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

Contact Name:

Dr John Radford, Joint Director of Public Health
Oak House, Moorhead Way, Bramley, Rotherham, S66 1YY
Tel. 01709 302161 Email: john.radford@rotherham.nhs.uk

Gilly Brenner, Specialty Registrar in Public Health
Tel: 01709 302171 Email: gilly.brenner@rotherham.nhs.uk

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.

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- 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;

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- 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.

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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

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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	

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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

Appendix 2: Public Health Transition Plan

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.

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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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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.

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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.

Appendix 2: Public Health Transition Plan

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.

Appendix 2: Public Health Transition Plan

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.

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,

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

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

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)*

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

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)*

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)*