key leadership positions within the local authority.

The appointment process will be run jointly with Public Health England (on behalf of the Secretary of State for Health) to ensure that the best possible people are appointed to these key positions. Many local authorities have already made joint Director of Public Health appointments, and others are moving to take delegated responsibility for public health teams ahead of the statutory transfer of responsibility. We continue to encourage such action.

Real improvement will be secured by local authorities putting the public's health into their policies and decisions. However, they will also have responsibilities for commissioning specific public health services and will be supported with a ring-fenced public health grant.

While local authorities will be largely free to determine their own priorities and services, they will be required to provide a small number of mandatory services (sexual health services, NHS health checks, National Child Measurement Programme, providing public health advice to NHS Commissioners and ensuring plans are in place to protect the health of the public).

A ring-fenced public health grant will support local authorities in carrying out their new public health functions. We will make shadow allocations to local authorities for 2012/13 to help them prepare for taking on formal responsibility in 2013/14.

Shadow allocations for local authorities in 2012/13 will be published to support planning for the transition.

How does Public Health England fit in?

Public Health England will be created as a new integrated public health service. It will bring together the national health protection service and nationwide expertise across all three domains of public health. We are setting out the mission and values we expect Public Health England to deliver. Public Health England will be an advocate

for public health – its actions will be based on the highest professional and scientific standards and it will promote a culture of subsidiarity, focused on supporting local action, with national action only where it adds value.

Public Health England will have three key business functions:
1. It will deliver services to protect the public's health through a nationwide integrated health protection service, provide information and intelligence to support local public health services, and support the public in making healthier choices.
2. It will provide leadership to the public health delivery system, promoting transparency and accountability by publishing outcomes, building the evidence base, managing relationships with key partners, and supporting national and international policy and scientific development.
3. It will support the development of the public health workforce, jointly appointing local authority Directors of Public Health, supporting excellence in public health practice and providing a national voice for the profession.

Public Health England will bring together the wide range of public health specialists and bodies into one integrated public health service. Its organisational design will feature:
- a national office including national centres of expertise and hubs that work with the four sectors of the NHS commissioning board
- units that act in support of local authorities in their area
- a distributed network that allows Public Health England to benefit from locating its information and intelligence and quality assurance expertise alongside NHS and academic partners across the country.

Public Health England will be an executive agency of the Department of Health. It will have its own Chief Executive who will have operational independence.

Public Health England will have non-executive directors on its advisory board. The non-executives will support the Chief Executive in his/her role as accounting officer and provide an independent challenge. The Chief Medical Officer will provide independent advice to the Secretary of State for Health on the population's health and on the public health system as a whole, including Public Health England's role within it.

Public Health England's status will depend on its ability to provide high-quality, impartial, scientific and professional advice. To demonstrate its commitment to transparency and the highest professional standards, Public Health England will proactively publish its expert scientific and public health advice on relevant issues, and its advice to professionals and the public.

The NHS still has a role in public health

The NHS will continue to play a key role in improving and protecting the public's health. The provision of health services and ensuring fair access to those services will contribute to improving health and reducing inequalities.

The NHS will also continue to commission specific public health services and will seek to maximise the impact of the NHS in improving the health of the public, making every clinical contact count.

The NHS Future Forum is currently

considering how the NHS can contribute to improving the health of the public. Its interim findings have been published and are available.

The public health workforce

The success of the public health system will depend on harnessing the skills and energies of public health staff and on those staff building the effective relationships needed to make public health part of everyone's core business.

There is a diverse public health workforce, working for a wide range of employers. In managing the transition to the new system we need to ensure all staff are treated fairly and have access to the exciting opportunities to shape a 21st century public health service.

We are working closely with staff representatives and local government to ensure fair and transparent processes, and appropriate terms and conditions. We have published a Human Resources Concordat setting out key principles and will follow this with Local Government Transition Guidance and an initial People Transition Policy for Public Health England. The final People Transition Policy will follow formal agreement to the new terms and conditions.

Maintaining a vibrant professional public health workforce into the future will underpin the success of the reforms. The workforce strategy will be key to this and will be subject to specific consultation from January 2012.

Making it happen

Subject to the passage of the Health and Social Care Bill, these statutory changes will take place from 1 April 2013. Yet there is much that can be done to implement the reforms through local agreement before April 2013. We encourage all partners to engage actively in delivering the new systems and new ways of working in 2012/13.

There are a number of key milestones for the transition including:

- completion of transition plans for transfer of public health to local authorities – March 2012
- Public Health England's Chief Executive appointed – April 2012
- Public Health England structure agreed – May 2012
- pre-appointment processes complete – October 2012
- formal transfers of statutory responsibilities – 1 April 2013.

We will continue to develop our plans for the public health system in collaboration with our stakeholders and details will be published accordingly.

Stay in contact with our progress in establishing the new system at http://healthandcare.dh.gov.uk/category/public-health

DH Department of Health

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Rotherham
Clinical Commissioning Group

Executive Summary

Your Life, Your Health

Single Integrated Plan 2012

19 03 12

Message from the Chair

Welcome to Rotherham CCG's first Single Integrated Plan which sets out our three year plan for the commissioning of health services for the people of Rotherham. The plan is based on significant dialogue with local people and representative groups, and detailed discussions with our partners and local service providers. It is consistent with the priorities of the Rotherham Health and Wellbeing Board and NHS South Yorkshire and Bassetlaw.

A key driver for change is our ageing population and the numbers of people with chronic medical conditions. We need to redirect our focus from the current emphasis on acute and episodic care in hospitals towards prevention, self-care and proactive management in the community using all the resources across the health and social care community. Central to this transformation is giving local people the information and support they need to make the right choices for their own wellbeing – this is about ***Your Life, and Your Health***.

We will focus on improvements in primary and community care, planned care, giving children the best start in life, the management of long term conditions, services for those in need of urgent care, continuing (long-term) care, the needs of those with mental health problems or learning disabilities and care at the end of life. We are introducing information systems to allow us to focus the full resources of the health and social care system upon those individuals at greatest level of need.

We know that the significant changes and improvements we are planning to deliver can only be achieved in partnership and we will continue to strengthen and develop these partnerships working across health and social care to meet the health needs of our community.

David Tooth
Chair
Rotherham CCG

John Gomersall
Vice-chair
Rotherham CCG

Chris Edwards
Chief Operating Officer
Rotherham CCG

Who are Rotherham Clinical Commissioning Group and what do they do?

Rotherham Clinical Commissioning Group (CCG) spends £338 million a year to improve the health of people in Rotherham and to provide safe, high quality health services. The CCG is responsible for commissioning community health services, hospital health services, health aspects of social and continuing care, GP prescribing and GP out of hours services that Rotherham people use.

The CCG was established in January 2011 and is led by local GPs who have day to day knowledge of the health problems that Rotherham residents face. Eight GPs lead the **Strategic Clinical Executive** which is responsible for producing clear and credible plans to improve health and health services and leading their delivery. A further eight GPs sit on the **GP Reference Group**. This is responsible for two way communication and engagement between the CCG and all 150 GPs in Rotherham. Every Rotherham General Practice is a member of the CCG. CCG decisions are made by the **CCG Committee.** This is currently accountable to the Department of Health through **NHS South Yorkshire and Bassetlaw** Board. If the current Health Bill is passed by Parliament the CCG will apply to be authorised as a statutory body before April 2013. The CCG Committee will become the **CCG Board** whose membership will include lay members, GPs, senior managers, a nurse, a hospital consultant and Rotherham's Director of Public Health.

The CCG will be supported by a small team of managers who work directly for the CCG. Further support for the CCG clinicians will be provided by **South Yorkshire and Bassetlaw Commissioning Support Services** who will also support four other CCG's in South Yorkshire.

Our Vision for Rotherham CCG

'Your Life, Your Health' - A dynamic, clinically led commissioning organisation committed to the efficient delivery of high quality care and to responding to the challenges set by the new health system. Patients and carers are at the heart of our business as we deliver safe, seamless patient-centred care, as close to patients' homes as possible. Supported by a competent and experienced management team and working in partnership with high achieving local organisations to improve the quality and experience of health care for Rotherham people.

Our Vision for improved health and health services in Rotherham

"Your Life, Your Health' – Rotherham CCG will work with partners to help deliver key priorities identified by Rotherham's Community Strategy:

- The best start in life
- Supporting the most vulnerable communities
- Supporting and sustaining the growth of the local economy

We will improve communication with the public including communicating the costs of health services and the efficiency challenges the health service faces.

We will transform the way health services are delivered, by:

- Preventing as many health problems as possible
- Helping patients to take more control over their health and the management of their health problems and supporting their carers
- Transforming the case management of 8000 people with long term conditions
- Improving the quality and efficiency of the use of diagnostic tests, medicines and referrals for specialist care
- Making sure patients with urgent needs get the right care at the right time, with better assessments and more alternatives to hospital admission. This will mean less people in hospital beds and more people being cared for in the community

Transformation is necessary if we are to continue to deliver a change for better health for the people of Rotherham now that the era of increasing NHS spending has come to an end.

CCG Values

In **everything** we do we believe in:

- Clinical leadership
- Putting people first, ensuring that patient and public views impact on the decisions we make
- Working in partnership
- Continuously improving quality of care whilst ensuring value for money
- Showing compassion, respect and dignity
- Listening and learning
- Taking responsibility and being accountable

CCG Corporate Priorities

Our **four key priorities** are:

- **Delivery** – making sure services are safe, improving outcomes and quality, ensuring vulnerable people have effective safeguarding and meeting our financial targets
- **Improving GP quality and efficiency** – achieving consistent improvements in primary care in partnership with NHS South Yorkshire and Bassetlaw
- **Commissioning for quality and efficiency** – leading system wide efficiency programmes
- **Transition** – achieving full accreditation by April 2013, ensuring safe transition of PCT responsibilities to successor organisations and developing strong relationships with existing and new agencies in Rotherham

What challenges does the health service in Rotherham face?

Rotherham is fortunate in that overall it has good quality health services but we need to overcome significant challenges to continue to improve the quality of services.

- **NHS Efficiency requirements.** Health service funding is expected to rise in line with inflation but demands on health services rise much faster than this. Nationally the NHS has to produce £20 billion of efficiency savings over the next three years to be able to continue to afford new treatments, meet the health needs of an aging population and rising public expectations. Rotherham's share of this efficiency challenge is £74.9 million. This is a dramatic change from the situation up to 2010 when the NHS was fortunate to receive year on year real increases in funding.
- **Impact of the economic downturn**. The NHS is not alone in having efficiency challenges. Partners such as Rotherham Metropolitan Borough Council, the voluntary sector and health service providers also have severe financial challenges and we will work closely with them so we understand the impacts we have on each other.
- **NHS reorganisation**. The CCG is one of several new NHS organisations being set up as part of the NHS Reforms at the same time as NHS management costs reduce by up to 50%. The overall aims of the health reform are to make the NHS more accountable to patients, reducing management costs to free up resources to invest in front line staff and to focus on clinical outcomes rather than management targets.

Our partners

As well as CCG funding the NHS spends an additional £130 million a year on health in Rotherham. This includes spending on public health which will become the responsibility of **Rotherham Metropolitan Borough Council** and on specialist services and primary health (such as GPs, dentists, pharmacist and opticians) which is the responsibility of the **NHS Commissioning Board**.

Overall health strategy in Rotherham is led by the **Health and Wellbeing Board**. This is led by **Rotherham Metropolitan Borough Council** and members include key agencies in Rotherham including the **voluntary sector**. The Health and Wellbeing Board is responsible for assessing the needs of the people of Rotherham by producing a Joint Strategic Needs Assessment and for producing Rotherham's Health and Wellbeing Strategy.

Rotherham CCG commissions health services from a wide range of providers such as The Rotherham NHS Foundation Trust (community care and hospital care), Rotherham Doncaster and South Humber NHS Foundation Trust (mental health and learning disability services), Care UK (Walk in centre, GP Out of Hours service and diagnostics), The Rotherham Hospice (end of life care services) and a range of continuing care providers. We will work with providers to improve the quality of their individual services and to make sure that all services are co-ordinated with each other and with services from GPs and RMBC.

Vision

'Your Life, Your Health'

Strategic Aims

General Practice

- Quality & efficiency visits
- Prescribing efficiency reviews in all GP practices
- 6 prescribing service redesign projects
- GP case management pilot (LTC)

In 2012/13 we will deliver £1.2m prescribing efficiency savings whilst maintaining high quality GP prescribing

Planned Care

- Better care pathways and GP-consultant communication reducing growth in hospital referrals and subsequent treatments
- Reducing outpatient follow-ups towards national average follow-up ratios
- More efficient blood tests (3.3% reduction)

In 2012/13 we will deliver £3.1m of efficiency savings by keeping elective growth to 1.1% from 2010/11 and reducing follow ups by 5.8%.

Unscheduled Care Efficiencies

- **Enhanced GP case management** of 8500 people with LTCs in practices covering 87% of the Rotherham population. Social prescribing scheme with voluntary sector giving alternatives to medical model
- **Transforming unscheduled care**. Efficient access and rapid assessments as alternatives to hospital admissions in 2012. NHS 111 & redesign of Walk in Centre, GP Out of hours and A&E in 2013.
- **Alternative to hospital admissions**. 3 enhanced community care services and intermediate care pathways
- **Care pathway reviews** starting with 5 adult and 3 children's care pathways

In 2012/13 we will deliver £4.8m efficiency savings by reducing emergency admissions by 18.2% from 2010/11 levels.

Mental Health & Learning Disabilities

- Commission for outcomes through Payment by Results (PBR)
- Improved pathways including dementia and autism and pathways for psychological therapies
- Better mental health for children and young people

In 2012/13 we will increase the proportion of people with depression receiving psychological therapies from 13% to 15%

End Of Life Care

- Improve services and choice for end of life care
- New community end of life palliative care team leading to more efficient use of hospital and hospice beds and more choice for end of life patients and carers

In 2012/13 we will increase the number of people who die in their usual own home or care home from 40% to 45%.

Quality Assurance:

37 GP visits, 7 acute hospital clinical visits & 5 mental health visits. Monthly contract assurance on patient experience, safety and outcomes. Ongoing monitoring of complaints and incidents.

Effective Partnerships:

working with partners to develop and deliver Rotherham's Health and Wellbeing Strategy and Community Strategy

Corporate Priorities

Delivery	**GP quality and efficiency**
Commissioning for quality and efficiency	**Transition**

Outcomes

NHS Outcomes Framework

Domain 1:	Preventing people from dying prematurely
Domain 2:	Enhancing quality of life for people with long term conditions
Domain 3:	Helping people to recover from episodes of ill health or following injury
Domain 4:	Ensuring that people have a positive experience of care
Domain 5:	Treating and caring for people in a safe environment and protecting them from avoidable harm

Social Care Outcomes Framework

Public Health Outcomes Framework

HEALTH AND SOCIAL CARE ACT 2012

Implications for the Trust, its Directors, governors and members

Peter Lee
Chairman

Key issues

- Where we start from
- A new commissioning regime
- New initiatives
- New roles and responsibilities – Governors
- New roles and responsibilities – Directors of the FT
- Non NHS derived income (private income)
- Overall impact

Where we start from

- Combined hospital and community services
- Income £225m from 1 year contract
- Over 4,000 staff
- Cost improvement programme 2012/13 £14 m
- FRR – 3 (1-5) and Governance – Green (green/amber/red)
- Lowest waiting times
- Infection control record - excellent

A new commissioning regime

- Present position – Primary Care Trust until April 2013
- Future position – Clinical Commissioning Group from 2013
- Transitional arrangements exist

- CCGs – locally managed and directed – all primary care providers have to be members – regulatory supervision – obligations to be transparent

- CCGs – mandated to continuously improve services…..reduce inequalities…..promote patient involvement and patient choice…innovation…..research and …..the integration of health and social care

New Initiatives

- Promotion of section 75 NHS Act 2006 arrangements
- Every provider of health services will need to be licensed
- Changing role for Monitor (Foundation Trust regulator)
- Increasing role of Council of Governors
- Duty to promote the NHS Constitution
- Caps and conditions to non NHS income
- FT Board meetings to be held in public

New roles and responsibilities - Governors

- New specific duties :
- (a) to hold the NEDs individually and collectively accountable for the performance of the Board
- (b) to represent the interests of the members (as a whole) and the interests of the public
- (c) to require the directors to attend Council of Governors to supply information regarding the performance of their duties and functions
- Any amendment to the Constitution of the Trust regarding the powers or duties of the Governors (or their role) is subject to a members' vote. More than 50% of those voting must be in favour and the motion must be put by a member of Council of Governors
- Any other amendments to the Constitution of the Trust are subject to more than 50% of the Directors voting in favour and more than 50% of those Governors actually voting being in favour.
- NOTE: Influence over mergers, acquisitions, separations and dissolutions – any proposal is subject to approval by 50% of all of the Governors (not just 50% of the Governors voting!
- Constitution can be changed to specify partnering organisations which may appoint one or more members of the Council e.g. major charity?

New roles and responsibilities - Directors

- General duty to act with a view to promote the success of the Trust so as to maximise benefits for the members (as a whole) and for the public
- Must supply Governors with meeting Agendas prior to their meetings and minutes as soon as practicable after meetings
- Constitution must be amended to provide for meetings to be open to the public and may provide for exclusion of the public for special reasons
- Obligation to promote the NHS Constitution to members of the public in discharging the Trust's functions
- Ensure that the Governors are equipped with the skills and knowledge required in their capacity as such, to discharge their duties

Directors …….cont.

- Accountability to Governors (all directors) for performance of their functions and duties and the requirement to attend at Council, if requested by Council, to supply information and answer questions regarding their functions and performance of their duties
- Constitutional changes require Governors approvals (NB the voting majorities required)
- What is a significant transaction may be defined in the Constitution of the Trust (or not) (and not by Monitor) and entry into such a transaction will be subject to approval by more than 50% of the Governors actually voting
- Governors influence over mergers, acquisitions, separations and dissolutions – any proposal is subject to approval by 50% of the Governors (in numerical terms – whether they vote or not) (not 50% of the Governors voting!)
- Obligations re the “complexion” of the membership
- Obligation to hold an annual meeting of its members (open to the public)

Members

- Change to an obligation (not an option) upon the Trust to secure that the actual membership of any public constituency is representative of those eligible for such membership
- In deciding which areas are to be public constituencies, (or in deciding whether there is to be a patients constituency), FTs must have regard to the need for those eligible for such membership to be representative of those to whom the Trust provides services
- Obligation to provide a members' annual meeting

Overall impact?