SERVICE LEVEL AGREEMENT FOR THE PROVISION OF PUBLIC HEALTH ADVICE TO THE ROTHERHAM CLINICAL COMMISSIONING GROUP

1. Parties to the agreement:

Rotherham Metropolitan Borough Council ("the Council")	NHS Rotherham Clinical Commissioning Group ("the CCG")

2. Date of agreement:
3. Term of agreement:
    a. The agreement will commence from 1 April 2013
    b. The agreement is indefinite; however, the agreement will be subject to annual review and will be managed by not less than 6 meetings between the CCG and Public Health..
    c. The agreement will be reviewed in March 2014.
    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. In accordance with the Health and Social Care Bill, and subsequent Regulations. 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 RCCG for cooperation will be borne fully by the RCCG.
    d. Any support to RCCG 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 RCCG in relation to the population resident within the geographic boundaries of Rotherham metropolitan borough. The framework sets out the scope of

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responsibilities of all that are party to this agreement and a suite of three operational documents (covering the "three pillars" of Public Health practice) will detail the priorities and mutually agreed inputs, outputs and obligations.

7. The aim of this agreement is to facilitate the commissioning of efficient and effective NHS, PHE and Council services within Rotherham in order to protect, 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. In the case of dispute relating to matters covered by this agreement, that these should be resolved by the CCG Chief Officer and the Director of Public Health where agreement cannot be reach this should be referred to the lay member of the CCG who Chairs the CCG Audit Committee and the Chair of the RMBC Audit Committee.
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 with sufficient resilience and support 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 regulations, including those for continuing professional development, professional registration and revalidation and mandatory NHS training in relation to information governance.
      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 RCCG 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 (where possible) 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 RCCG based on the available evidence and in good faith.

f. Some public health tasks are delivered most effectively and efficiently at larger geographical levels 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, including threats and incidents arising from communicable disease

    ii. Implementation of Health Improvement initiatives, and

    iii. Healthcare public health encompassing provision of Public Health intelligence, rigorous framework for clinical effectiveness and quality, and sustainable approach to prioritisation

g. The Council will provide advice within the scope of the core offer from Public Health to the RCCG 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 RCCG 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 RCCG:

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

    b. The RCCG will provide and/or facilitate access to intelligence and capacity to the analysis of healthcare related data sets such as (but not restricted to) that from SUS, QOF/QMAS, ePACT, PbR, local surveys, performance data and data held on GP systems aggregated by (where possible) Lower Layer SOA, GP Practice, Secondary/Tertiary care and Mental Health service providers and/or RCCG (as appropriate). Where information relates to Public Health Services the RCCG will support a partnership arrangement over data access.

    c. RCCG will share information on patterns of prescribing where these relate to the Public Health Functions of the Council.

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d. RCCG will provide and/or facilitate access to electronic systems and networks to enable provision of advice such as (but not restricted to) N3 access, guest WiFi access, NHSmail/NHSmail2 accounts and Open Exeter
e. RCCG will provide access to mandatory NHS Information Governance training in order to satisfy the requirements of para 8.b.i above.
f. RCCG will provide and/or facilitate access for Public Health staff to Library and Knowledge Services to support evidence-based decision-making.
g. RCCG will obtain Public Health advice in relation to any commissioning, redesign or decommissioning decisions it intends to make.
h. RCCG will obtain Public Health advice on an on-going basis in the management of existing services.
i. The level and quantum of Public Health advice will be determined through negotiation subject to paragraph 8.i above.
j. For issues where Public Health advice has been sought, the RCCG agree to engage with the Advisors in an open and transparent manner so that the advice received is impartial.
k. The RCCG 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 RCCG will normally be available Monday – Friday, 0900 – 1700.
    b. Out of hours provision will normally provide response to public health emergencies only.

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Mr Martin Kimber Chief Executive RMBC	Mr Chris Edwards Chief Operating Officer NHS Rotherham
Dr John Radford Director of Public Health RMBC/NHS Rotherham	Dr David Tooth Chair of the CCG NHS Rotherham

Abbreviations in use within this document:

SUS – Secondary Uses Service

QOF – Quality and Outcomes Framework

QMAS – Quality Management and Analysis System

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

CBRN – Chemical, Biological, Radiological and Nuclear

ePACT – System for providing electronic access to prescription data

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Appendix 1 – the Core Offer from Public Health to RCCG

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
   f. Agreed level of Creative Media Services support to the CCG.
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. CBRN, pandemic flu, major incidents, outbreaks (including those associated with healthcare) 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 and is fully informed of any issues to allow them to mobilise NHS resources as necessary.
   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
   g. Provide immunisation expertise to support the commissioning, provision and monitoring of immunisation services, including care pathways for programmes such as neonatal Hepatitis and BCG and school based programmes.

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h. Provide the CCG and other health and social care professionals infection prevention and control expertise.

i. Ensure IPaC remains a core underlying element in the commissioning of services to enhance patient safety and secure the delivery of high quality services by:

    i. Supporting the CCG in strategic planning, implementation and evaluation of services, contributing to the development of contracts and service specifications and challenging providers where necessary with clinical and specialist credibility

    ii. Providing expertise to monitor and interpret HCAI metrics, data and practice against mandated standards, facilitating the development of strategies for improvement where necessary and interpreting national policy, regulations, guidelines, best practice and changes to legislation, advising the CCG regarding the implementation and monitoring of these as necessary.

    iii. Providing specialist IPaC advice in relation to the built environment e.g. new builds, refurbishments, ventilation, facilities contracts etc, ensuring a link to planning teams, architects and the national Estates and Facilities provider.

    iv. Maintaining strategic relationships across health and social care to ensure a link between the CCG and partner organisations in relation to IPaC e.g. Local Authority and HPA.

    v. Acting on behalf of the CCG with regards to healthcare associated outbreaks/Incidents:

        1. Notification of outbreak to CCG, PHE and Local Public Health Team
        2. Assurance regarding the management of the outbreak by the Provider
        3. Information regarding the support required to address/respond to the outbreak
        4. Assurance regarding Providers response to the outbreak/incident

    vi. Holding Rotherham CCG Commissioned Services to account for CCG infection control targets and outcomes required by the NHS Commissioning Board.

    vii. Supporting the CCG to fulfil their responsibility in relation to vaccination and immunisation and their commissioned services/providers. This includes:

        1. Assurance that providers are supporting immunisation programmes as appropriate/required
        2. As Public Health lead, advising on all aspects of any mass vaccination programme as required

3. Seeking and providing assurance regarding the delivery of the programme by their commissioned services/providers.

viii. Ensuring appropriate investigation and management of MRSA Bacteraemia, C.diff infections and other HCAI related incidents i.e. isolates reported to commissioners within agreed timeframes, HCAI related deaths reported as SI's, Root Cause Analysis is carried with contribution from all relevant providers/partners and lessons identified are appropriately disseminated.

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
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
    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. Support to the appreciative inquiry process

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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.

9. Support to Clinical Research & Development:
   a. Representing the CCG at the Compressive Local Research Network Board (CLRN)
   b. Representing the CCG at the Collaborative Leadership and Health Research and Care (CLARHC) Board
   c. Oversee the research activities of the Rotherham Research Alliance, including research governance
   d. Work with the designated GPs on the CCG to fulfil the CCG research agenda

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Appendix 2 – the Core Offer from RCCG 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
    c. Ensure primary and secondary prevention is incorporated within commissioning practice
    d. Commission to reduce health inequalities and inequity of access to services
    e. 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

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