Self Assessment - Sunderland	
Overall strength of transition planning	Your assessment of position reached and issues arising
Are arrangements for managing the transition in your locality clear and achievable?	Clear arrangements are in place for the transition of Public Health (PH) in Sunderland. The transition is being project managed in line with the LA project management methodology, with a dedicated LA project manager to facilitate the process. Officers from both Public Health and the LA started work on planning the transition in July 2011. An established Public Health Transition Board made up of senior officers meets on a monthly basis to update, make decisions and agree forward tasks (TOR available). The project has a detailed project plan illustrating key tasks, timescales and dependencies to ensure a progress overview. The project is made up of five dedicated work streams each with individual working groups (with joint LA and PH leads), overseeing tasks and feeding back progress to the PH Transition Board. Both the PCT and LA attend regional transition meetings to ensure Sunderland is progressing in line with national developments.
Are you confident that the PH function will be fully operational in your council post April 2013?	The PH function is progressing in line with the project plan time line. There are some risks, which have been identified as part of the overall risk log, for example Intelligence and Information and Clinical Governance with plans under development to mitigate. A Clinical Governance workshop is planned for 31st October to try to address/mitigate risks and following the recent Information and intelligence fact sheet this work stream is not able to plan for the April deadline Additionally more guidance and clarity nationally is required from government in some areas of the transition, e.g. staff transfers etc, but to date there is sufficient time to factor these into the timescales.
The Operating Framework for 2012/13 contains the following specific milestones where PCT's and local authorities need to work together:	
• test arrangements for the role of public health in emergency	The Tees exercise on the 7th November 2012 will test arrangements for

planning, in particular the role of the Director of Public Health and local authority based public health by end of October 2012	emergency planning. For North East Plans. The outcome and lessons learned from this will be incorporated into Sunderland and local plans.
• ensure an early draft of legacy and handover documents is produced by end of October 2012	The SoTW appointed a Transition Project Manager who has co-ordinated responsibility for legacy document & the quality handover document. The quality handover document is being reviewed by the monthly PH Transition Board in line with progress and the final document is planned for 2013
• ensure final legacy and handover documents are produced by end of January 2013	As above
• PCTs and local authorities to have effective information governance arrangements in place that will ensure public health teams will have access to the information they need to carry out their duties from April 1 2013, by end of December 2012	There is an SOTW/LA Information & Intelligence work stream which has a work plan in place that includes Information governance arrangements. These plans have scheduled arrangements to be in place for March 2013. This is to allow testing during March in line with public health staff starting in April.

Questions to consider	**Briefing updates and contacts**	**Your assessment of position reached and issues arising**
1. Leadership, Vision and governance		
1.1. Has your authority developed a vision of what it hopes to deliver in improvements to the health and wellbeing of its residents?	A number of councils have now established strong political ownership of a vision for health and wellbeing and updated their overall priorities. The national vision for Public Health at local level can be found here https://www.wp.dh.gov.uk/healthandcare/files/2012/07/Public-Health-England-vision.pdf	1.1 The Health and Wellbeing Board have an established vision that was developed specifically to align with that of the CCG. It was developed at a Board development session and refined at a public consultation event to ensure broad ownership. It also aligns with the Sunderland Partnership Outcomes Framework.
1.2 Is there clear political leadership on health issues?	Responsibility for health issues is allocated to a cabinet member in most authorities, often alongside adult social care responsibilities.	1.2 The HWBB is chaired by the Leader of the Council. There are portfolio holders for both PH and Wellbeing and for Health Housing and Adults Services. The cabinet secretary also has an oversight role for health matters and is a political representative on the WHO Healthy Cities network**.**
1.3 Do the arrangements provide for direct access to the Chief Executive and leading Members that is required for the DPH on health issues? 1.4 Is the position of the PH function within the overall operating structure of the authority clear and well-understood across the organisation and by the public health staff transferring to the	Some authorities have revised their wider operational structure to fully embed new PH functions.	1.3 There have always been arrangements for regular updates from the DoPH and the CX and the plan to house the DoPH within the Office of the CX will support this going forward. In relation to elected members there are monthly Cabinet portfolio meetings in the diary with elected members relating to health, social care and public health to give a more holistic approach. There are regular briefings to the direct Cabinet lead for public health and their Cabinet policy

local authority?		lead. There is regular liaison with Scrutiny and the health policy review is on the transition of public health. Members of the public health team also attend area committee arrangements too**.** 1.4 The PH Function structure has been developed to align with Sunderland's Business Operating Model (BOM), as outlined in Phase 2 of the PH Transition for Sunderland (19.02.12). The development of the structure has gone through a significant consultation period with senior managers in PH, LA and Politicians. This structure has now been agreed with the Chief Exec of Sunderland PCT and the LA and this will now be shared with both PH and LA staff. As part of the communication work stream plan there has been ongoing consultation with PH staff, via LA Managers Briefings and HWB updates. A series of workshops starting in October will detail the operating model and explain how it functions in the LA and what this means for PH staff and functions transferring across... The communication plan also includes a schedule for consultation with transitioning staff; LA staff; politicians, and the HWBB, to ensure the operating structure is understood by all.
2.0Funding, contracts and indemnities		
2.1 Are local arrangements costed against the likely funding allocations for 2013/14? How will	A summary of the financial arrangements determined so far, and the dates for the	2.1 To date local arrangements are not yet fully costed against the 13/14 funding allocation. Work is

they be adapted as allocations move towards the longer-term application of the funding formula and premium arrangements?	dissemination of final allocations for 2013/14 and arrangements for moving to formula funding, is attached as Annexe A. Attention to existing contracts is giving rise to significant issues in some localities. Further guidance and FAQs relating to contract transfers and novation issues should be available later in September.	progressing between the Council and PCT to analyse existing PH spend which will be used to inform current commitments. Current commitments will be compared to actual funding allocations for 13/14 once final funding allocations are made available from the DoH later this year. Future commissioning intentions and PH structures are also being formulated. Although definitive funding allocations from the DoH won't be available until later this year the council and PCT are planning for the future based on a reduced funding allocation.
2.2. Is it clear what contracts need to be novated to the local authority as the transition is concluded?	Authorities will have indemnity and insurance arrangements that cover their staff as they perform the range of their duties. Some specific issues will arise for the DPH, or other PH staff, when they are operating on behalf of LA's at regional level, on Health Emergency Planning duties for instance.	2.2. A list of contracts currently commissioned by PCT are outlined in a contract portfolio, however this requires further attention due to certain gaps/issues raised with PCT. The LA are still determining its commissioning intentions for the contract portfolio before it is clear on what contracts need to be novated/transferred. Awaiting national guidance regarding how contracts will be novated by order of statute.
2.3. Is there satisfactory progress on any variation required in the terms of the contract? Have funding and performance issues been fully understood and clearly expressed in the contract?		2.3 Any variation to the terms of the contract would be subject to the outcome of the commissioning intentions. The funding and performance issues are currently being established and discussed between the LA and the PH.
2.4. Have appropriate arrangements been made to include the functions of PH teams in the authority's arrangements for indemnities and insurance for its staff?		2.4 Sunderland LA are in discussion with PCT insurers and brokers regarding the degree to which PH existing liability insurance needs to be extended to cover the additional duties and responsibilities. Medical and clinical risks are not

		insurable under the standard council policy, so additional medical malpractice insurance is being explored.
3.0 Workforce issues		
3.1 Are the processes that will ensure successful resolution of outstanding workforce issues advancing appropriately?	A summary of workforce issues is attached as Annexe B. It contains some prompt question that are specific to workforce matters.	3.1 The processes to ensure the appropriate transfer of staff are progressing appropriately and feedback to the monthly Joint PH Transition Board. Regional meetings of all LA's and appropriate PCT HR representatives take place every 2/3 months. The transfer process will be managed in accordance with the Statutory Order. A draft structure has been developed and shared with senior managers in the PCT. It will be the subject of full consultation with employees and trade unions before it is approved by the Council's HR Committee. Formal consultation on the transfer will begin in October/November and will be lead by the Director of HHAS and the Director of HR and OD. Work is commencing on an induction programme for the employees who are to transfer.
4.0 Information and Intelligence		
4.1 Is there a clear understanding of the information and intelligence required to underpin the PH functions that will become responsibilities of the local authority? 4.2. Have issues of access to data sources,	Delivery of PH functions relies on access to a range of data sets, from the NHS and elsewhere. There is a need for attention to issues of technical connections and system compatibility, information governance and confidentiality, MOU's with CCG's and the	4.1 Information & Intelligence (I&I) requirements that underpin PH functions are currently being scoped 4.2 These issues are being considered by local I&I

confidentiality and information governance, functional relationships with CCGs and CSSs, and skills been identified and addressed? 4.3 Is the CCG sufficiently clear as to the information and intelligence requirements that it must secure from its Commissioning Support Service so that the local authority can fulfil its responsibilities?	Commissioning Support Services, and the availability of key staff with the required knowledge and skills. A fact sheet setting these issues out more fully should be available to local authorities later in the autumn.	working groups 4.3 The regional I&I work stream is actively engaging with the North East Commissioning Support Service to ensure this issue is resolved
5.0 Mandatory functions		
5.1 Are you confident that the mandatory PH functions will be maintained through the transition period and will be well-delivered post-April 2013? 5.2 Is there clarity over the transfer of staff necessary to exercise the mandatory functions, for ensuring health protection plans are in place for example?	A list of the mandatory PH functions, and others that most authorities will wish to deliver, is set out at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131901.pdf, and summarised in Annexe C.	5.1 Robust arrangements are in place to ensure delivery of mandatory functions during transition. Arrangements for the maintenance of commissioned mandatory services will be described above for all commissioned services with mandated services being prioritised. A Memorandum of Understanding between the CCG & LA is under development which will detail the delivery of PH advice to commissioners. The maintenance of Health Protection arrangement post April 2013 will be finalised as new organisations emerge. 5.2 The public health structure is being developed to ensure that mandatory functions can transition seamlessly as part of the process. This will become clearer as staff transfer arrangements are finalised during October/November
6.0 Other functions		

6.1 Is there clarity as to which of the remaining PH functions will be commissioned and delivered in your locality?		6.1 Arrangements for the transfer of contracts from the PCT to receiver organisations are complete and relevant contracts have been shared with the LA. Staff transfer arrangements will be finalised in October, including staff providing a shared service

7.0 Emergency Planning and Resilience		
7.1 Are roles, responsibilities and procedures for public health-related emergency preparedness, resilience and response (EPRR) post-April 2013 fully understood and included in the local PH service design? 7.2 Is it clear which DPH will lead on EPRR issues and represent local authorities at the LHRP?	A resource pack describing the EPRR elements of local authority DPH roles and the arrangements for Local Health Resilience Partnerships (LHRPs) was distributed in July 2012 http://www.dh.gov.uk/health/2012/07/resilience-partnerships/ The Emergency Planning and Resilience arrangements can be found at http://www.dh.gov.uk/health/2012/04/eprr/ A further resource, developed by the DH, Health Protection Agency, the ADPH and the LGA will be available in October. It will provide the basis for checking local arrangements against appropriate scenarios.	**7**.1 There is still potential confusion over roles, responsibilities and procedures for EPRR post April 2013. Locally a workshop has been held with a range of representatives from the Northumbria, Durham and Cleveland LRFs and partner organisations (4th October). This explored potential arrangements for local EPRR planning but was less clear around response arrangements. It is not clear that all 12 local authorities are sighted or have signed up to the suite of arrangements which need to be put in place although progress is being made. 7.2 Within the NHS arrangements, there is a current lead DPH for planning for all three LRFs (ie including Northumbria). This arrangements and the range of parameters associated have not been formally signed up to by LAs across Tyne and Wear.
8. Wider Arrangements		
8.1 Have arrangements in your authority taken		8.1 Functions of the new organisations have

account of the emerging arrangements for Public Health England's Centres, and the roles of local PH officers in contributing to functions organised via PHE and the NHS Commissioning Board's local structures?	The sub-national structures for the NHSCB were determined in February 2012 and for PHE in July 2012	been identified. Roles and responsibilities will be discussed as senior appointments are made within the LA. This again will start when staff are identified in October/November
8.2 Is there sufficient clarity over the local authority's relationship with the CCG in relation to the overall planning and commissioning of health services, including public health services?	Arrangements for those functions that will be nationally and regionally coordinated, but which will call on contributions from local PH teams have also been described. National Screening and Immunisation arrangements were set out in a letter to all chief executives dated 23 August 2012.	8.2 The relationship between LA and CCG in terms of overall planning is demonstrated through the alignment of the CCG Commissioning Plan and the developing Health & Wellbeing Strategy. Both their membership and future roles and responsibilities on the HWBB will ensure that future public health services will align and compliment CCG service delivery.
8.3 Are local arrangements for the Health and Well-Being Board developing appropriately? Do HWB members fully understand their leadership role of the new public health system?	A summary of the responsibilities of the local authorities to the CCG's, and the necessary expectations of CSS's can be found at: http://www.dh.gov.uk/health/2012/06/public-health-advice-to-ccgs	8.3 The HWBB members are aware of their responsibilities in relation to system leadership which has been reinforced through development sessions and the commissioning of the NHS Institute for Innovation and Improvement to undertake a health and social care systems review on behalf of the Board. The Board has standing Public health updates on its agenda which cover PH issues and assurance on the transition process.
8.4 Are local arrangements for the procurement of local Healthwatch developing appropriately? Is it clear that public health will also be part of	There is a separate, parallel, process for supporting the creation of effective HWB Board and Healthwatch arrangements at local level. But there are inter-	8.4 The HealthWatch service specification is completed after a number of consultation workshops and events to ensure it was locally

the remit of Local Healthwatch, along with NHS services and social care?	dependencies with the local arrangements for PH functions, particularly in the role of the DPH, the information and intelligence functions needed to underpin JSNA's and Joint Health and Well-Being Strategies, and the influence of the strategies on the overall vision and priorities of the council.	focused and took on board lessons learned from the commissionees of the LINKs initiative. Public Health, CCG and NHS representative have had involvement in the whole process and as well as being members of the HW Steering Group they were members on the Task & Finish Group to develop/ support the service specification thus ensuring these services are embedded within the remit. The procurement exercise is in progress and further discussions on the timeline are taking place due to involvement of partners. There are however still concerns/risks that the funding package will not be established until after tender process has took place, (December), with the potential that this will impact on submissions by organisations to deliver HealthWatch as without clear understanding of available funding it is difficult to detail how HealthWatch will be delivered and meet the objectives outlined in the specifications and within the Bill.
9. Two-tier issues		
If you are a chief executive of a county council in a two-tier system, have the roles and contributions of the district authorities in your	District council functions make significant contributions to the public health of populations. They may also have particular	NOT APPLICABLE

area been fully reflected in transition planning?	contributions to make to community engagement and the understanding of circumstances in particular neighbourhoods.	
10Shared approaches		
10.1 If you have plans to share aspects of the public health function with another council, are the operating arrangements to deliver the function sufficiently well-developed to ensure a safe transition?	Decisions over shared services were still to be made in a number of areas of the country when progress was reviewed in April. It is understood that decision have now been taken in nearly all cases, but chief executives need to be confident that the consequential planning of delivery and accountability arrangements is advancing appropriately.	10.1 Discussions are well advanced with other councils that will potentially share operations and there are plans in place for MoU's to formalise arrangements between other LA's.

Other Comments

Overall plans are progressing satisfactorily although there has necessarily been more emphasis on transactional issues than on transformational issues for the Council taking on PH responsibilities; however this position is changing as time moves on.

It is disappointing that there has not been more movement around issues eg Informatics and information, clinical governance, local government indemnification around clinical issues, response arrangements for EPRR. All of these require additional movement/guidance from national level and time is moving on. Within the last week (5th October on) there has been additional guidance on public health information, roles and responsibilities of a DPH, and scenario planning around EPRR. There is a definite increased emphasis on health protection and EPRR which, whilst not unexpected by DsPH may cause some confusion as Councils seek to understand the difference in responsibilities they currently hold and those in the future. The Scenario planning guidance is not what was expected and the scenarios identified do not fit into understanding how new arrangements will work. EPRR continues to be a high risk area.