Peterborough 'Shadow' Health and Wellbeing Board
Draft Terms of Reference

1.1 Purpose

1.1.1 To act as the Shadow Peterborough Health and Wellbeing Board until April 2013.

1.1.2 To oversee and implement the creation of a Peterborough Health and Wellbeing Board in readiness to assume its statutory responsibilities from April 2013.

1.1.3 To develop and facilitate the delivery of transitional arrangements to meet statutory requirements within the emerging health and social care agenda.

1.1.4 To determine health and wellbeing improvement priorities in Peterborough.

2.1 Functions

2.1.1 To identify and join up areas of commissioning across the NHS, social care, public health, and other services directly related to health and wellbeing and reducing health inequalities.

2.1.2 To develop and oversee :

- The development of a statutory Health and Wellbeing Board (as set out in the Health and Social Care Bill);
- The transfer of Public Health to local authorities;
- Relevant sections of the Peterborough Single Delivery Plan
- The development of HealthWatch

2.1.3 To encourage and develop integrated working, for the purpose of advancing the health and wellbeing of, and reducing health inequalities amongst, Peterborough people.

2.1.4 To develop a shared understanding of the needs of the local community through the development of a Joint Strategic Needs Assessment (JSNA).

2.1.5 To oversee the development of a Joint Health and Wellbeing Strategy (JHWS), ensuring that it provides an overarching framework for commissioning plans related to health and wellbeing and health inequalities.

2.1.6 To oversee and challenge key commissioning plans, strategies, and policies relating to health and wellbeing and health inequalities.

2.1.7 To consider and take advantage of opportunities to more closely integrate health services and social care services in provision and procurement.

2.1.8 To keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

2.1.9 To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

2.1.10 To oversee the development of the Pharmaceutical Needs Assessment.

2.1.11 To performance manage the achievement of, and progress against, key outcomes identified within the Joint Health and Wellbeing Strategy.

2.1.12 To facilitate a key forum for local democratic and public accountability of the NHS, social care for adults and children and other commissioned services that the Shadow Health and Wellbeing Board agrees are directly related to health and wellbeing in Peterborough.

2.1.13 To consider how best the Shadow Health and Wellbeing Board can work with the Greater Peterborough Partnership ensuring the relationship is productive and does not duplicate activity.

2.1.14 To identify and act upon changes that may be required following the enactment of the NHS Health and Social Care Bill in order to establish the Statutory Health and Wellbeing Board to replace the Shadow Board.

3.1 Proposed Membership

3.1.1 Membership of the shadow board will mirror the statutory requirements as will be confirmed by the Health and Social Care Act 2011.

3.1.2 At least one elected representative, to include the relevant Cabinet Member.

3.1.3 A representative of each of the relevant GP Clinical Commissioning Consortia (those within the Local Authority Area).

3.1.4 Statutory directors of public health, adult social services and children's services.

3.1.5 A local HealthWatch representative.

3.1.6 A representative of the NHS Commissioning Board (in relation to their local commissioning responsibilities on request from the Health and Wellbeing Board).

3.1.7 Other representatives as appropriate to be appointed by the local authority and/or the Health and Wellbeing Board. Additional membership should be considered by the Shadow Health and Wellbeing Board as part of its development of the Statutory Board as well as a framework to engage with the widest forum of stakeholders.

4.1 Chair Arrangements

4.1.1 To be determined at the setup meeting of the Health & Wellbeing Board

5.1 Meeting Frequency

5.1.1 Monthly for the initial six months.

6.1 Governance and Approach

6.1.1 The Board will function at a strategic level, with priorities being delivered and key issues taken forward through the work of the partnership organisations.

6.1.2 Decisions taken and work progressed will be subject to scrutiny in accordance with the procedures of the local authority.

7.1 Wider Engagement

7.1.1 The Shadow Health and Wellbeing Board will communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control of their personal health and wellbeing.

7.1.2 The Board will want to ensure that the decisions it makes and the priorities it sets take account of the needs of all of Peterborough's communities and groups, particularly those most in need.

7.1.3 To develop and implement a communications engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public.

8.1 Support for the Shadow Health and Wellbeing Board

8.1.1 The Shadow Health and Wellbeing Board will be supported by a member of the Governance Team.

DECISION NOTICE – Cabinet Member for Adult Social Care

PETERBOROUGH CITY COUNCIL

Report Title	ESTABLISHMENT OF A SHADOW HEALTH AND WELLBEING BOARD
Delegations Checked	This decision is proposed in accordance with the delegations for the Cabinet Member for Adult Social Care, exercising delegated authority under paragraph 3.3.3 of Part 3 of the constitution in accordance with the terms of their portfolio at paragraph 3.10(d).
Name and contact details of officer requesting the decision	Terry Rich – Executive Director of Adult Social Services
Is the report or background information attached to this request exempt?	No
Is this a Key Decision?	No
Details of decision required	The Cabinet Member for Adult Social Care is requested to approve the establishment of a Shadow Health and Wellbeing Board from January 2012.

Reasons for recommending decision and any relevant background information	The Health and Social Care Bill, which is currently making its way through Parliament, will require all upper tier local authorities to establish Health and Wellbeing Boards (HWB) by April 2013. In the interim, the establishment of Shadow Health and Wellbeing Boards are being encouraged by the Secretary of State in order to prepare for the transition to a 'live board' in April 2013 and to encourage cultural and behavioural changes. This will ensure a joint approach to meeting local need. A key step in the implementation of a Shadow Health and Wellbeing Board has been the preparatory work undertaken by the Health and Wellbeing Board / Public Health Transition Project Group. Discussions held by the Project Group, including elected members, have identified that the Shadow Board will operate more effectively if membership is initially limited, whilst ensuring that key representatives are present. It is therefore proposed to have an initial membership of 12; those being: Membership: 1. Councillor Cereste – Leader of the Council and Cabinet Member for Strategic Planning, Economic Development and Business Engagement (Chairman) 2. Councillor Fitzgerald – Cabinet Member for Adult Social Care (Vice Chairman) 3. Councillor Scott – Cabinet Member for Children's Services 4. Councillor Holdich – Cabinet Member for Education, Skills and University 5. Gillian Beasley – Chief Executive, Peterborough City Council 6. Dr Sushil Jathanna - PCT/'NCB' Chief Executive 7. David Whiles – LINk / HealthWatch Representative 8. Dr Mike Caskey – Peterborough Local Commissioning Group 9. Another LCG/CCG rep 10. Terry Rich – Director of Adult Social Services 11. Malcolm Newsam – Director of Children's Services 12. Dr Andy Liggins – Director of Public Health The Shadow Board will meet once a month from February 2012 onwards, with an initial setup meeting to be held in January 2012. The terms of reference, currently in draft form, will be approved at the first meeting of the Shadow Board. Meetings will not be held in public for the first six months and this arrangement and the future frequency of meetings will be reviewed after that time. The Shadow Board will not have any decision making powers as envisaged by the legislation until April 2013, so in the interim will not be a formal decision making body. During this period, decisions will continue to be made in accordance with the Council's Constitution, with input as necessary from the Shadow Board. A number of significant statutory duties have been identified for the Health and Wellbeing Boards and it is recognised that interaction will take place with a number of other bodies. During the shadow period, exploration will be undertaken in order to identify how relationships will be developed and operated and how the significant statutory duties will be addressed.

Alternative options considered and rejected	The following options were considered and rejected: Option one – Do not establish a Shadow Health and Wellbeing Board. This was rejected because the establishment of a Shadow Health and Wellbeing Boards will assist in the preparation for the transition to a 'live board' in April 2013. The establishment of a Shadow Board would encourage cultural and behavioural changes, which in turn will go towards ensuring a joint approach to meeting local need. Option two – Establish a larger Shadow Health and Wellbeing Board. This was rejected because a smaller group is likely to operate more effectively, and if it should be necessary to increase the membership, inviting additional members to join is easier than asking previously invited members to resign their membership.
Declarations / conflict of interest	**Declarations of any other Cabinet Members consulted by the Cabinet Member making the decision.** *The Cabinet Member should be reminded to declare any interests/conflicts of interest here.*
Dispensations granted	**In respect of any declared conflict of interest in relation to the decision, any dispensation granted by the Secretary of State/Standards Committee.** *The Cabinet Member should detail any dispensations granted in this box.*

Consultation (officers/ward councillors) *Legal and finance should be consulted regarding the proposals. Ward Councillors, other Cabinet Members and officers should be consulted if the proposals will have an impact on their service area/ward.*	**Section**	**Name**	**Outcome**	**Date**
	Ward Councillors *(if decision is ward specific)*	N/A		
	Legal	Helen Edwards	Approved.	
	Finance	Steven Pilsworth		
	Democratic Services	Gemma George	Approved	
	Procurement Project Director (if decision is contract/procurement related)	N/A		
	Head of Strategic Property *(if decision is property related)*	N/A		
	Other Officers / Members	Dr Andy Liggins	Approved	

Director's approval *Directors are requested not to sign if the above section is incomplete*		**Date**
Date sent to Cabinet Member <u>if key decision</u>	*To be inserted by Democratic Services*	
<u>If key decision</u> – date decision may be taken	*To be inserted by Democratic Services*	
Cabinet Member approval		**Date**

Reasons for making decision **Please tick one of the Options**	**Option 1** I agree with the officer's reasons for recommending the decision.	
	Option 2 I agree with the officer's reasons for recommending the decision and have the following additional comments to make.	
Once signed by Director, please pass to Democratic Services. We will contact the Cabinet Member and arrange for signature.		

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SHADOW HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 5
16 JANUARY 2012	

Cabinet Member(s) responsible:	Councillor Fitzgerald – Cabinet Member for Adult Social Care	
Contact Officer(s):	Dr Andy Liggins, Director of Public Health & Terry Rich, Director of Adult Social Care	Tel. 758520

MEMBERSHIP OF PETERBOROUGH SHADOW HEALTH AND WELLBEING BOARD

RECOMMENDATIONS	
FROM : *Health and Wellbeing Board / Public Health Transition Project Group*	**Deadline date :** *to be agreed at HWB 16 January 2012*
For the Board to: 1. Agree the membership of the Shadow Health and Wellbeing Board; and 2. Agree how to engage with other key stakeholders	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Shadow Health and Wellbeing Board following previous discussions with Cabinet Members and the Health and Wellbeing Board / Public Health Transition Project Group.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

(a) provide additional or background information to inform
(b) a decision on membership of the shadow Peterborough Health and Wellbeing Board.

3. BACKGROUND

3.1 The Health and Social Care Bill, which is currently making its way through Parliament, will require all upper tier local authorities[1] to establish Health and Wellbeing Boards (HWB) by April 2013. In the interim, the establishment of Shadow Health and Wellbeing Boards are being encouraged by the Secretary of State in order to prepare for the transition to a 'live board' in April 2013 and to encourage cultural and behavioural changes. This will ensure a joint approach to meeting local need.

3.2 Membership of the Shadow Board from April 2012 will mirror the statutory requirements required from April 2013 (as will be confirmed by the Health and Social Care Act 2011). The proposed Health and Wellbeing Board membership requirements are as follows:

- At least one elected representative, to include the relevant Cabinet Member.

[1] Although health and wellbeing boards will be set up as committees of local authorities, the Health and Social Care Bill 2011 has a clause that enables the disapplication of legislation that relates to those committees – such as legislation covering voting processes and terms of membership, among other issues. This recognises that health and wellbeing boards are unusual in comparison to normal s102 committees in having officers, clinical commissioning groups and local HealthWatch representatives sit on them.

- A representative of each of the relevant GP Clinical Commissioning Consortia (those within the Local Authority Area).

- Statutory directors of public health, adult social services and children's services.

- A local HealthWatch representative.

- A representative of the NHS Commissioning Board (in relation to their local commissioning responsibilities on request from the Health and Wellbeing Board).

- Other representatives as appropriate to be appointed by the local authority and/or the Health and Wellbeing Board. Additional membership should be considered by the Shadow Health and Wellbeing Board as part of its development of the Statutory Board as well as a framework to engage with the widest forum of stakeholders.

3.3 A key step in the implementation of a Shadow Health and Wellbeing Board has been the preparatory work undertaken by the Health and Wellbeing Board / Public Health Transition Project Group. Discussions held by the Project Group with elected members have identified that the Shadow Board will operate more effectively if membership is initially kept small, whilst ensuring that key players are present. It is therefore proposed to have an initial membership of 12; those being:

1. Councillor Cereste – Leader of the Council and Cabinet Member for Strategic Planning, Economic Development and Business Engagement (Chairman)
2. Councillor Fitzgerald – Cabinet Member for Adult Social Care (Vice Chairman)
3. Councillor Scott – Cabinet Member for Children's Services
4. Councillor Holdich – Cabinet Member for Education, Skills and University
5. Gillian Beasley – Chief Executive, Peterborough City Council
6. Dr Sushil Jathanna - PCT/'NCB' Chief Executive
7. David Whiles – LINk / HealthWatch Representative
8. Dr Mike Caskey – Peterborough Local Commissioning Group
9. Another LCG/CCG rep
10. Terry Rich – Director of Adult Social Services
11. Malcolm Newsam – Director of Children's Services
12. Dr Andy Liggins – Director of Public Health

3.4 There is clearly a need to engage with other key local stakeholders, including the voluntary and community sector, local NHS and independent sector providers of health and social care, the public, business sector, Greater Peterborough Partnership and others.

3.5 This can be achieved through formally involving key stakeholders at appropriate times, e.g. within the annual commissioning and business cycle, in order to benefit from their experience of needs and solutions. In addition, relevant sectors will be involved on specific issues.

4. CONSULTATION

4.1 The views of local NHS providers on the composition of the Peterborough Health and Wellbeing Board have been sought. Responses received to date are attached at **Appendix A**.

4.2 Two responses are in favour of including providers on the Health and Wellbeing Board and one not in favour.

5. ANTICIPATED OUTCOMES

5.1 An agreed membership and effective functioning of the Peterborough Shadow Health and Wellbeing Board.

6. REASONS FOR RECOMMENDATIONS

6.1 The formation of the Shadow Board meets statutory requirements.

6.2 To ensure the efficiency of operation and productivity of the Shadow Health and Wellbeing Board.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 To include other key stakeholders within the membership of the Shadow Health and Wellbeing Board.

8. IMPLICATIONS

There are no further implications.

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LETTER TO LOCAL NHS PROVIDERS **APPENDIX A**

Dear xyz,

Re: Peterborough Health & Wellbeing Board

You will be aware that a key element of the Health & Social Care Bill 2011 (currently at committee stage in the House of Lords) is the development of a Health & Well-being Board (HWB) at the level of every upper tier local authority. This means that there will be a Peterborough Health & Well-being Board (as well as equivalents set up by Cambridgeshire, Lincolnshire & Northamptonshire County Councils). The intended function of the Health & Well-being Boards is illustrated by the following extracts from the Department of Health website:

Health and wellbeing boards bring everyone together. The Bill gives Health and wellbeing boards a duty to encourage health and care commissioners to work together to advance the health and wellbeing of the people in its area. Boards will bring all of the relevant people together - representatives of the different health and care services will, together, have to draft and agree a Joint Health and Wellbeing Strategy for their local area. How different services work together around patient needs will be a key part of the strategy. The Bill places a duty on Boards to consider the partnership arrangements under the NHS Act (such as pooled budgets) when developing their strategy.
https://www.wp.dh.gov.uk/healthandcare/files/2011/10/C3-Promoting-better-integration-of-health-and-care-services.pdf

Improving Local Accountability Health and Wellbeing Boards will strengthen joint working between local government and the NHS. The Bill will establish Health and wellbeing boards in all upper tier local authorities, to promote integrated health and care services and increase accountability. The boards will significantly increase local democratic legitimacy in the commissioning of health and care services, bringing together locally elected councillors, clinical commissioning groups, local HealthWatch and Directors of Adult Social Services, Children's Services and Public Health to jointly assess local needs and develop an integrated strategy to address them. Elected councillors will be involved in this process and will be held to account by the local electorate if they are ineffective. Local HealthWatch will ensure patients and the public have a direct say in their health and wellbeing board and so in the strategic planning for meeting the health and care needs of their area. https://www.wp.dh.gov.uk/healthandcare/files/2011/10/B5-Greater-accountabilty-locally-and-nationally.pdf

Peterborough City Council has the organisational responsibility for forming the Peterborough Health & Well-being Board and has decided to convene the Board (which will operate in shadow form until 2013) initially according to the suggested membership in the Bill (at least one elected representative, to include the relevant Cabinet Members, a representative of each of the relevant GP Consortia, Directors of public health, adult social services and children's services, a local HealthWatch representative and a representative of the NHS Commissioning Board when established, other representatives as appropriate to be appointed by the local authority and/or the Health and Wellbeing Board.

The issue of whether, and if so which, providers should be members of the Health & Well-being Board is still under discussion and the shadow Board would appreciate your formal opinion on this as our local providers. In a nutshell, should the Board be comprised of commissioners only or be the forum for tackling 'whole system' issues with membership including both commissioners and providers?

I look forward to your responses which would be appreciated by Friday 16 December.

Yours sincerely
Dr Andy Liggins
Director of Public Health for Peterborough

RESPONSE 1

Andy, I hope all is well and sorry for the late response to your letter dated 1st December 2011.

Our initial response is that the Board should be convened with the membership specified in your letter. This should ensure local accountability, efficient administration and ensure the Board remains focused on the work in hand. Adding all relevant providers would in our view make the Board unwieldy and potentially ineffectual. It would also be difficult to identify from the broad spectrum of providers which should attend and which should not. This is especially important given the role of the Board across all age ranges for health and social care issues and presumably education and housing issues as it gets into its work.

However and equally of importance is that the Board will be bereft of appropriate advice and input without the views, innovation and experience of providers and professionals and therefore there needs to be explicit and organised mechanisms to involve providers and clinicians/professionals. This could be undertaken on a regular basis' themed according to priorities; part of an annual cycle of priority setting; focused on specific developments; focused on specific age groups, disability and or conditions. All of these would ensure the involvement of providers is focused on achieving the right outcomes for Peterborough residents without building a mammoth bureaucracy or apparatus. Of course this applies to NHS/non NHS, health and social care providers – not just the incumbent NHS Trusts!

The overriding message from the Trust is that we all have a responsibility to deliver the outcomes of the health and well being board, but we should be able to separate the corporate governance of decision making and authority to make decisions that rests with the Board, from the need to engage and involve all parties in a dynamic way in the work of the Board.

Hope that is helpful.

Kind regards
Matthew

Matthew Winn
Chief Executive

RESPONSE 2

Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Peterborough City Hospital
PO Box 404
Management Suite
Edith Cavell Campus
Bretton Gate
Peterborough
PE3 9GZ

Louise Barnett
Interim Chief Executive
Direct Dial: 01733 677933
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Executive Assistant: Rebekah Pickles
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Our Ref: LB/JP/16 Dec 11 HWB Response

16 December 2011

Dr Andy Liggins
Director of Public Health
NHS Peterborough
2nd Floor
Town Hall
Peterborough
PE1 1FA

Dear Andy

Peterborough Health & Wellbeing Board

Thank you for your letter of 1 December regarding the formation of the Peterborough Health and Wellbeing Board.

The Trust Board has discussed potential membership and believes that a provider view is important to feed into the considerations of the Health & Wellbeing Board. General Practitioner involvement will cover both primary care provision and wider commissioning and our inclusion as a secondary care provider will broaden diversity and representation across the health agenda. We therefore welcome and value involvement and would envisage this being delivered from a clinical quality viewpoint.

In addition, as a NHS Foundation Trust, we have local membership who elect our public and staff governors and therefore we can bring added democratic legitimacy into the process. This would include inviting our members to take part in any surveys, focus groups, local meetings etc that the Health & Wellbeing Board may wish to undertake to ensure that key strategic decisions are underpinned by robust local patient and public involvement.

The Trust's involvement will also reflect initial discussions undertaken between the leader of the Council and our Chairman.

If you have any queries to our response prior to your further considerations please contact either myself or Chris Wilkinson, Director of Care Quality on 01733 677927.

Yours sincerely

Louise Barnett
Interim Chief Executive

RESPONSE 3

From: Tara Cafferty
To: Liggins Andy
Sent: Thu Dec 08 15:13:43 2011
Subject: Re: Peterborough Health & Well-being Board
Dear Dr Liggins,

Thank you for your letter regarding the above. My view is that the Health & Well-being Board should comprise of both commissioners and providers to ensure 'whole system' change is actually implemented in a joined up way.

Thank you,

Regards,

Hayden

Tara Cafferty
Secretary to the Office of the CEO & Chair

East of England Ambulance Service
Building 1020
Cambourne Business Park
Cambourne
Cambs.
CB23 6EB

SHADOW HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 8
16 JANUARY 2012	

Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald – Cabinet Member for Adult Social Care	
Contact Officer(s):	Dr Andy Liggins – Director of Public Health Sue Mitchell – Assistant Director Public Health	Tel. 758520 Tel. 758530

REVISED PUBLIC HEALTH TRANSITION PLAN

RECOM.MENDATIONS	
FROM : *Dr Andy Liggins, Director of Public Health*	**Deadline date : 18 January 2012**
That the Board notes the revised Public Health Transition Plan (Appendix A).	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Shadow Health and Wellbeing Board following the publication of Department of Health guidance and the letter from David Flory, NHS Deputy Chief Executive dated 19th December 2011, (Gateway reference number 17042). Public Health Transition plans must be submitted as part of this process by 18th January 2012.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the Shadow Health and Wellbeing Board of the revised Public Health Transition Plan that has been updated to include a summary of the latest guidance from the Department of Health, and also reflects further steps that have been taken since the draft plan was shared with Corporate Management Team in November 2011. It now includes a draft detailed project plan at Appendix J, contained within the Transition Plan.

2.2 The Department of Health requires that NHS Peterborough and NHS Cambridgeshire Cluster PCT has a detailed draft Transition Plan for Public Health that should be submitted as part of the Cluster PCT's Integrated Plan. The Public Health Transition Plan has been developed in response to Department of Health Guidance. Further guidance was issued on 23rd December 2011 requiring a detailed project plan with timescales. The Integrated Cluster PCT Plan must be submitted to the Strategic Health Authority for assurance by 18th January 2012.

3. TIMESCALE *(If this is not a Major Policy item, answer **NO** and delete second line of boxes).*

Is this a Major Policy Item/Statutory Plan?	**YES**	If Yes, date for relevant Cabinet Meeting	
Date for relevant Council meeting		Date for submission to Government Dept *(please specify which Government Dept)*	18th January 2012 to the Strategic Health authority for Midlands and East

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NHS PETERBOROUGH AND PETERBOROUGH CITY COUNCIL

UPDATED PUBLIC HEALTH TRANSITION PLAN

V.4: January 2012

CONTENTS

1. Introduction

This Public Health Transition Plan will provide a clear outline of the steps and processes that will be taken in order to ensure a successful and streamlined transfer of public health responsibilities, staff and financial resources over to Peterborough City Council. It offers a summary of the national policy context, provides details of public health staff and finance, discusses the roles and functions of Public Health, identifies some key questions that need to be addressed and provides a timeline to achieve 'shadow running' by April 2012.

A Transition Project Group has been established to lead this process and to establish the 'shadow health and wellbeing board' for Peterborough. This group is jointly chaired by Denise Radley, Director of Adult Social Care and Dr Andy Liggins, Director of Public Health.

Between October 2011 and April 2012, a range of steps and decisions need to be made. To assist with this process, a timeline and Gantt chart (Appendix G) have been developed. However it is accepted that certain decisions still depend on direction from central government. Further guidance is expected during the autumn of 2011.

2. Policy summary

Funding and accountability through the public health system

The NHS White Paper *Equity and Excellence* (DH 2010) states that PCT responsibilities for local health improvement will transfer to local authorities (LAs), who will employ the Director of Public Health (DPH), jointly appointed with Public Health England. A ring-fenced public health budget will be created, part of which will be allocated to upper tier or unitary authorities through Public Health England (PHE). The allocation formula will take into account relative population need and local DsPH will be responsible for the use of these funds. The formula will also include a new health premium to reward LAs for progress against elements of the PH outcomes Framework (DH 2010), taking health inequalities into account.

Healthy Lives, Healthy People (DH 2011) reiterated that each upper tier/unitary authority will lead a statutory Health and Wellbeing Board (HWB). The HWB will bring a partnership focus to health and wellbeing, supporting integration across health services, social care, public health and wider public services. This function is described within the Health and Social Care Bill published in January 2011 and currently progressing through parliamentary stages following the Government's Listening Exercise earlier this year.

The white paper sets out an expectation for each HWB to develop a local Health and Wellbeing Strategy. The strategy will provide a high level framework within which partners commission their respective services. This would encompass those services related to health improvement.

The feedback from the consultation on the Public Health white paper: *Healthy Lives, Healthy People: Update and way forward, published in July 2011* (DH, 2011) reaffirms the Government's commitment to making the bold changes proposed within the white paper.

Equity and Excellence (DH, 2010) and *Healthy Lives, Healthy People* (DH, 2010) recognise the central importance of the Joint Strategic Needs Assessment (JSNA) in underpinning commissioning and policy decisions, placing an equal obligation on local authorities and clinical commissioning groups to prepare the JSNA and have regard to it when commissioning. The enduring role of the NHS in public health is clearly stated. It proposes that PHE should be responsible for funding and ensuring the provision of services such as recovery from drug dependency, sexual health, alcohol prevention, obesity, smoking cessation, nutrition and health checks. In most cases funding will be passed to LAs with an expectation that the majority of services will be commissioned. An 'any qualified provider' basis is favoured to encourage innovation in service delivery approaches.

Healthy Lives, Healthy People outlines the proposed timetable for transfer of health improvement functions to local government, with shadow funding allocations to LAs in 2012/13 and real funding from April 2013. LAs and PCTs need to prepare for this transfer, with working arrangements being set up from 2011. The wider NHS transition context will influence the timings of local health improvement changes. Key stages include clinical commissioning groups, health and wellbeing board implementation, PCT wind-down and the development of health and wellbeing strategies.

A Summary of the New Public Health System (DH, Dec 2011) provides the latest policy position and confirms that, subject to the passage of the Health and Social Care Bill, 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 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. 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 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 health of 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. Shadow allocations to local authorities will be made for 2012/13 to help them prepare for taking on formal responsibility in 2013/14.

More detailed DH factsheets outlining the new public health roles of Local Authorities are attached as Annex A.

The relationship with PHE is important given the links between the LA health improvement responsibilities and the national system, as well as the potential for it to provide a home for other PH functions delivered locally, for example health protection. PHE is expected to be running in shadow form from April 2011.

3. Current and future public health/health improvement arrangements

An understanding of the distribution of functions and responsibilities is necessary when considering how to organise public health/health improvement structures and partnerships at local level. The new approach to improving health as described in *Healthy Lives, Healthy People* (DH, 2010*)* will change the nature of activity undertaken by public health teams*. Healthy Lives, Healthy People: consultation on the funding and commissioning routes for public health* (DH 2010) sets out five domains within which responsibilities for PH commissioning sit. In addition to

commissioning services, developing effective partnerships remains an important dimension to improving health.

A number of public health functions will not be the responsibility of the local authority however significant levels of PH input at local level will be required. A 'package' or 'offer' for PH commissioning advice and input into healthcare commissioning provided by local clinical commissioning groups is described within the *Healthy Lives, Healthy People update* (DH, 2011) and must be made available by LAs. The *Healthy Lives, Healthy People update* also includes a list (subject to further engagement) of the new LA responsibilities. This list is included at Appendix A within this document. A table describing local public health roles and functions is attached as Appendix F.

4. Wider determinants of health

It is expected that the health improvement responsibility for LAs must extend to influencing the strategic framework for each policy area, including but not limited to influencing commissioning of services. Strong matrix working and working relationships, an awareness of decision-making processes, the ability to influence at appropriate junctures, evidence of the effectiveness of health improvement benefits and an understanding of areas of win-win.

5. Preparing for change

Successful transition and transformation require a strong infrastructure and the right conditions to support the start-up and ongoing process. In this case we are preparing for the transition of all PH resources, people and accountabilities either to the LA, PHE or the NHS Commissioning Board and also a transformation in how health improvement is commissioned and delivered in line with Government policy described in earlier sections. This has not been done before, and there is no local road map to follow. Staff may be uncertain of the future and the prospect of employment outside the NHS, an organisation to which many are committed. This transition must be planned for within a period of uncertainty and financial challenge for NHS Peterborough itself. Therefore to ensure the smooth roll-out of the transition plans, whilst maintaining our focus on achieving public health outcomes, it is crucial that we consciously create the conditions needed to facilitate the change, and which may be missing currently.

A Public Health Governance undertaking was signed off by both PCC and NHSP and submitted to the Strategic Health Authority (SHA) in June 2011 (Appendix H).

A detailed draft project plan has been developed in response to the Public Health Checklist issued by DH in December 2012. This is now attached as Appendix J. This project plan outlines the work and timescales required to ensure the smooth transfer of PH roles and responsibilities as required during the shadow transition year 2012/2013. This draft plan must be signed off by both the City Council and PCT Cluster Executive prior to inclusion within the Cluster PCT's Integrated Plan and submitted TO THE Strategic Health authority by 18th January 2013. A final signed off Detailed Transition plan must be completed for implementation by April 2013. This will be informed by HR and other further Guidance due, but not yet issued.

6. Public Health Staffing and Finance

An exercise to scope and quantify the expenditure against specific public health activities was undertaken against the 2010/2011 outturn. The Department of Health (DH) asked for this exercise to be re-validated during August/September. DH

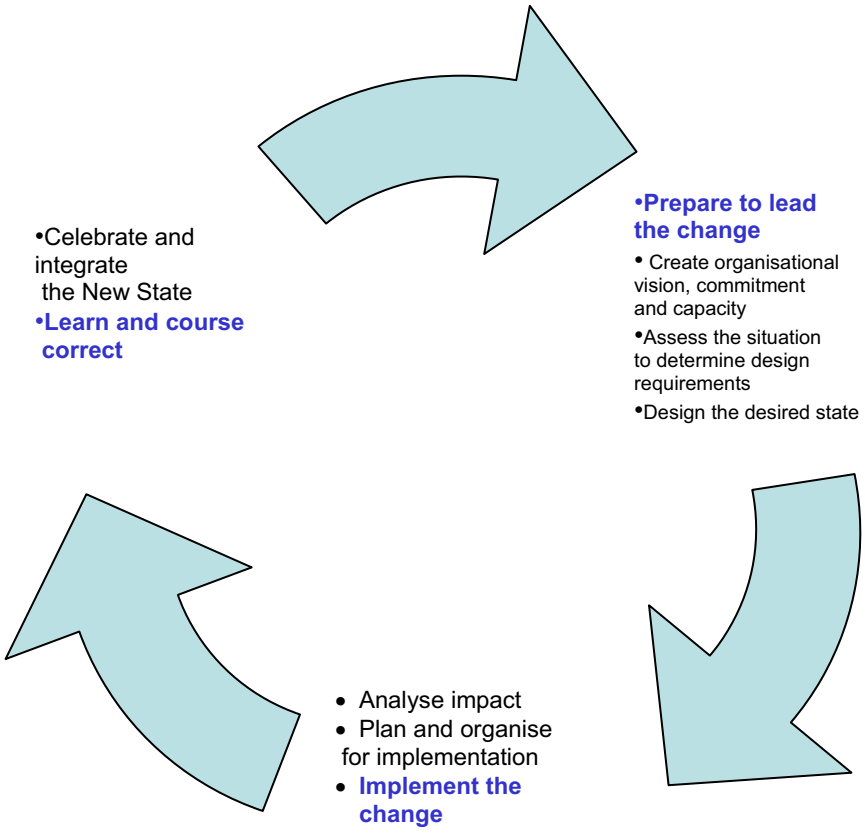
required sign-off of this return by LA chief executives. This work was completed within required timescales and further work will be taken forward by a joint finance sub-group of the Transition Project Group. Separately as part of FIMS returns, this process will continue on a quarterly basis with Quarter 2 validation commencing in early October 2011. The financial summary, submitted to DH is attached as Appendix B.

A staff list is attached at Appendix C. Due to significant turnover of staff in critical posts, a review is currently underway to ensure that these critical functions may be covered during the transition year. This approach will enable us to eliminate duplication and make best use of resources available to commission and deliver priority programmes as required by DH and reflected in local needs. In line with DH and HR Concordat requirements, the Cluster PCT is required to provide all staff, including Public Health staff, with up to date information about their alignment to emerging NHS organisations or LA by the end of January 2012.

7. Managing change within the Public Health Directorate

The Change Process Model (Ackerman Anderson, 2001) illustrated below outlines a full stream road map for getting an organisation from where it is to where it wants to be – in this case getting the PH Directorate and its resources from within NHSP across to the City Council or elsewhere as appropriate. There are several phases of activity that represent how transformation takes place within organisations. Although as a model it cannot tell us what the precise end destination will look like, or what turns we need to make to get there, it can provide guidance regarding what lies ahead. It outlines the general process to take, and how to arrive at our destination most expediently.

The Change Process Model



A more detailed draft transition diagram has been developed by City Council colleagues (Appendix E) and this has been used to inform the draft detailed project plan at Appendix J. The Gantt chart (Appendix G) has been used to illustrate the range of infrastructure and other tasks required to be undertaken and the amount of time required for each. This will be updated and finalised as part of the detailed project plan. A draft PH Governance Checklist developed by the SHA is attached as Appendix D.

In order to take forward the change process specifically within the PH Directorate and involve staff in the process, the following steps have been taken:

- A project lead will is appointed with time allocated to lead this project. An infrastructure project team consisting representatives from key business support areas is to be established.
- A detailed project brief has been produced in draft (Appendix J) and will be signed off and finalised by April 2012. Responsibilities will be clearly assigned that will ensure crucial issues are adequately addressed (e.g. accommodation requirements, HR, contracting and financial management issues, maintenance of good transparent communication lines with staff and colleagues, a focus on service delivery is maintained, including planning for any disruption and communication with our customers).
- A broad time line is laid out, becoming more specific as further details are firmed up
- Staff workshops will provide the setting through which staff will work together to develop a vision and tools to use as we move through the process ensuring ownership and 'buy-in from the team (already commenced).

8. Target operating model and associated design principles

Following discussion with senior officers within the City Council, a number of options or choices have been identified in relation to how Public Health functions may be configured and delivered locally in the future. From the long list , three options have been selected for further consideration. Design principles have been identified, that should underpin these considerations. These are that:

- Any structure should enable specialist PH staff to engage with and support a range of external partners in order to improve and protect population health
- Enable specialist PH staff to engage across the range of PCC functions
- Consideration of any structure should be based on likely impact on population health outcomes
- It should fit with localism agenda
- It should enable ongoing leadership and development of a strong JSNA
- Should complement existing expertise within PCC and should aim to build capacity of PCC to become a truly PH organisation
- Should aim to achieve value for money, through improving quality, efficiency and integration
- Should be creative, innovative and build on partnership approaches

<u>Opportunities and Synergies</u>

- Thinking out of the box – using this as an opportunity to work differently, breaking down barriers and silos involving Neighbourhood Teams, Children's Services and Adult Social Care
- Development of a lifelong pathway
- Jointly commissioning for outcomes – identifying and dealing with duplication
- Commissioning the voluntary sector – include the piece of work currently underway led by SERCO.

- Opportunities to identify longer term quality improvements and efficiencies as a result of service redesign and improved outcomes.

Long list of options:

- *No change – continue to operate current PH Team structures and functions, moving 'en-block' into PCC.*

- *Keep PH Team as a unit, but reconfigure based on servicing new 'customer' base, facing outwards to PCC directorates, CCG/LCGs, NHSCB, PHE, H&WB, PH Network.*

- *Keep PH Team as a unit but matrix work, so that PH Team members sit within different offices/directorates and are closely involved in those directorates' work programmes.*

- *Split PH Team across different PCC offices/directorates so that they are line managed within that office/directorate, but continue to have professional leadership from DPH.*

- *Establish shared service arrangements across Cambridgeshire and Peterborough for PH specialty, PH commissioning, PH offer to CCG/LCG; and consider shared direct delivery services – e.g. smoking cessation.*

- *Outsource Public Health Service direct delivery, whilst maintaining Public Health Specialty and commissioning - possible 'homes' might include Vivacity, although other NHS providers and not for profit sector would be interested.*

- *Grow the PH Team functions to incorporate PCC Teams that face outwards to a similar range of customers and have strong links to health and wellbeing– eg DAAT commissioning, other preventative work, Environmental Health.*

Short list of three options that will be developed and costed fully:

The aim is to enable a new integrated approach to commissioning and delivering preventative services.

Three Models

- A fully integrated PH Improvement function, alongside specific elements of Children's Services, Adult Social Care, Neighbourhoods, focussed on improved outcomes. Shared services elements to be identified within a shared PH function with Cambridgeshire City Council to include the LA offer to NHS commissioners. A real focus on joint commissioning and delivery for improved outcomes.
- All PH functions delivered in-house, with PH provision integrated above alongside other related preventative services and the commissioning function along with the DPH (no shared services).
- All PH functions outsourced, possibly either including the DPH function, or excepting that function.

9. Key questions and decisions

A number of questions need to be answered and decisions made during the next few months, alongside work to develop the costed models described in the previous section. These will impact directly on plans for operating in shadow form by April 2012. The key questions that now need to be addressed are:

What does operating in 'shadow' form mean for NHSP's Public Health Directorate?

and

What are the implications?

The following issues can then be addressed and associated decisions made:

- Accommodation, location and associated costs
- Access to IT/telephones/mobile communications – blackberries, mobile phones (PCC/NHS) and associated costs
- Financial systems (will these change?), contracting processes
- HR processes and ongoing support
- Communications to our customers and service users
- Team set-up and links
- Scoping the PH 'offer' to clinical commissioning group
- The process for matching current resources/commitments to the new funding allocation when announced

10. Project Plan

A detailed draft project plan for addressing the issues identified above and within the recently issued public health transfer checklist is attached at Appendix J.

11. Conclusion

Although there are still significant decisions to be made at national level, it is crucial that focus and resources are brought to bear to achieve the initial transition of the PH Directorate in shadow form by April 2012 and to further develop models and ways of working to ensure they are robust for the statutory transfer in April 2013. This document provides the background and outline of actions that need to be taken forward over the coming months. Further detailed work will form the second phase of this process. Analysis of possible future operating models, including the extent of joint working with the Peterborough system, as well as with local partners in District Councils, Local GP led Commissioning Groups and the voluntary and community sector, and decisions regarding the chosen option, will provide the basis needed to develop and implement longer term plans.

Sue Mitchell
Associate Director Public Health

6th January 2012

Appendix A

Extract from *Healthy lives, Healthy People, update and way forward*: Annex A

A.10 In light of the above, and subject to further engagement, the new responsibilities of local authorities would include local activity on:

- Tobacco control
- Alcohol and drug misuse services
- Obesity and community nutrition services
- Increasing levels of physical activity in the local population
- Assessment and lifestyle interventions as part of the NHS Health check Programme
- 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 programmes
- Comprehensive sexual health services
- Local initiatives to reduce excess deaths as a result of seasonal mortality
- Role in dealing with health protection incidents and emergencies as described in annex B
- Promotion of community safety, violence prevention and response; and
- Local initiatives to tackle social exclusion.

Paragraphs A11 to A 14 detail associated links, opportunities and responsibilities shared across the NHS, National Commissioning Board, PHE and local clinical commissioning groups

Appendix B **Public Health financial summary** **Public Health - 2010/11 Outturn**	**Sub Code**	**Maincode 01** **Admin £000s**	**Maincode 02** **Programme £000s**	**Maincode 03** **Outturn Total £000s**	**Maincode 04** **Income from outside the NHS/DH £000s**	**Maincode 05** **Costs of medicines supplied via FP10 prescription included in Outturn £000s**
Local Authority	**100**					
Public health leadership	**110**	187	167	**354**		
Information & Intelligence functions	**120**	2	124	**126**		
Nutrition, Obesity and Physical activity	**130**	6	405	**411**	52	
Drug misuse	**140**	40	2,569	**2,609**		178
Alcohol misuse	**150**	6	358	**364**	191	
Tobacco	**160**	9	549	**558**	4	203
Dental public health	**170**	0	0	**0**		
Fluoridation	**180**	0	0	**0**		
Children 5-19	**190**	9	567	**576**		
NHS Health Check Programme	**200**	1	94	**95**		
Misc health improvement and wellbeing	**210**	24	186	**210**	42	
Sexual health (STI testing and treatment, contraception, abortion, prevention)	**220**	18	1,141	**1,159**		104
Total	**230**	**302**	**6,160**	**6,462**	**289**	**485**
Commissioning Board	**240**					
Non-cancer screening	**250**	13	868	**881**		
Cancer Screening	**260**	18	1,158	**1,176**		
Healthy Start Vitamins	**270**	0	0	**0**		
Children 0-5	**280**	32	2,056	**2,088**		

Childhood immunisations	**290**	5	322	**327**		
Targeted neonatal immunisation programmes	**300**	0	21	**21**		
Seasonal flu and pneumoccal immunisation programmes	**310**	6	407	**413**		202
TD/IPV and HPV immunisation programmes	**320**	1	79	**80**		
Contraception additional service - GP contract	**330**	14	888	**902**		
Prison public health	**340**	16	1,065	**1,081**		
Total	**350**	**105**	**6,864**	**6,969**	**0**	**202**
Public Health England	**360**					
Dental public health leadership	**370**	0	7	**7**		
TOTAL	**380**	**407**	**13,031**	**13,438**	**289**	**687**

Additional Information	**Sub Code**	**Maincode 01** **Admin £000s**	**Maincode 02** **Programme £000s**	**Maincode 03** **Outturn Total £000s**	**Maincode 04** **Income from outside the NHS/DH £000s**	**Maincode 05** **Costs of medicines supplied via FP10 prescription included in Outturn £000s**
Child Health Information Systems	**390**	420	0	**420**		
Preparedness, resilience and response for health protection incidents and emergencies	**400**	0	7	**7**		
PCT support for surveillance and control of infectious disease	**410**	2	106	**108**		
HIV treatment and care	**420**					
Safeguarding	**430**					
TOTAL	**440**	**422**	**113**	**535**	**0**	**0**

Public Health Directorate **Appendix C**
Staff list by name, grade and function

Name	**Role**
Shakeela Abid	Manager
Julian Base	Head of Health Development
Jane Beever	Smoking Specialist
Judith Merson	Project Support Mgr
Emma Darling	Administrator
Helen Dighton	Health Promotion Adv
Diane Dignam	PA to Consultant
Angela Fappiano	Administrator
Vacant (from 6th Oct)	Senior PH Specialist
Gen FitzJohn	PH Analyst
Nazia Hasan	PH Nutritionist
Helen Haste	Smoking Specialist
Vacant	Smoking Specialist
Mark Kroese	Consultant
Ferzana Kusair	Health Promotion Adv
Karen Lake	Public Health Specialist
Yasmin Lee	Administrator
Andy Liggins	DPH
Kathie Longbone	Neighbourhood Lead
Cheryl McGuire	PH Programme Mgr
Sue Mitchell	Associate Director PH
Vacant	Manager stop smoking
Geeta Pankhania	PH Programme Mger
Vacant (from 20th Oct)	Health Promotion Adv
Vacant	Smoking Specialist
Jane Robinson	Senior PH analyst
Sarah Smith	Health Promotion sport
Andrew Robson	PH analyst
Claire Stevenson	PA
Mandy Workman	PA

Appendix D

Public Health Governance Plans – content checklist

For discussion with Directors of Public Health, 15th April 2011

1. Background

Anita Marsland's transition letter of 17 March 2011[1] specified that:

"(PCT) cluster Chief Executives together with Local Authority CEOs should develop a joint governance plan for Public Health to be in place by June 2011";

And:

"As part of their overall responsibility during the transition period Regional Directors of Public Health will be seeking this assurance from their respective PCT clusters."

The Public Health Transition Group on 30th March requested that a checklist of content for governance plans be drafted and brought back to the Group for consideration. The Group considered the draft on 13th April and agreed it should be discussed with DPHs at the earliest opportunity.

2. Purpose of Governance Plans

The checklist has been created to ensure the governance plans fulfil two core purposes, based on the content of Anita's letter and the expectations set out in Government policy for the public health transition.

A. To ensure that PCT Cluster accountability for Public Health remains clear, with appropriate systems in place for each DPH within the cluster*

B. To set out the intentions for establishing interim working arrangements for DPHs and PH teams to discharge their PH functions in local authorities or other settings as appropriate

* The above point relates to those clusters where two or more DPHs are based within a Cluster

3. Proposed checklist of content

Each PCT Cluster's Governance Plan should contain:

Ongoing accountability of PH

a. An opening statement that recognises the continuing accountability of PCTs for PH functions until April 2013

b. Clarity over how the DPH in each PCT area will be accountable to the PCT Cluster Executive Team and Board, including reporting arrangements and arrangements for providing PH advice to the Board

c. Confirmation of how PCT Cluster budgets for PH will be set for constituent PCT areas (c.f. points o and p below)

Transition to interim arrangements

d. Timelines for major phases of the transition to April 2013 - including (if applicable) when PH staff will move to interim working arrangements outside of the PCT setting

e. Recognition of the need and proposed mechanism to balance competing demands on the PH resources and staff time from PCT and LA (and any other sources such as GP Consortia)

f. Identification of where current PCT-based PH functions will sit in the transitional period, and if possible in the future system

g. Plans for providing GP Commissioning Consortia with specialist PH support to inform their commissioning decisions

h. Clarity over what, if any, current PCT PH activities will be stopped during the period to April 2013

i. The main objectives and work areas for PH during the period to April 2013

j. Identification of where support functions (e.g. HR, media, IT) will come from

k. Identification of the mechanism for placing staff in interim arrangements (e.g. flexible placement, secondment, delegated statutory function)

l. A statement of support for staff to show how clarity over job description and line management structures will be provided

m. Clarity about how staff and representatives will be engaged in the transitional process

n. Key transition risks and how these will be addressed

<u>If a shadow PH budget is to be established:</u>

o. Identification of intended budget sources and control processes

p. Confirmation of how Cluster PH budgets will be divided between different upper tier/unitary LA areas (NB this applies where PCT areas are not coterminous with LA areas)

There should also be an unequivocal statement of what any interim working arrangements <u>do not</u> mean: i.e. no formal transfer of functions, no changes to staff Terms & Conditions, no change of employer or shift in employer liabilities, no expectation that an interim placement gives an advantage in applying for roles in the event of competitive processes being required either during the formal transfer or after

4. **Optional content**

- Proposals for how PH will realise local opportunities to do things differently (e.g. by taking on new roles in the local authority, contributing to health and wellbeing strategies, working across to pathfinder GP consortia)

- Recognition of and planning for staff development needs

5. Plans to be signed off by:

PCT Cluster CEx (and Board)

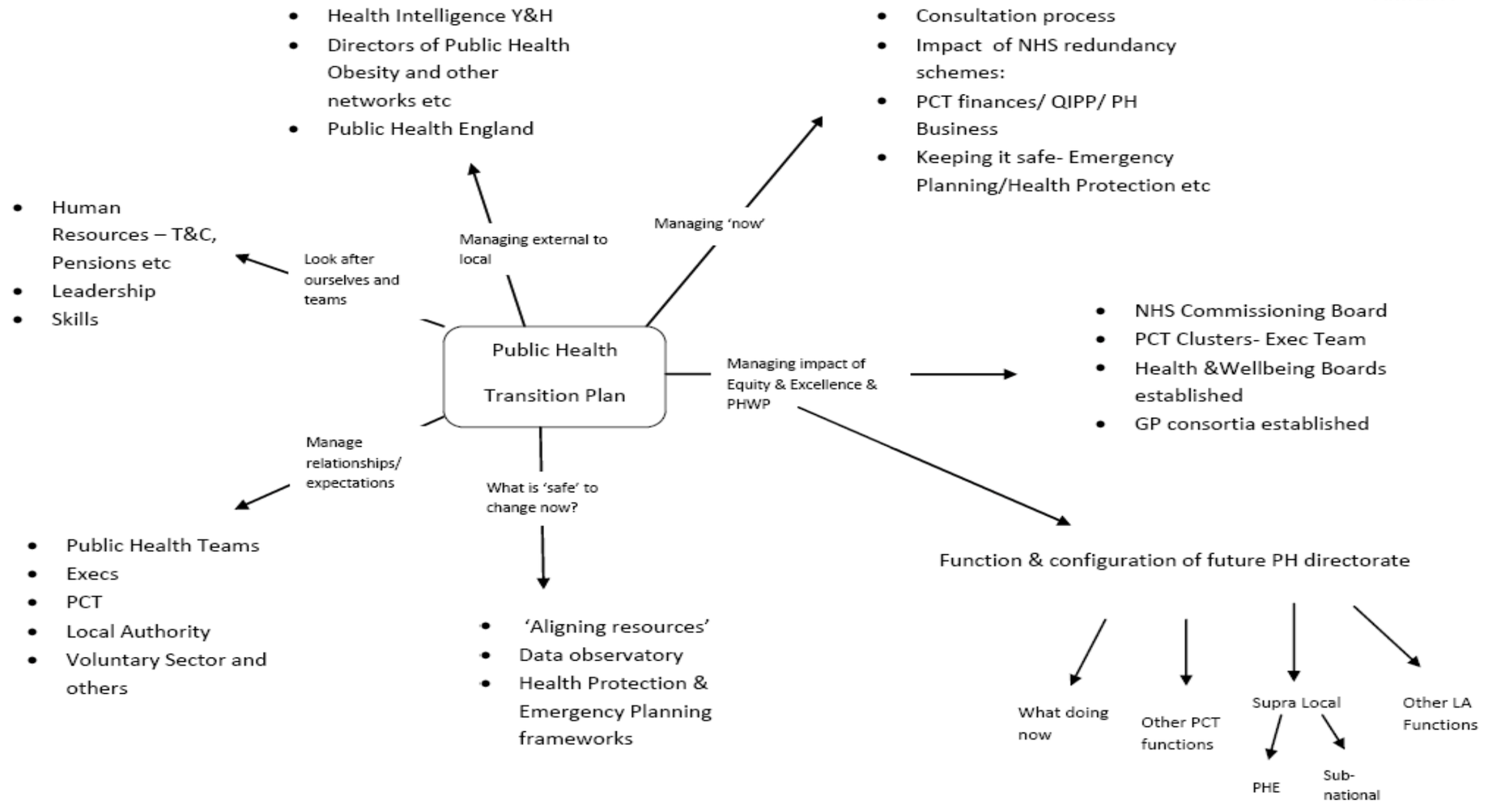
Relevant LA CEx/s (and Members)

Relevant DPH/s

J. Bowen, April 2011

Framework for developing public health transition plans: small 'c' checklist

Annex A



Defining the Local Public Health roles and Functions – Appendix F

Function	Role	Clinical commissioning group/locality	City-wide
Health Intelligence	Providing high quality PH intelligence to improve local understanding of health needs	• Neighbourhood/ locality level needs assessments • Locality profiles contributing to Neighbourhood window	• Leading & co-ordinating the development of the JSNA to inform commissioning decisions across all stakeholders • Public Health Annual Report
	Undertaking/ advising on the production of Health Equity Audits, Equality Impact Assessments and Health Needs Assessments to identify unmet need and improve the commissioning of more equitable service delivery	• Comprehensive Cluster profiling (including all equality groups)	• EIA commissioning tool and process in place across PCC/NHSP. NHS Equality Delivery System in development • Service/ pathway specific HEAs e.g. flu vaccination uptake, sexual health, lifestyle service uptake.
	Management and coordination of public health data	• Scoping and structuring of what's available at locality level	• Scoping and structuring what's available at city wide level and integration with neighbourhood window
	Critical appraisal of published evidence on preventative interventions	• Providing an evidence based response to GP enquiries • Updating evidence based guidance in line with NICE	• Input to service redesigns • Updating service specifications for key service areas e.g. alcohol; sexual health, smoking cessation
	Population segmentation and customer insight	• Training on use of population segmentation models • Smoking activity and profiling within 20% most deprived MSOAs	• Dept of Health 'Healthy Foundations' attitudinal segmentation model is being used to inform the design and future commissioning of behavioural change services • Use of social marketing techniques and population profiles to develop *LiveHealthyLiveGreen* Strategy and Campaign, and interventions such as Let's Get moving and Change4Life programme • Tailoring services for hard to reach communities e.g. cervical screening uptake amongst lesbian women, flu vaccination uptake/ screening campaigns directed at BME communities??
	Identifying funding and resources to develop research proposals and influence system change		
	Designing and advising on the commissioning of programme and service evaluations (providing access to national and regional research networks)	• Mapping childhood obesity levels • Health trainer activity • Smoking cessation activity • NHS Health Checks Programme • Universal services (0-19)	• PH currently leads on the evaluation of *LiveHealthyLiveGreen* projects such as Let's Get moving, Chang4Life, Carnegie weight Management Programme, Health Trainer service • Introduction of early years nutritional standards and associated commissioning of national support in partnership with Children's Services
	Predictive modelling and risk assessment (horizon scanning)	• Application of ACG and other modelling	• Understanding the future impact of changes in local demographic and socio-economic determinants on health priorities
	Health economics and programme budgeting (understanding investment against outcomes)	• Giving advice on how to use and interpret comparative analyses such as the NHS atlas of variations and the Spend and Outcome tool.	• Building the economic case for investment in health improvement programmes through QIPP prevention strands • Specific cost impact work underway for alcohol pathway redesign
	Public Health intelligence related to primary care performance (outcomes and value)	• Consortia level health needs and impact analysis e.g. workbooks re chronic disease management	• Benchmarking data for Quality score card
	Providing data/ intelligence to support service redesign processes. Using data to influence decision making. Data interpretation, priority setting	• Using evidence on cost and clinical effectiveness to challenge secondary care clinicians	• Health intelligence provided to inform service redesign • Advising on prioritisation processes and providing ethical frameworks to enable clinical commissioning group to take tough commissioning decisions
Commission	Working to secure health gain	• Providing the evidence base and	• Advocating for inclusion of sustainability criteria within procurement services

Function	Role	Clinical commissioning group/locality	City-wide
-ing & business planning	across contracts and service specifications Advising commissioners on use of CQUIN and other quality frameworks Budget management, value for money, defining health outcomes	rationale for specific points on patient pathways across the health and social care spectrum to deliver best value	• Advising commissioners about the incorporation of Equality standards into service specifications • Development of health gain schedules/ partnership agreements for health
	Business planning and administration development of business proposals	• Development of business cases/services specifications to meet the needs of specific localities	• Development of business cases for population level Public Health programmes
	Facilitating user/ community engagement in policy making, service redesign and planning, and integrating patient pathways across health and social care	• Support for clinical commissioning group to develop local engagement processes and structures	• GPP Single Delivery Plan, particularly through the *LiveHealthy LiveGreen* Programme Board • Engagement of young people to explore service needs • Implementation of 'Your Welcome' standards in services locally including primary care. • Engagement and involvement of groups representing the nine protected characteristics in assessing and rating standards of care provided locally as part of CQC assessment
	Lead commissioning of lifestyle and other prevention services including performance management of contracts	• Quality assuring the local implementation of national screening programmes	• PH currently leads the commissioning of weight management services (including bariatric provision), Stop Smoking services, physical activity programmes, Health Trainers, adult drug and alcohol treatment and prevention services including IDTS and CARATS services into HMP Peterborough, breastfeeding, children's obesity programmes, sexual health and contraceptive services, domestic and sexual violence services, Health Promoting Schools Programme
	Influencing commissioning strategies and service redesign to ensure prevention approaches are embedded	• Providing advice on appropriate population levels for the commissioning of different services	• Public Health input into GP led service redesigns • Advising on population health interventions and their effectiveness • Advising on areas for disinvestment • Statutory partner in Safer Peterborough Partnership, influencing community safety strategy and decisions • Member of HMP Peterborough Health care Partnership board, influencing and advising health care and health development within the prison, young offender institute and mother and baby unit
	Market shaping to support innovation and service development to encourage early intervention and prevention		• 3rd Sector capacity development through accredited training and development opportunities • Developing new approaches to delivery of stop smoking services
	Public Health expert input to the commissioning of healthcare services	• Public Health leadership and input to consortia management committee business planning • Providing a profile of local populations to identify those at highest risk of admission; comparisons across practices • Providing key indicators and quality targets for inclusion in service specifications • Public health leadership to consideration of exceptional case requests, clinical priorities policies and forum and clinical review group	• Development of locally enhanced services related to prevention e.g. LARC and Smoking LES • Advice and support on the use of Equality Impact Assessments to ensure services meet the needs of vulnerable groups • Contributing to demand management e.g. alcohol active flyer case management programme • Influencing the development of specifications and service redesign to incorporate outcomes to address wider health determinants
	Commissioning of services to meet the health needs of marginalised groups		• Domestic Violence outreach service and • ISVA service • Live Healthy champions delivering through homelessness centres and NACRO • Job Centre Plus, Reed in Partnership
	Development of strategic commissioning frameworks		• Development of strategic commissioning framework for CVD prevention
Unleashing	Facilitating access to community/	• Neighbourhood Health champions	• Roll out of *LiveHealthyLiveGreen* Campaigns at city-wide

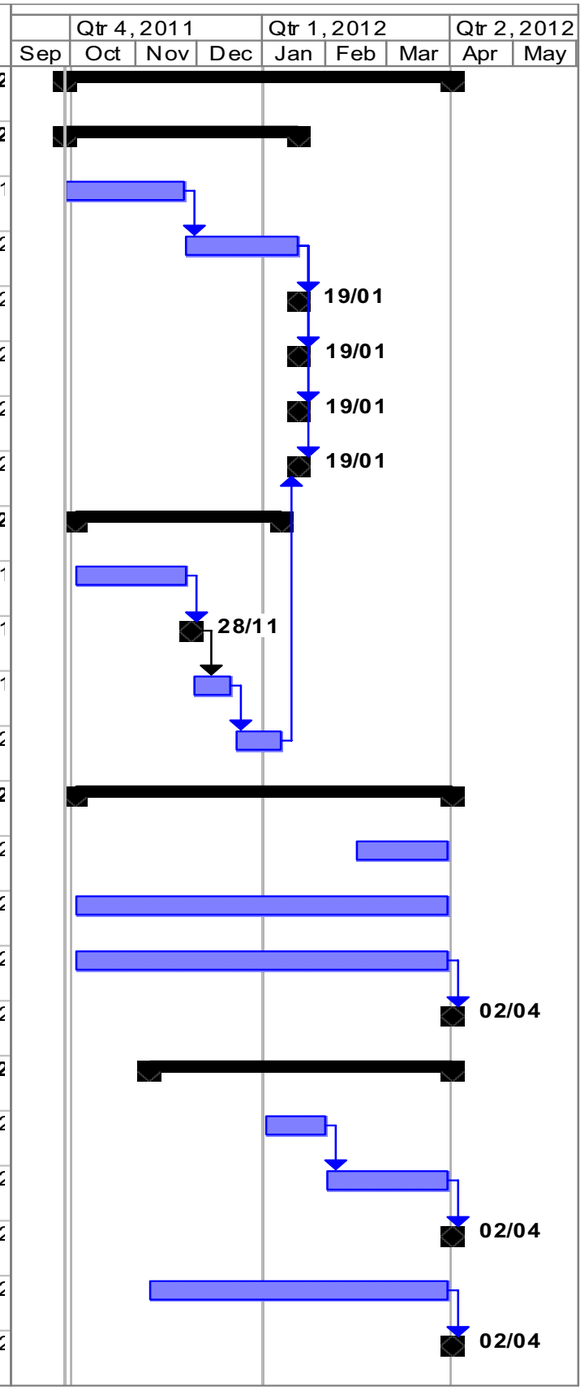
Function	Role	Clinical commissioning group/locality	City-wide
talents/ Community Engagement	neighbourhood based networks to support engagement or promotional activities	• Love Local and similar initiatives	
	Delivery of programmes to support the development of health literacy and promote self-care *(LiveHealthy*)	• Developing and maintaining network of Health Champions in range of settings	• As accredited Level 3 Training Centre, delivery of RSPH level 1 and 2 Award in Understanding Health Improvement and delivery of RSA Level 3 Health Trainer course • *LiveHealthy LiveGreen* Strategy and Campaign • Developing and maintaining network of Health Champions in range of settings
	Supporting communities to develop their own plans and programmes for health improvement (co-production)	• Work with neighbourhood based health sub-groups to identify priorities and develop health improvement plans • Working with local groups to offer community based Health Checks	
	Strengthening the capacity and contribution of voluntary, community and business sectors to support local health improvement	• Developing local connections and supporting the development of opportunities for local organisations to engage in health improvement e.g. involving local businesses in *Livehealthy Live Green* Campaign	• Development of healthy stadia programme within amateur sports sector • Through the GPP Charity and social responsibility (CSR)Forum
PH capacity Development / Workforce Skills Dev.	Strategic development and advice for public health workforce planning	• Plan and develop a wider Public Health workforce • Enhance the role of frontline staff 'to make every contact count'	• Lead development and implementation of local strategy to increase public health skills and competence amongst frontline staff • Develop regional workforce role
	Commissioning and delivering programmes to support local public health training networks and capacity/ Building capacity for health improvement at all levels of the system	• Delivery of specific programmes to increase public health knowledge and competence e.g. • Cultural competence training • Mental health awareness training • Topic specific training on key public health issues e.g. alcohol, smoking, obesity, sexual health • Training/ developing an understanding of wider determinants of health e.g. unemployment and health	• Level 3 Accreditation Centre • Commissioning of Essential Public Health training
Policy & Partnership Work	Partnership development to improve health and reduce inequalities (particularly to address wider determinants)	• Improving joint working around the wider determinants of health and links to key programmes across the Single Delivery Plan • Public Health input into stake holder events as part of PBC pathway redesigns	• Lead the *LiveHealthy, Livegreen* Programme Board and Partnership • Lead the development of the Tobacco Control Alliance and action plan in 2012 • Develop a Marmot action plan in order to develop a multi-agency approach to tackle health inequalities
	Support system reform	• Development of Equality Delivery System as a legacy for the clinical commissioning group	• Co-lead development of Health & Wellbeing Board including facilitation of stakeholder events
	Influencing strategic planning & performance frameworks		• Development of outcome frameworks for health & wellbeing eg Public Health Framework • Development of public health commissioning priorities based on a thorough assessment of local health & wellbeing needs
	Leading the development of health promoting settings	• Provide PH specialist advice and input into operation Can-do (Central, Millfield and Dogsthorpe)and lead the alcohol element of the initiative	• Workplace health programmes • Health Promoting Schools • Commissioning of Healthy Business Programme • Specialist PH advice and input into HMP Peterborough including refresh of the health needs assessments
	Provide specialist advice to the	• Provide knowledge and expertise	• PH support to operation Can-do

Function	Role	Clinical commissioning group/locality	City-wide
	commissioning of programmes that address wider determinants e.g. worklessness	around specific health at work programmes e.g. long term condition management	• PH support into Neighbourhoods and Safer Peterborough agendas
	Public health specialist input to public sector/ local authority policy developments	• Area based approaches/ Total Place pilot work	• Input to Sustainable Community Strategy and GPP Single Delivery Plan and • Housing policy frameworks • Input to Economic partnership plans
Health protection	Expert input into infection control, communicable disease control and outbreak management.	• Support clinical commissioning group in infection control policy development • Providing support and advice in respect of new buildings and upgrades to ensure compliance with current infection control legislation. • Assist Root Cause Analysis for MRSA bacteraemia, C. difficile infections and other emerging health care associated infections. • Support and advice for independent contractors (GPs, dentists) in ensuring compliance with current decontamination guidelines. • Support to GP consortia redesigning pathways in regard to health care acquired infections.	• Targeted surveillance of Health Care Associated Infections (e.g. MRSA, C. difficile) • Co-ordination of immunisation programmes • Training of staff on immunisation and infection control • Provide advice to staff on immunisation and infection control • Provide advice to the general public • Ensuring compliance with Hygiene Code of Practice for all providers (Health Act 2008) • With partners (e.g. Local Authority, care homes, etc) monitor and respond to communicably disease outbreaks (e.g. Norovirus, E. coli, etc.)
	Planning for emergencies	• Provide knowledge and expert advice concerning emergency planning and resilience • Provide support in assessing local risks (e.g. flooding of health care premises). • Support local planning to address identified risks. • Provide training on emergency planning and response to incidents • Support clinical commissioning group business continuity planning	• Support city wide risk assessment including contributing to the City Community Risk register. • Produce, update and maintain City wide emergency plans (e.g. Major Incident Plan, Severe Weather Plan, Influenza Pandemic Response Plan, etc.) • Support the maintenance, updating and exercising multi-agency plans (e.g. multi-agency flood plan) • Support 'Whole System' business continuity management in respect of health and social care.
	Responding to emergencies	• Support clinical commissioning group in managing local incidents and the local effect of wide scale incidents. • Communication of health related information and advice to the general public during an incident. • Support local recovery phase following an incident.	• Support multi-agency response to an incident. • Lead tactical response (including command and control) to incidents that have a major health component (e.g. influenza pandemic). • Support media response by providing expert advice. • Support City- wide recovery phase following an incident.
Corporate and Statutory Functions	Co-ordination of national screening programmes.	• Risk management & quality assurance of programmes • Advice on improving uptake of screening programmes	
	Providing robust and evidence based information and advice to the local population on public health issues	• Potential for clinical commissioning group specific and tailored campaigns to meet local needs/ tackle specific issues e.g. increase uptake of services (boost campaigns)	• Providing advice to the general public and the media concerning measures to reduce the health consequences of heatwave in the summer and cold, snow and ice in the winter. • Provide advice to the general public and the media concerning communicable diseases and immunisation. • Leading local dissemination of national public health campaigns • Developing proactive campaigns to address and raise awareness of local public health issues

(Adapted from source: K Ardern)

Appendix G: Gantt chart (Example timeline)

ID	Task Name	Duration	Start	Finish
1	**Public Health Transition Plan**	**133 days**	**28/09/11**	**02/04/12**
2	**Governance**	**81 days**	**28/09/11**	**19/01/12**
3	Develop and Agree Public Health Transition Plan	42 days	28/09/11	24/11/11
4	Develop Recommendation Papers	39 days	25/11/11	18/01/12
5	Senior Leadership Team Approval	0 days	19/01/12	19/01/12
6	Corporate Management Team Approval	0 days	19/01/12	19/01/12
7	PCT Board Approval	0 days	19/01/12	19/01/12
8	PCC Cabinet Approval	0 days	19/01/12	19/01/12
9	**Accomodation / Location**	**71 days**	**03/10/11**	**09/01/12**
10	Review Location Options	40 days	03/10/11	25/11/11
11	Location Confirmed	0 days	28/11/11	28/11/11
12	Accomodation Planned	14 days	29/11/11	16/12/11
13	IT/ Telecommunications Planned	16 days	19/12/11	09/01/12
14	**HR Processes**	**130 days**	**03/10/11**	**02/04/12**
15	Plan Developed and Implemented	33 days	15/02/12	30/03/12
16	Communication Plan Implemented	130 days	03/10/11	30/03/12
17	Directorate Structure / Links Scoped	130 days	03/10/11	30/03/12
18	Directorate Structure / Links Implemented	0 days	02/04/12	02/04/12
19	**Finance**	**105 days**	**07/11/11**	**02/04/12**
20	Identification of New Resource Allocation	22 days	02/01/12	31/01/12
21	Mapping Commitments Against New Allocation	43 days	01/02/12	30/03/12
22	Resources Confirmed and Implemented	0 days	02/04/12	02/04/12
23	Financial Reporting and Contract Management Systems Planned	105 days	07/11/11	30/03/12
24	Financial Reporting and Contract Management Systems Implemented	0 days	02/04/12	02/04/12



Appendix H

Cambridgeshire and Peterborough Joint Public Health Governance Plan

1.0 Introduction

The purpose of this joint public health governance plan is:

A. To ensure that Primary Care Trust (PCT) Cluster accountability for Public Health remains clear within Cambridgeshire and Peterborough during transition, with appropriate systems in place for both Directors of Public Health (DsPH).

B. To set out the intentions for establishing interim working arrangements for DPHs and Public Health teams in Cambridgeshire and Peterborough to discharge their public health functions in local authorities or other settings as appropriate.

2.0 Ongoing accountability of Public Health

- Cambridgeshire and Peterborough Primary Care Trusts will remain accountable for public health functions for their populations until April 2013.
- Both the Cambridgeshire DPH and the Peterborough DPH are members of the Cluster Executive Team, and both report to the Cluster Chief Executive.
- The DsPH will provide public health advice to their respective PCT Boards, which meet separately, and to their respective local authorities.
- Public health budgets for the two PCT areas, which are co-terminous with the two upper tier local authority areas for Cambridgeshire and Peterborough, will be set separately.

3.0 Transition to interim arrangements

We are currently awaiting further clarity nationally from the government response to the Future Forum and the Public Health Command Paper, before finalising local models and timescales for transition.

3.1 Cambridgeshire

Governance Structures

The joint governance arrangements in place to oversee the transition in Cambridgeshire are as follows:

- The 'Joint Workstreams Officer Group' (JWG) which has director level representation from Cambridgeshire County Council, Cambridgeshire PCT, a District Council, LINks, the GP Commissioning Senate and the LMC is taking forward Local Authority/NHS transition workstreams in Cambridgeshire, including public health transition. The work of the JWG is overseen by two Member/Non-Executive Partnership Boards – the Community Wellbeing Partnership Board and the Children's Trust Board.

- In Cambridgeshire PCT, the Board has devolved a range of clinical decision making, and some budgetary responsibility to the GP Commissioning Senate and GP Local Commissioning Groups. Governance arrangements make it clear that public health decision making will remain with the cluster PCT senior leadership team, although it will often be appropriate to consult with the GP Senate/LCGs.
- Within the County Council, transition issues are taken forward through the internal Public Health Management Team, with representation from all the Council Offices. In addition the Director of Public Health attends the County Council Strategic Management Team and has regular one to one meetings with the County Council Chief Executive.

Public Health Team objectives and workload

- The Director of Public Health objectives for 2011/12 have been agreed by both the PCT and County Council CEs. It is the role of the DPH and Public Health senior management team to balance and prioritise competing demands during the year – with support from the governance arrangements already outlined.

- There are no current plans to cease identified public health activities, but this will need to be reviewed during the year.

Transition plans

- The existing position is that public health staff remain physically based within Cambridgeshire PCT, although desk numbers have been shared with the County Council to enable forward planning.
- There will be an organisational development approach to building links between the current PCT public health team and the county council staff. There are already many areas of joint working. One priority we have identified is for public health staff to gain a better understanding of the internal bureaucratic and democratic processes within the County Council, as they apply to policy development and decision making. A joint implementation plan to involve PCT PH staff in these processes will be produced.
- Cambridgeshire has established a link public health consultant for each GP consortium and is in process of agreeing a model for public health input to GP consortia with the Cambridgeshire GP Senate and local commissioning group chairs.
- Options for the future configuration of public health within the County Council are being developed, but further national clarity, together with consultation with local stakeholders and PH directorate staff will be needed before these are finalised.
- Support functions for public health such as finance/HR currently come from the PCT, and the costs of these have been recognised in the end of year accounts public health return. Many of these functions are provided by a small number of staff and may be difficult to disentangle, so transition will need to be pragmatic.
- Transition has been discussed at public health directorate meetings, and both the concerns and ideas of current public health staff have been incorporated into the organisational development approach to transition as outlined earlier.
- Line management structures for public health staff are currently clear and there is no short term intention to change these, although - as always, changing circumstances may lead to new options being explored in consultation with the staff involved.
- Cambridgeshire PCT currently acts as a public health training location, and training of public health specialist registrars within the County Council setting needs further discussion.

3.2 Peterborough

The joint governance arrangements in place to oversee the transition in Peterborough are as follows:

- A Transition Project Group has been established and its membership is evolving. Its role is to oversee the development of the shadow Health and Wellbeing Board, development of Health Watch, as well as the transition of public health functions to the City Council. There is director level representation from Peterborough City Council, Greater Peterborough Partnership, Peterborough PCT and the GP Commissioning Sub-committee. Further representation has been sought from LiNKs and from the voluntary sector.

- Within the City Council, transition issues are taken forward through the Transition Project Group to the Corporate Management Team, of which the DPH and the DASS, in their joint roles for the City Council and PCT, are executive members.

- Elected members will be involved in the transition planning and any necessary decision-making process.

Public Health Team objectives and workload

- The Director of Public Health objectives for 2011/12 will be agreed by both the PCT and City Council CEs. It is the role of the DPH and Public Health senior management team to balance and prioritise competing demands during the year – with support from the governance arrangements already outlined.

- There are no plans to change identified public health objectives or resources this year.

Transition plans

- The existing position is that public health staff remain physically based within Peterborough PCT.
- A Transition task and finish sub-group established by the PCT Cluster SLT has almost completed work to quantify numbers and associated costs of staff and support functions that will be expected to move across to PCC. Further discussion will be undertaken with Peterborough City Council
- A Business Plan and a Transition Plan for Public Health are being completed. These plans will ensure that a systematic approach, built on organisational development and change management processes underpins the transition. Engagement and involvement of staff are key to this approach. The business plan will also ensure that a focus on delivering outcomes is maintained during the transitional period.
- Options for the future configuration of public health within the City Council will be developed, but further national clarity, together with consultation with local stakeholders and PH directorate staff will be needed before these are finalised.
- Support functions for public health such as finance/HR currently come from the PCT, and the costs of these have been recognised in the end of year accounts public health return. This area has been considered as part of the work of the task and finish group referred to earlier.

- Transition has been discussed at the Public Health/Health Improvement Delivery Board and at public health directorate meetings, and both the concerns and ideas of current public health staff have been incorporated into the organisational development approach to transition as outlined earlier.
- Line management structures for public health staff are currently clear and there is no short term intention to change these, although - as always, changing circumstances may lead to new options being explored in consultation with the staff involved.
- Peterborough PCT currently acts as a public health training location, and training of public health specialist registrars and FY2 doctors within the City Council setting needs further discussion.

4.0 Financial and HR issues

- We are awaiting national guidance on shadow public health budgets, and have no immediate plans to transfer public health resource prior to this guidance being available.

- Similarly we are awaiting national guidance on employment and HR issues. There are no current local plans to formally transfer public health functions, and the informal arrangements for individual staff members to work more closely with the local authority or with GP consortia will not cause any changes to staff Terms and Conditions, or any change of employer or shift in employer liabilities.

5.0 Key risks

The key risks in relation to transition are

- Failure to retain skilled public health staff in a climate of uncertainty
- Competing demands from different organisations leading to overload of individual staff members.
- Failure to focus on delivery of population health outcomes, due to the workload related to transition.
- Potential change or Instability in support functions provided to the public health team by the PCT as it moves to a GP commissioning support model.

These risks will be actively managed by the Directors of Public health and their Public Health Senior Management Teams, with support from the governance arrangements outlined in section 3.1 and 3.2.

6.0 Signatures

Chief Executive Cambridgeshire and Peterborough PCT Cluster
Chief Executive Cambridgeshire County Council
Chief Executive Peterborough City Council

Workforce and the New Public Health System

Department of Health

Public health transfer from primary care trusts to local authorities

Staff working in public health are our greatest asset. In transferring primary care trust public health commissioning functions to local government, employers and trade unions are determined to ensure that staff are treated fairly and transparently.

Primary care trusts and local authorities will be responsible for developing public health transition plans and consulting with their constituent trade unions and staff on these and the associated workforce plans.

To support this, key guidance and support are being developed at national level, which outline the human resources (HR) processes and expectations on primary care trusts, councils, NHS and local government trade unions in managing this important change.

Public Health Human Resources Concordat

The Public Health HR Concordat, developed by the Department of Health with NHS Employers and the Local Government Association, and in partnership with NHS and local government trade unions, has been published.

This provides a best practice framework for organisational changes affecting staff as part of the transfer and sets out a range of principles and HR standards for managing the processes involved, complementing the HR Transition Framework.

The Concordat has the following objectives:

- provides guiding principles and HR standards for the transfer of primary care trust public health commissioning activity and functions ("senders") to local authorities ("receivers")
- provides a fair and consistent approach to managing the related detailed HR processes in a local context – advancing equality and promoting diversity
- outlines the indicative timescales for change and the requirements on NHS and local government employers and trades unions in managing this important change
- identifies where and when decisions will be made or where further detailed information can be obtained
- promotes effective partnership working and consultation with staff and trade unions across the NHS and local government.

PLEASE NOTE THAT YOU NEED TO DOUBLE CLICK ON THIS ADOBE DOCUMENT TO VIEW IN FULL

Appendix J

NHS Cambridgeshire and NHS Peterborough Cluster PCT

Public Health Transition

Project Plan

Objective	Current position	Plan	Timescale	Lead
Annex 2: Health and Wellbeing Boards				
1. Enable the emerging CCG to work with CCC and PCC to establish the two local H&WBs in shadow form by end March 2012 and begin refreshing the JSNAs for Cambridgeshire and Peterborough	The H&WBs for both Cambs. and Peterborough are established in shadow form, with engagement from clinicians. Both JSNAs have very recently been refreshed.	Both boards will operate in shadow form and further developed during the shadow year • **Cambridgeshire**: Work is now in train to add further financial and activity information to the JSNA to ensure it is fit for purpose to support development of the Health and Wellbeing Strategy	Completed April 2012	AL/LR LR/ND
2. Enable emerging CCG to jointly lead the H&WBs, identifying high level priorities from the JSNAs as a basis for the Joint JHWS **Agreed JHWS to be used as foundation for 2013/2014 CCG/LCG planning and commissioning processes, and subsequent planning cycles, updating both the JSNA and the JHWS regularly**	Existing JSNA findings have already been shared widely in both areas. These will be used to underpin the H&WB agendas	Both Boards will work jointly with CCG/LCG representatives to develop JHWS • **Peterborough:** Draft JHWS developed • **Cambridgeshire** Draft JHWS to be developed Three month public consultation JHWS approved Cambs & Peterborough This will be built into the annual H&WB planning cycles	By April 2012 by June 2012 by May 2012 May- August 2012 Sept/Oct 2012	AL/LR AL/LR Chair H&WBs/Chair CCG
Annex 3: Questions to support narrative assurance				
3. Ensure that the cluster PCT Integrated Plan include delivery	Yes there is a section within the draft plan that relates specifically to delivery of Public Health Reforms in		Completed	

of the Public Health Reforms	Cambs. and Peterborough.			
Annex 6: Public Health Checklist				
4. Ensuring a robust transfer of systems and services				
• PCT cluster/LA arrangements for operating the local PH systems during 2012/2013 in readiness for the statutory transfer in 2013.	• **Peterborough** . A comprehensive Transition plan was produced in October. This Plan is regularly refreshed to reflect emerging guidance and local developments in thinking. PH staff are working closely with City Council executives and officers through a Transition Group. A business plan for 2011/2012 has been produced and this will be refreshed for 2012/2013 to ensure that systems and services are disrupted as little as possible during the Transition year. • **Cambridgeshire** A governance agreement was agreed and submitted to the SHA in 2011 outlining how the PCT Cluster/LA would work together to ensure delivery of public health functions over the transition period.	• **Peterborough** A refreshed business plan will be produced for 2012/2013 There is clear agreement in principle to run a shadow year from April 2012, which will include relocation of public health staff to County Council premises and testing of models of joint working. Safe transition of statutory functions such as emergency planning will be a priority; and arrangements will be developed in parallel with more detailed national policy as it emerges. More detailed work on budget transfers and HR issues will be carried out by the PH transfer infrastructure steering group. • **Cambridgeshire** There is clear agreement in principle to run a shadow year from April 2012, which will include relocation of public health staff to County Council premises and testing of models of joint working. Safe transition of statutory functions such as emergency planning will be a priority; and arrangements will be developed in parallel with more	April 2012	SM/AL LR/PH

		detailed national policy as it emerges. More detailed work on budget transfers and HR issues will be carried out by the PH transfer infrastructure steering group.		
• Clear local plan in place setting out the main elements of transfer for 2012/13, including agreed transition milestones	• **Peterborough** The Transition Plan addresses these issues but will be further developed to reflect emerging guidance and sections added that will focus on specific elements such as transfer of staff, commissioning, contracts. The current milestone chart will be revised following the new guidance received. • **Cambridgeshire** A roadmap for the key transition milestones to March 2013 has been agreed	• **Peterborough** The Transition Plan and associated milestoneswill be further developed to include specific sections on these and other issues in line with Guidance as it emerges. This will be developed jointly with PCC officers and with direction from the H&WB • **Cambridgeshire** The details of plans and milestones will be further developed in line with emerging national policy	April 2012	SM/AL LR/PH
• JSNA development for use by H&WBs/CCG	The JSNAs for both Cambridgeshire and Peterborough have very recently been updated and are now being disseminated widely	JSNAs will be used to inform visioning and planning by both H&WBs and the CCG/LCGs as part of their organisational planning cycles **Cambridgeshire** – further work is being taken forward to factor financial and activity information into the JSNA, to further support strategy development.	Completed April 2012	LR/ND
• Clearly developed plans in place for the smooth transfer of commissioning arrangements for services described in Healthy Lives Healthy	• **Peterborough** This is covered within the existing transition plan. Officers have been tasked to develop fully costed options (models) for the effective future delivery of all associated functions, focussing on innovative	• **Peterborough** Work currently underway, and when completed will be used to brief senior executives and elected members	March 2012	SM/AL

People	solutions that will improve quality, effectiveness and efficiency of both commissioned functions and services and direct service delivery • **Cambridgeshire** The relevant services and budgets have been identified.	• **Cambridgeshire** Further work will be needed to (a) develop models for future delivery of PH commissioning functions in the local authority setting including the potential for joint working with Peterborough (b) carry out detailed financial analysis and novation of existing contracts.	October 2012	CCC SMT Infrastructure steering group
• Clearly developed plans in place for ensuring smooth transfer of functions migrating to PHE and NHSCB	Discussions have been held and it has been agreed to establish a specific cluster PCT-wide task group to take this work forward	Task Group to be established and a subsequent plan produced for sign-off by cluster PCT Executive and Board. Regular updates on progress will be submitted to CET and Board during the year.	April 2012 Quarterly	AL/LR/AM
• Delivering the core offer of LA-based PH advice to the CCG/LCGs	• **Peterborough** Discussions have been held and this element of service provision will be included in the work to develop costed options(models) • **Cambridgeshire** A brief local core offer document had been agreed between GP commissioning senate and the PH team prior to national guidance being issued.	• **Peterborough** The decision on future operating model will incorporate this offer. Once the decision has been made work will progress immediately on the practical arrangements required for this element. • **Cambridgeshire** Further discussions have been held with agreement to pilot the national 'core offer' through a jointly agreed workplan for 2012/13	March 2012 March 2012	 SH/LR
5. Delivering Public Health Responsibilities	• **Peterborough** The business plan for 2012/2013 will be refreshed to reflect new	• **Peterborough** Robust delivery mechanisms are in place and these will be reviewed in		AL

during transition and preparing for 2013/2014	guidance on specific delivery of mandated functions Specific arrangements are in place for the delivery of critical PH services/functions such as screening programmes, Imm. And Vacc., Drug and Alcohol Services, Infection Control • **Cambridgeshire** 2012/13 delivery of sexual health services, childhood measurement programme and health checks are under negotiation in the current contracting round. Health protection plans are agreed through the joint local Health Protection Committee. Arrangements are in place for critical functions such as screening, imms and vaccs, drug and alcohol services and infection control	line with project work referred to above. This will be covered within the business plan and Transition Plan • **Cambridgeshire** Further work will be carried out to establish the detail of the transfer of these functions nad contracts, and to enable local authority leadership of the 2013/14 contracting round, in close collaboration with partners.		LR/Infrastructure Steering group
6. Workforce planning	• **Peterborough** Plans to date are in line with the HR Concordat. All staff have been fully informed about PH reforms and potential implications for their future. In addition a series of workshops is currently underway, providing support, guest speakers, including local Cabinet Portfolio holder, and Deputy Directors for PCC and refresh of key skills. A section is always dedicated to	• **Peterborough** All staff will receive formal communication regarding future alignment. All staff will have access to HR and line management support. The Transition plan will be updated in line with HR guidance.	31 January 2012	SM/AL

	ensuring all fully understand and are up to date with latest local and national position and guidance. HR issues are covered within the Transition Plan • **Cambridgeshire** Plans to date are in line with the HR Concordat. An OD programme has been agreed, which has so far included attendance by the Cabinet portfolio holder for health and wellbeing at a PH team awayday, and a welcome/induction at County Council headquarters, with input from the Chief Executive, portfolio holder and HR team.	• **Cambridgeshire** Workforce planning will be further developed following issue of national guidance on PH workforce and specific transfer issues.	Dependent on timing of national guidance	AM/CR
7. Governance	• **Peterborough** A Governance agreement was agreed and submitted to the SHA in 2011 outlining how the PCT cluster/LA would work together to ensure delivery of PH functions over the transition period. A Board Assurance Framework has been developed and this will be used by the H&WB to enable monitoring of progress towards transition, key risks and associated mitigation. This can also be shared with the Cluster PCT Executive and relevant identified risks incorporated into the PCT's BAF. Key functions such as emergency planning have existing arrangements which include clear	• **Peterborough** Further develop the BAF in line with risks identified following further guidance and issues flagged through the PH Transition check list. Add the BAF as a standing item to the H&WB agenda Further work needs to be done to amend the City Council Constitution to incorporate the transfer of public health functions PH performance needs to be incorporated into City Council performance reporting systems. While the statutory responsibility remains with the PCT Board, work will be done over the year to clarify	February 2012 April 2012 May 2012 October 2012	AL HE/CMT SM/SERCO AL

	lead PCT and DPH arrangements for the LRF. We are expecting NHS EP to remain with NHSCB, while the DPH retains significant responsibilities for health protection EP. Clinical governance. In the short term we expect to continue using PCT clinical governance support and systems for SUIs etc. • **Cambridgeshire** An overall governance framework for the PH transfer was agreed and submitted in 2011 PH Performance monitoring reports are made on a regular basis to the PCT Board. Key functions such as emergency planning have existing arrangements which include clear lead PCT and DPH arrangements for the LRF. We are expecting NHS EP to remain with NHSCB, while the DPH retains significant responsibilities for health protection EP. Clinical governance: Transition risks are identified as part of the NHS Cambridgeshire PH directorate risk register and escalated to the NHSC BAF if appropriate. In the short term we expect to continue using PCT	how the City Council will ensure robust health protection, emergency Planning (EP), and to ensure effective joint working between PH and the local authority EP functions. Further work is needed to add risks when appropriate to the City Council risk register, and ensure public health is integrated into City Council risk management processes. There are a number of clinical governance issues which will be relevant when health professionals working in PH move to local government. This was raised as an area where specific SHA level guidance would be valued to support PCTs. A task group will also be set up within NHSC/NHSP to assess this in more detail. As policy and future models become clearer, appropriate risk sharing agreements will need to be developed. Clear risk shares would also need to be agreed for the option of an integrated system with Cambridgeshire. Discussion is needed within the City Council on use of the sector led improvement approach for public health. • **Cambridgeshire** Further work needs to be done to amend the County Council	May 2012 October 2012 February /March 2012 April 2013	HE/AL SM/AL/Transition Innovation Group

	clinical governance support and systems for SUIs etc.	Constitution to incorporate the transfer of public health functions		Q
		PH performance needs to be incorporated into County Council performance reporting systems.	May 2012	SMT
	A risk sharing approach to transition has not yet been agreed.	While the statutory responsibility remains with the PCT Board, work will be done over the year to clarify how the County Council will ensure robust health protection EP, and to ensure effective joint working between PH and the local authority EP functions.	October 2012	LR/LS/PH
	Sector led improvement models have not yet been agreed. The County Council is supportive of the mutually agreed approach with the PCT Cluster to the public health transfer.	Further work is needed to add risks when appropriate to the County Council risk register, and ensure public health is integrated into County Council risk management processes. There are a number of clinical governance issues which will be relevant when health professionals working in PH move to local government. This was raised as an area where specific SHA level guidance would be valued to support PCTs. A task group will also be set up within NHSC/NHSP to assess this in more detail. As policy and future models become clearer, appropriate risk sharing agreements will need to be developed. Clear risk shares would also need to be agreed for the	May 2012 May 2012	SMT Infrastructure

		option of an integrated system with Peterborough. Discussion is needed within the County Council on use of the sector led improvement approach for public health.	October 2012	steering group PHMT
8. Enabling infrastructure	• **Peterborough** Officers and executives from PCC are working closely with PH to develop and implement all aspects of the Transition plan. As PH has been based within LA accommodation for several years, and has had a number of services/functions jointly delivered or commissioned, we are familiar with many of the infrastructure issues that may arise. • **Cambridgeshire** The public health infrastructure steering group is currently being established to ensure appropriate capacity is available from both organisations to provide infrastructure support for the public health transfer. It includes both PCT and county council representatives as follows: Lead directors (LR/PH) Finance lead HR lead IT lead	• **Peterborough** A separate section of the Transition plan will be updated to address all infrastructure elements of transfer. Any associated risks identified will be added to the BAF. • **Cambridgeshire** Plans to address the infrastructure issues outlined will be developed through the public health infrastructure steering group.	April 2012 Infrastructure steering group	Infrastructure steering group Ongoing to April 2013

	Estates Lead Legal input - CCC only (as CCC already provides the legal support to the PCT)			
9. Communication and engagement	• **Peterborough** A Transition Project Group has been meeting for several months and has both overseen PH Transition issues but also developed the H&WB and early plans for HealthWatch. GP leads from the local Clinical commissioning Group are also members of this group. • **Cambridgeshire** A communications plan with a focus on PH and county council staff is in development, as part of the existing public health transfer roadmap. Updates for wider stakeholders on the public health transfer are produced regularly as part of the joint workstreams newsletter (which also covers the HWB, joint commissioning developments and development of HealthWatch). The newsletter is circulated to partners including GP commissioners, district councils, LINks, local HPU director. A stakeholder survey and stakeholder event were both carried out in December 2011.	• **Peterborough** A robust communication plan should be developed building on the work of the Transition Group. • **Cambridgeshire** The communications plan will be finalised and implemented. Stakeholder engagement will continue to be an integral part of the planning and implementation of the transfer, building on the December survey and stakeholder event.	April 2012 February 2012	Infrastructure steering group AB/LR Ongoing to April 2013

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PETERBOROUGH CITY COUNCIL

SHADOW HEALTH AND WELLBEING BOARD

MONDAY 6 FEBRUARY 2012
1.00 PM

Viersen Room - Town Hall

AGENDA

Page No

1. **Election of Chairman and Vice-Chairman**
2. **Apologies for Absence**
3. **Declarations of Interest**
4. **The Role of the Health and Wellbeing Board**
5. **The Roles and Responsibilities of Partner Organisations**
6. **The Joint Strategic Needs Assessment (JSNA) – Process and Sign Off**
7. **The Joint Health and Wellbeing Strategy (JHWS) – Local Priorities and Process**
8. **The Public Health Transition Plan**
9. **Local HealthWatch Development**
10. **Draft Agenda for March**
11. **Dates of Future Meetings**
    26 March 2012 – 1pm Viersen Room
    23 April 2012 – 1pm Viersen Room
    28 May 2012 – 1pm Viersen Room
    18 June 2012 – 1pm Viersen Room

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Gemma George on 01733 452268 as soon as possible.

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