Appendix 1

Sunderland City Council

Sunderland NHS Teaching Primary Care Trust

Sunderland Public Health Transition Plan 2012/2013

19 February 2012

EXECUTIVE LEADS
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Background

The Health and Social Care Bill is currently under discussion in the House of Lords as part of its legislative journey and sets out a radical plan to reform the commissioning of healthcare and the delivery of public health. New statutory entities are to be created and are already in development including: Clinical Commissioning Groups (CCG), the NHS Commissioning Board (NHSCB), Healthwatch (HW), statutory Health and Wellbeing Boards within top tier local authorities (HWBB) and a national public health agency, Public Health England (PHE).

A summary of the reformed public health system was published as a series of factsheets in December 2011 (The New Public Health System, Public Health England's (PHE) Operating Model, and Public Health in Local Authorities, DH); these define the roles and responsibilities of PHE and local authorities. These are summarised below:.

- **Local Government leading for public health** – emphasises the role of local government as shapers of place and tackling inequalities. It highlights importance of close NHS engagement and local political leadership. Health and wellbeing should be incorporated across the local government agenda. Local Authorities will have a duty to promote the health of their population. Directors of public health will be employed by local authorities (LAs), jointly appointed by PHE and LAs. Councils will be mandated to provide: sexual health services, NHS health checks, National Child Measurement Programme, public health advice to NHS Commissioners and ensure plans are in place to protect the health of the public. Shadow public health budget allocations will be made known during 2012/13
- **Local government's new public health functions** – include tackling the causes of ill-health, reducing health inequalities, promoting health, health protection and promoting social justice and safer communities. LAs will commission quality and safe services, while maximising user choice. Services prioritised for choice will be chosen through a diverse provider model according to the Joint Strategic Needs Assessment (JSNA), current delivery on the Public Health Outcomes Framework and the strategic journey identified through the local Health and Wellbeing Strategy.
- **The role of the Director of Public Health (DPH)** – Guidance on the appointments process, transition and key processes is being developed. The DPH will act as lead officer for health across all LA business, be accountable to the chief executive and have direct access to elected members.
- **Commissioning responsibilities** – a list of all public health services to be commissioned by LAs is provided and five are mandated (see appendix 1). The government reiterates that public health services

for children under 5 as well as child health information will rest with NHSCB, as will commissioning sexual assault services. Regarding health protection, a lead DPH within a Local Resilience Forum (LRF) area will coordinate public health input into planning and response, PHE will provide the services and NHSCB will appoint lead director for NHS preparedness and response. NHSCB will be responsible for national screening and immunisation programmes, informed and guided by PHE and DPHs. Further consideration is being given to the role of public health advice in supporting NHSCB.

- **Public health advice to NHS Commissioners** – this will be provided by specialists in LAs as a mandated function across the different stages of the commissioning cycle, such as strategic planning, designing shape and structure of supply, planning capacity and managing demand and monitoring and evaluation.
- **Workforce development- Professional, appraisal and support, and capacity building** – medical and non-medical public health specialists will be expected to undergo professional appraisal guided by the Faculty of Public Health. This will link with the managerial appraisal undertaken by local authorities.
- **Public Health England (PHE)** will promote a culture of subsidarity focusing on support local action and only national action where it adds value. PHE will: deliver health protection services; lead public health delivery system; and support workforce developments. It will have a national office and four hubs working alongside NHS Commissioning Board (NHSCB) structures, acting in support of LAs. The chief executive will be operationally independent, with non-execs on the advisory board. The CMO will continue to provide advice to the Secretary of State (SoS) on population health and the public health system
- The **NHS** will continue to play an important role through commissioning (CCG) and provision of health services and ensuring fair access. It will also commission specific public health services (NHSCB) and seek to increase impact of health services on the public's health by making every clinical contact count.

The Local Transition Story : progress so far

Locally we have been working jointly across Sunderland City Council and Sunderland Teaching Primary Care Trust on preparing ground work for these changes over the last nine months.

- A refreshed Joint Strategic Needs Assessment was produced during 2011/12, whilst work continues on Equality Impact Assessments /Impact Needs Related Assessments and an asset based approach to local areas needs.
- We initiated our 'Early Implementer Health and Wellbeing Board' in September 2011 and we are already engaged in evaluating what changes are required on its journey through shadow form (2012/13)

until it becomes a formal committee of the Council in April 2013 and assists in aligning the strategic and commissioning plans of a range of Sunderland Partners, Council, Clinical Commissioning Group and others (e.g. Safer Partnership) going forward.

- Significant time and effort is being put into the development of the Sunderland Health and Wellbeing Strategy and identification of priority workstreams going forward which will enhance and improve health and wellbeing for local people as individuals, families and communities.
- We have established arrangements within Sunderland City Council and NHS SoTW to take forward the workstreams involved in transition. The Sunderland PH Transition Board, chaired by Sarah Reed and Nonnie Crawford and the NHS SoTW/LA Group chaired by David Hambleton. NHS SoTW oversees the work from an NHS perspective through its overarching transition structures led by Moira Davison Director of Corporate Governance.

On the 20th January 2012 our first phase public health transition plans were considered and assured by the Regional Director of Public Health on behalf of NHS North. Since then there has been additional national guidance and intelligence received which impacts on this next planning and implementation phase. The next section identifies some of the implications of the work underway and the guidance currently available although over the coming 12 months we will see iterations of this as workstream processes deliver their outcomes and additional national guidance and local information informs decision making on the transition journey.

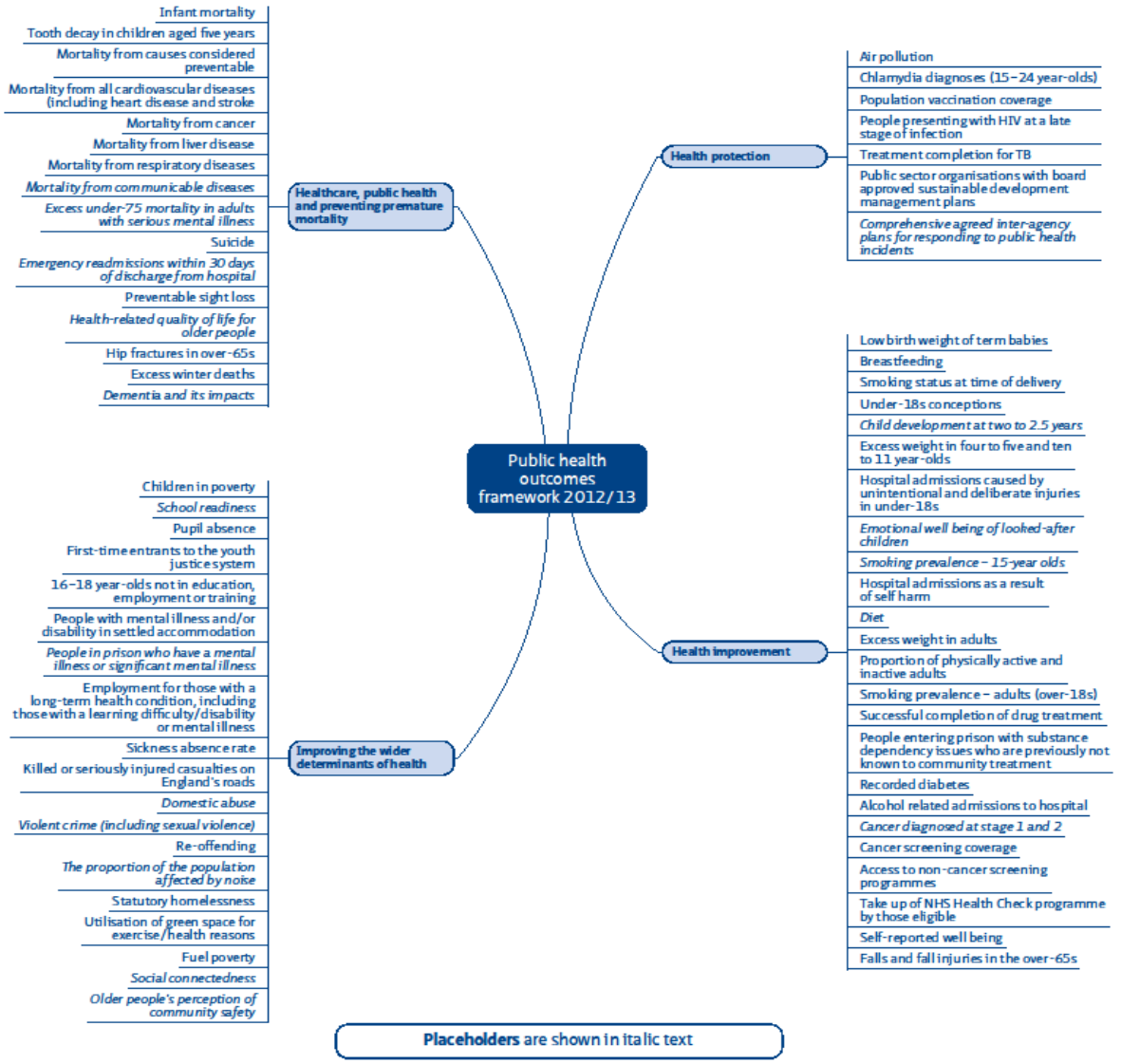
Implications

- **Public Health Outcomes**

In February, the Public Health Outcomes Framework, which complements the NHS Outcomes Framework and Adult Social Care Outcomes Framework was delivered. The diagram below identifies how the various elements of the outcomes framework map to public health priority areas, health protection, health improvement and accelerating quality improvement within health and social care on a population basis.

It is essential that our forward plans will contribute towards improved outcomes in the areas below which have equally been highlighted within our JSNA and are implicit in the strategic journey identified within our Health and Wellbeing Strategy. The processes and workstreams identified within the attached transition plan can be cross referenced to these outcomes and within he coming months we will have integrated this work into the Sunderland Outcomes Framework.

Public health outcomes framework 2012/13



- **Financial Allocations**

Advice on the 2012/13 public health financial baseline allocations was published in mid February and this will be supplemented with more accurate information on the 2013/14 allocations by the end of the 2012 calendar year. Based on analysis carried out by the Department of Health on 2010-11 spend on public health, it is estimated that during 2012-13, the NHS will spend £5.2 billion on public health services. The table below shows the future commissioning route for this estimated spend.

Future commissioning route	**2012/13 allocation**
Local Authorities	£2.2bn
NHS Commissioning Board	£2.2bn
Public Health England	£210m
Department of Health	£620m
Total	**£5.2bn**

Of the local authority element approximately £19.468m will be allocated to Sunderland. , This equates to approximately £65/head of local population. The north east average is £65 with a range of £33 (Northumberland)-£99 (Middlesbrough), the national average is £40 with a range of £15 (Buckinghamshire) - £117 (Tower Hamlets)> Regional averages varying from £27 (South West) to £65(North East). Whilst we have been told by DH that the 13/14 allocations will be similar to these figures, there is an element of risk in planning on this assumption, as there are potential changes likely due to the Advisory Commission on Resource Allocation (ACRA) arrangements, any changes in the drugs income (Home Office and Police Commissioners), NHS Income (general austerity) and the implementation of the health premium (currently unclear). However the allocation is intended to support initial planning. For our future planning purposes the £19.468m figure will be used. This compares to £19.889m based on 2010/2011 information collected by the Department of Health in respect of baseline spend analysis on public health activity within Sunderland that in future would be commissioned by the local authority.

- **Integration and Transformation**

The early thinking on how the integration of Public Health from the NHS will continue to drive the Transformation agenda locally as identified in the Sunderland Ways of Working and the Sunderland Operating Model was

identified in our previous plan. Specific workstreams which will deliver the model will be led by task and finish groups, which will report to the Public Health Transition Group and are identified within the attached plan.

Integrating and leading different ways of working with each of the existing teams within Sunderland City Council is essential to ensure the successful delivery of public health outcomes. The Council currently delivers significant health improvement and protection roles through both strategic influencing and service delivery. There is scope to apply population health perspectives in these areas of work to improve public health outcomes.

In the domain of service improvement for public health, the focus is not solely to be on health care and social care services. A public health perspective to service improvement in all areas (e.g planning and urban space management) enables the commissioning and delivery of effective, efficient and equitable services.

We expect additional guidance during 2012 but are now in a position to work up our more detailed transition plans, accepting that these will require continuous updating and adjustment through 2012/13 as new information is made available to the system allowing outstanding decisions to be made and acted upon. It is essential that in order to assure a smooth and safe transition of a complex system of arrangements, that we pay due attention to ensuring that appropriate assurance is in place from both the 'sender' and current host of the public health function, Sunderland Teaching Primary Care Trust within the mantle of NHS South of Tyne and Wear, and the 'receiver' and future host of the public health function Sunderland City Council. This assurance needs to be clear at both the Executive Officer and Board / Cabinet levels of the two organisations. The successful outcomes of the transition are predicated on enhancing democratic legitimacy within healthcare and health and wellbeing decision making going forwards as well as establishing closer leadership arrangements through local political leaders, ie councillors and cabinet portfolio holders.

- **Information and Intelligence**

A specific area of the public health function relates to the sharing of information and intelligence for health improvement- this is more significant than access to raw data but is about its conversion into meaningful and useful information. The Information and Intelligence workstream will need to ensure that Sunderland City Council is able to benefit from the full range of information and intelligence workstreams that Public Health in the NHS currently receive. The public health team currently benefits from being part of the NHS and is able to access health information, but in the future, when public health is incorporated into local authorities, there may be restrictions in information sharing across organisations. There is ongoing national work to discuss information governance across organisation boundaries. A regional workstream has been initiated to assist PCTs and Councils in their planning for transition and we would recommend the Sunderland plan not being formalised in this area until the outcomes of the regional work are available.

Another area for review is in relation to the public health intelligence function. There is an opportunity to provide a public health perspective to the analytical support required for the Sunderland Joint Strategic Needs Assessment and to support commissioning including population healthcare advice to the broader NHS and to NHS commissioners. This will require a close working arrangement with the existing information and intelligence functions within the City Council and possibly the developing of Memoranda of Understanding (MoU) and Service Level Agreements(SLA) with other service providers (eg PHE, CSS).

- **Staffing**

Following the detail of discussions on how public health functions, system, programmes and services are to be integrated /commissioned/delivered from 1 April 2013, there is likely to be impact on both PH Staff and Sunderland City Council health improvement team is likely. The positioning of the Director of Public Health and team within the council's organisational structure builds on the ongoing Transformation of the Council and is highlighted in the Sunderland Operating Model. This is currently being quantified and though the future model is not fully established and may be impacted by HR guidance currently being worked on centrally It is essential through this transition, to ensure that leadership for public health is clear, agreed, enabled across all domains of public health practice, and across the life-course, and supported by chief officers and elected members.

- **Risk**

There are 2 elements to risk, that during wider NHS transition which has been identified to this point and which we are putting plans in place to mitigate (reviewed monthly) but there is also risk going forward and a number of work programmes are underway e.g. looking at indemnification, commissioning arrangements etc. These areas again require constant surveillance to ensure smooth transition arrangements during 13/14. Workstreams identified in the attached plan are all being risk rated and reviewed moving forwards. Significant risk is felt to attach to smooth transition of mandated functions with particular concern around the emergency planning function in the absence of granular detail over arrangements post 12/13. There is also a distinct lack of clarity over the arrangements for those parts of the PH function which will either be commissioned or quality assured by other parts of the system (PHE/NHSCB) with specific concern around arrangements for screening, immunisation and vaccination and infection control moving forwards

- **Equality and Diversity/Public Sector Equality Duty**

Whilst there is no direct impact during the pre transition year (12/13), as the JSNA and the Health and Wellbeing Strategy clarifies priorities for decommissioning and commissioning (whether strategic or actual) going forwards, cognisance will need to be given to Equality Impact Assessment (EIA) and Impact Needs Risk Assessment (INRA) in advance of decision

making around intentions across 13/14 and onwards to demonstrate our meeting of requirements under the duties.

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- **Accommodation of staff**

Placing and accommodating PH staff in transition to the LA in such a way as to assist in delivering the integrated and transformative public health function will be required and managed through the transition process. This is not anticipated as high risk given the relatively small number of staff involved (max 25 fte) but is an opportunity.

- **Consultation**

HR Transition processes will include full consultation with relevant staff in Sunderland TPCT PH team and amongst Sunderland City Council staff where relevant e.g. around delivering of core functions or commissioning arrangements going forwards.

- **Commissioning and Procurement**

SCC will be mandated under the Health and Social Care Bill (when passed) to commission public health functions, systems, programmes and services utilising the ring fenced PH budget and all other means at its disposal. Discussions are already underway amongst the Council and partners over the best ways to achieve the benefits of aligned commissioning intentions and commissioning arrangements moving forwards. The transition of PH offers opportunities to model and pilot new arrangements in this area but the transition plan needs to ensure that proper account is taken of the range of legal, financial and operational issues in moving almost £20M worth of current contracts held with NHS , Private, Independent Sector and Voluntary Sector providers from one set of public sector arrangements to another. Again this will be a common act in a common timeframe across North East Local Authorities and there will be merit in establishing some common principles under which we can all operate safely. Processes which will deliver this secure transition are underway and are detailed in the PH transition plan.

Appendix 1 Mandated and Non mandated Public Health Functions, systems, Programmes and Services

A further new and significant role for Local Authorities is to develop the commissioning of a range of integrated health improvement services as identified below:

• tobacco control and smoking cessation services
• alcohol and drug misuse services
• public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
• the National Child Measurement Programme
• interventions to tackle obesity such as community lifestyle and weight management services
• locally-led nutrition initiatives
• increasing levels of physical activity in the local population
• NHS Health Check assessments
• public mental health services
• dental public health services
• accidental injury prevention
• population level interventions to reduce and prevent birth defects
• behavioural and lifestyle campaigns to prevent cancer and long-term conditions
• local initiatives on workplace health
• supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
• comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
• local initiatives to reduce excess deaths as a result of seasonal mortality
• the local authority role in dealing with health protection incidents, outbreaks and emergencies
• public health aspects of promotion of community safety, violence prevention and response
• public health aspects of local initiatives to tackle social exclusion
• local initiatives that reduce public health impacts of environmental risks.

Only some of the above services are to be mandated and these identified mandatory services are:

- Sexual Health Services
- Health Protection including Emergency Preparedness
- Popluation healthcare advice to the NHS including Public Health Advice to NHS Commissioners
- The National Child Measurement Programme
- NHS Healthcheck Assessment

The commissioning of other services will be discretionary, guided by the Public Health Outcomes Framework (to be published), the local joint strategic

needs assessment (refreshed 2011/12) and the joint health and wellbeing strategy (under development).

Additional Information on Mandated PH Functions, Programmes and Services

1. National Child Measurement Programme
The Department of Health (DH) currently issues annual operational guidance for local areas on delivery of the NCMP. Guidance as setting out the requirements for the programme is available on the DH website:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129001

2. NHS Health Check
From April 2013, the intention is to require local authorities to deliver NHS Health Check assessments for eligible men and women (around 15 million people aged 40-74 in England). New public health responsibilities of local authorities, which will not be mandated, will include local activity on provision of lifestyle interventions – including intensive lifestyle interventions for those at high risk of diabetes, weight management, smoking cessation and physical activity interventions - as part of the NHS Health Check programme.

Guidance
The Department issues best practice guidance setting out how the NHS Health Check should be undertaken and how certain parameters and data should be measured and quality assured. The guidance also sets out thresholds for the tests that would trigger appropriate follow-up action and interventions, which is an essential part of the (NHS) Health Check programme. "Putting Prevention First. NHS Health Check: Vascular Risk Assessment and Management Best Practice Guidance". Gateway reference 11473. April 2009. Online guidance is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_097489

3. Public Health Advice to the NHS ("Core Offer")
From April 2013, the intention is to impose a duty on local authorities through Regulations to provide population based public health advice to NHS commissioners on the commissioning of NHS services. The regulations provide a means to ensure that specialist public health advice is provided by each local authority.
The intention is to ensure that public health advice remains central to NHS commissioning. This partially relates to the third element of public health sometimes referred population healthcare public health but which is essentially about driving quality improvement in NHS commissioning through using evidence base on quality and outcomes. The Association of Directors of Public Health defines this as including: *"quality; clinical effectiveness; support for commissioning; audit and evaluation; service planning; efficiency; clinical governance."*

The provision of specialist public health advice will be a duty imposed on local authorities, but will be led by appropriately trained and accredited public health specialists, as defined by the Faculty of Public Health . Directors of Public Health will, among their other duties, advise and support Clinical Commissioning Groups on the population aspects of NHS services and will work closely with their local GPs to help identify, prevent and manage a range of conditions. To ensure that appropriate and high quality public health advice is made available, the Department is working closely with public health and NHS colleagues to ensure that a 'core offer' of high quality public health expertise, advice and analysis, from the Directors of Public Health and their teams based in local authorities, is available to healthcare commissioners in Clinical Commissioning Groups and health and wellbeing boards to draw upon when developing their local commissioning plans.

4. Sexual health commissioning

From April 2013, Local Authorities will commission comprehensive sexual health services. This includes all aspects of sexual health provision except:- Abortion services, sterilisation and vasectomy which will be commissioned by Clinical Commissioning Groups although there will be a further consultation on the most appropriate commissioning route for these services;

Contraception which is currently provided as an additional service in the GP contract, which will continue to be provided via the GP contract although it is recognised that many local authorities and PCTs offer assistance to young people in accessing contraceptive services through a range of nhs and non nhs providers. To complete, the sexual health commissioning loops, HIV treatment, considered a specialist service, will be the responsibility of the NHS Commissioning Board.

LA Mandatory Functions within the commissioning of sexual health services

Subject to the passage of the Health and Social Care Bill, Local Authorities will fulfil the following mandatory functions with regard to sexual health:-
Local Authorities (and providers of sexual health care) must not share or disclose personally identifiable patient information received by any member of staff, except with the explicit, informed consent of the patient. However, there are some exceptions to this as follows:-
o When information is disclosed to or shared with a member of the integrated care team in connection with that patient's treatment, including partner notification;
o Where there is a serious risk to another person's health and if requested to do so by the appropriate legal authorities.

Local Authorities will be mandated to commission confidential, open-access STI testing and treatment services for all persons present in their local area (and not just people who are registered with a local GP), and that no charge should be made for any STI treatment, or supply of any drugs or medicines for STI treatment, provided through these services.

Local Authorities will be mandated to commission open-access contraceptive services for the benefit of all persons of all ages present in the area, including under 16s, and must meet all reasonable requirements for the provision of the full range of contraceptive methods (but not including sterilisation and vasectomy), by appropriately trained staff in line with national guidance. All contraception (including condoms) issued by these services should be provided without charge.

5. Steps Local Authorities must perform to protect the health of their local populations

From April 2013, local authorities will be required through Regulations under new section 6C of the NHS Act to perform steps to protect the health of their local populations, in particular to ensure there are plans in place to protect the health of their populations from natural hazards, accidents, infectious diseases, terrorism and other health threats. This will be a broader responsibility than that currently owned and Local authorities will also continue with their existing responsibilities for planning and responding to emergencies involving a risk to public health.

1. Ensuring a robust transfer of systems and services GG/PL

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
1.A Develop and agree arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013	Phased approach agreed, taking account of the wider NHS structural changes and changes to the LA operating model. Recommendations will be developed by the PH Transition Board and discussed at the LA/NHS SoTW group for onward decision making at EMT/Cabinet for the LA and the Directors Transition Group for NHS SoTW • Terms of reference required for Sunderland Public Health Transition Board including governance and decision making arrangements • Terms of reference required for LA/NHS SoTW high level group. *What is the process for involving SCC in commissioning decisions that will impact post March 2013* • To be included in LA/NHS SOTW high level group ToR *What is the process to agree if functions*	NC/SR TD NC/SR PL CH	Recommendations re transfer Apr 12. To be reviewed Jul 12, Oct 12, Jan 13. Transition Board ToR developed Feb 12 High Level group ToR developed Mar 12		Legal disagreements re MoU-difficulty in establishing lines of responsibility & accountability, during 12/13

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	should transfer prior to April 2013? • Sunderland Transition Board to make recommendations re IF any functions should transfer prior to April 2013, informed by internal council mapping exercise re commissioning and finance (completion due end Feb 2012) and assessment of risks to delivery. If functions are to transfer MoU will be required. • Recommendations will be made to EMT in the Council and Cabinet/HWB • PCT Directors will approve any transfer of function prior to April 2013 • Agree MOU (if needed) between TPCT and LA • PCT to identify all contracts which may transfer. LA to identify skills needed to undertake INRA and identify resources • SCC's Impact Needs Risk Assessment (INRA) process *(equivalent of Equality Impact Assessment in STPCT)* will be used to ensure transition plans, including		MOU (if required) to be agreed 1 month prior to transfer INRA of JSNA to inform prioritisation processes April		

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	any commissioning decisions, are robust, comprehensive and demonstrate due regard to the Public Sector Equality Duty.		12		
1.B. Develop a plan for the main elements of transfer including functions, staff and commissioning contracts for 2013/14 and beyond.	*What is the process to agree the public health vision?* • The Public Health vision will be informed by the refreshed JSNA. It will align to the H&WB Board vision and the emerging H&WB strategy. ***Functions*** Public health functions will integrate into SCC's operating model. The processes for achieving this will be identified in the detailed plan	GG/PL/ KG/CH	First draft public health vision Apr 12. Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis		

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	Staff See section 3 below				
	Commissioning contracts Commissioning is a workstream of the detailed plan. This will identify the steps to be taken to ensure appropriate transfer of contracts. *What is the process to consider which services should be delivered on a footprint larger than Sunderland?* • Following the mapping exercise, development of the integrated service model and integrated commissioning model, as part of the prioritisation exercise, the Commissioning workstream will consider what services (if any) could/should be delivered on a larger footprint than Sunderland. The work stream will make	GG/PL/ KG/CH	Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis Recommendations re service footprint April 12		Novation of contracts for what was previously NHS funded and what becomes non NHS funded post April 13 between NHS and LA poses legal issues Commissioning Model different across three local authorities in SoTW Lack of

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	recommendations to Sunderland Transition Board for consideration by SoTW/LA High Level Meeting (this does not exclude working with other LAs via existing communications channels) *What is the process to agree if contracts should novate?* • SCC to agree integrated model of wellbeing services informed by JSNA, operating model, budget modelling and mapping exercise • Prioritisation of expenditure of budget in relation to commissioned service to be agreed by H&WB Board. To be reviewed following publication of 13/14 allocations • Public Health Transition Board to make recommendations to NHS SoTW re if contracts are to novate or if notice to be given on all contracts based on outcomes of INRA, prioritisation process, business continuity, legal and resources implications and the 12/13 baseline allocation. To be reviewed quarterly		Development of model Mar 12 Prioritisation May 12. Review Jan 13 Recommendations re novation/notice Jun 12. Review Sep 12 and Dec 12. Give notice if required Jun 12		agreement on services to be delivered on a larger than locality footprint

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	as additional information (eg 13/14 allocations) emerges.. • SCC to agree Integrated Commissioning Model for public health informed by integrated (as per Operating model/Council transformation)		Agree Integrated Commissioning Model Jul 12		
1.C Identify and agree transition milestones	• Review milestones included in detailed plan • Additional milestones being identified as process continues	NC/SR	Agree detailed plan v1.0 March 2012. Review and refresh on a monthly basis.		Some milestones dependent on guidance, others on agreement between LAs across SoTW
1.D Develop the JSNA in order to support the H&WB strategy	Refreshed JSNA 2011/12 has informed commissioning intentions (12/13) and will support development of H & WB Strategy *Has the process for gathering information on community engagement/perceived need been documented and embedded?* • Embed process of refresh as new information emerges including ongoing engagement & Equality Impact Assessment	NC/NR	Paper detailing JSNA process as "business as usual" Feb 12 Appropriately timed refresh throughout 12/13 as data becomes available		Until Equality Impact Assessments completed, no assurance of full engagement

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	• Review JSNA process and outcomes against recently published guidance *What is the process for agreeing public health information requirements and information governance by September 2012?* *What is the process to determine if/how NHS information be made available to SCC in future?* *What is the process for ensuring knowledge and skills to collate/analyse and present data will be available post 2013* Regional work stream established to determine principles of access, skills available to ensure information needed is available in a timely manner. SCC has an intelligence hub and joint working re JSNA has been successful. Not a local priority until outcome of regional work known – see 1G re Core Offer to NHS Commissioners		Develop		

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
			information and intelligence options paper Sep 12 Information and intelligence arrangements identified Dec 12 Information and intelligences services developed/commissioned as required Mar 12		
1.E Develop a plan for the transition of commissioning of services to the LA	Current contracts identified and principles of integration into SCC commissioning agreed. Service reviews completed for commissioned services transferring. Commissioning identified as a workstream in detailed plan to build on the ongoing transformation of SCC operations to realise benefits of integration. Commissioning Intentions (12/13) identified potential risks to a	GG/BS/SR/PC	Agree detailed plan v1.0 March 2012. Review and refresh on a monthly basis.		If EIAs not sufficiently robust then notice and/or recommissioning arrangements may be challenged If NHS SoTW do not wish to give

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	range of services. Process for agreeing whether contracts should novate or notice to be given detailed in 1.B above. • Develop model of integrated service and commissioning model based on the recommendations of the work streams described in the detailed plan. *What is the process for prioritising the budget?* • The DPH will make recommendations for prioritising the budget for 2013/14 informed by JSNA, INRA and modelling of 12/13 indicative budget to the Public Health Transition Board for onward consideration by EMT, Cabinet and/or the H&WB Board (See 5.B below). This will be based on published 12/13 baseline allocations taking account of risk that 13/14 budget will be reduced and not published until December 2012. These will be reviewed following the publication of the 13/14 allocation. • The Commissioning work stream will consider contractual arrangements		Proposed model for delivery of integrated health improvement services developed by April 12 Indicative prioritisation of expenditure May 12. Final prioritisation of expenditure for 2013/14 Jan 13 Commissioning plan to achieve new delivery		notice on all PH contracts before 31.03.12, SCC may be at financial risk during Q1 of 2013/14 if rfb does not cover contractual outgoings

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
	and make recommendations to the Public Health Transition Board re commissioning arrangements for prioritised mandated and non-mandated services *How will SCC get clinical input into areas not the responsibility of the CCG?* • Where clinical services are to be commissioned, the Commissioning Work stream will make recommendations to ensure the relevant clinical expertise is available for approval by the HWB via the Sunderland Transition Board *Will SCC be required to comply with NHS standards e.g. You're Welcome?* • The Commissioning Work Stream will take account of current and future standards for services currently commissioned by the NHS, e.g. services free at point of delivery, You're Welcome, and make recommendations to the HWB via Sunderland Transition Board re if and how to commission		model developed by end May 12 Clinical advice option paper developed Sep 12 Clinical advice arrangements in place Mar 13 Standards for 13/14 commissioned services reviewed Jan 13		

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
1.F Develop a clear plan for the transfer of appropriate commissioning arrangements to NHS CB and PHE	Contracts to transfer to NHS CB identified through NHS SoTW internal stock take • Develop legacy document and issues log for commissioning arrangements transferring to NHS CB and PHE • Further clarification required before a detailed legacy/handover document can be developed.	LR(KH)/ DH(FAD)	First draft of public health legacy document/ issues log Jun 12		Lack of clarity persists through 2012/13- requires central action
1.G Develop a description of a core offer for LA based PH advice to NHS Commissioners	*What is the process for agreeing the core offer? Will this include working with other organisations LAs and or CSS?* • Options paper being developed for SoTW, to be considered by DsPH/LA/CCGs and recommendations made to through SCC governance arrangements • Arrange provision either directly or commissioned.	NC/IP/DB/ ML /SR	Options paper developed Sept 12 Provision of core offer identified Dec 12 Core offer services		Inability to establish agreement for core PH offer to NHS commissioners to be established across larger footprint

Objective	Progress and outstanding actions	Leads (PCT/LA)	Milestones	R/A/G	Risks
			developed/commissioned as required Mar 12		

2. Delivering Public Health Responsibilities During Transition GG

Objective	Progress and outstanding actions	Leads (PCT/LA	Milestones	R/A/G	Risks
2.A Develop a clear model for the delivery of mandated services during transition and in the new local public health service	***During transition*** There are clear arrangements in place for the delivery of commissioned mandated services during transition (sexual health services and NHS Health Check Assessment) with a shift to Sunderland-based commissioning for these services from April 2012. Arrangements will continue for the measurement element of the NCMP by commissioned school nursing services during 2012/13 with data management continuing to be part of the Child Health System. • If functions transfer before Apr 13, commissioning arrangements for mandated services to be detailed in the MOU (if required) • Current arrangements will continue for the core offer to NHS commissioners, this will be detailed in the future options paper (see below). If staff providing this function transfer to an emerging organisation	GG/MO/KG /CH	MOU/SLA to be agreed if required 1 month prior to any transfer of functions		Lack of stability in the system and early transfer of staff could impact on coordination of response to health protection issues

Objective	Progress and outstanding actions	Leads (PCT/LA	Milestones	R/A/G	Risks
	the continuation of this service will be detailed in an SLA • The HPA has identified arrangements for 11/12 and is making arrangements to test the system. Arrangements which have implications for 13/14 will be discussed at the LA/NHS SoTW meeting.		Lead DPH arrangements for Health Protection June 12.		
	New local public health system The detailed plan will identify actions and milestones to ensure that the new local public health service will deliver all mandated services. • Core offer to NHS Commissioners paper being developed to show current and future options (see 1G above) • After the commissioning model and supporting arrangements have been developed (see 1B) there will be a confirm and challenge session to test SCC commissioning arrangements in relation to mandated services with a focus on sexual health to ensure that issues relating to commissioning		Agree detailed plan v1.0 March 2012. Review and refresh on a monthly basis Confirm and challenge session re commissioning processes Oct 12.		Lack of clarity re hosting of/access to Child Health System Inability to agree where legacy costs reside of any currently unknown SUIs/Negligence claims/in system Transfer of commissioning arrangements from NHS funded to LA funded-

Objective	Progress and outstanding actions	Leads (PCT/LA	Milestones	R/A/G	Risks
	from a range of NHS providers, clinical governance and clinical advice to the commissioning process have been satisfactorily resolved. • Arrangements for the collection of data for the NCMP will be included in the information and intelligence workstream (see 1D above) • As further national guidance emerges health protection arrangements for 12/13 will be developed and tested.		Health protection operating model finalised Dec 12		unintended consequences NHSLA / CNST issues for LA as commissioners Support for Health Protection on establishment of HPA took many months to confirm through the development of an MOU/SLA. These transitions involve PHE /NCB /CSS /LA working together with the DPH the accountable Officer
2.B Develop a clear model for the delivery of critical PH services/programmes	Screening and immunisation programmes currently commissioned on PCT cluster basis by public health staff and others in the organisation, including some whose current function align to	DH/NC			Lack of clarity re commissioning and delivery of screening and immunisation

Objective	Progress and outstanding actions	Leads (PCT/LA	Milestones	R/A/G	Risks
locally during transition (screening programmes, immunisation programmes, drug & alcohol services and infection prevention & control)	PHE. Arrangements for drugs & alcohol services are as described in section 1.E for non-mandated services transitioning to the LA • As staff who support the commissioning of screening and immunisation functions are aligned to different organisations their ongoing commitment to these programmes will be detailed in SLA/MOU with emerging organisations to ensure continued delivery on behalf of the PCT until 31/3/13. • Issues throughout 2012/13 will recorded in a log which will be part of a legacy document that will facilitate transition to PHE and the NHS CB • Establish clarity re commissioning, delivery, quality and assurance of infection control. National guidance awaited.		SLA agreed 1 month prior to staff transferring to emerging organisations First draft legacy document and issues log June 12 Appraisal of options for the commissioning and delivery of infection control assurance September 2012.		functions and overview/delivery of infection control LA require SLA with STFT over Infection Control

3. Workforce PL

Objective	Progress and outstanding actions	Leads PCT/LA	Milestones	R/A/G	Risks
3.A Develop a plan to support the transition of workforce in line with the HR Concordat	Workforce identified as major strand in detailed plan, although HR work is being led regionally. • Develop a detailed plan as further guidance becomes available. Staff identified whose current functions in relation to PH functions, programmes and commissioned services align to future LA responsibilities. HR plans being developed including principles in the Public Health HR Concordat. HR work-stream needs to include the following: • *Consideration of if job descriptions be reviewed to ensure they are correct before consultation starts* ➢ *Development of a process to record decisions taken during transition which may affect the employment of groups and individuals* • *Development of a process to consult and engage with employees in LA and PCT* • *Development of a process to audit*	VT/JL/PC	Agree v1.0 of the detailed plan (Mar 12) complementary to the regional HR plan	Identification Awaitng guidance	Delays or lack of clarity in HR sender and receiver guidance Level of RFB and split between PH administrative and commissioned services funding HR guidance not published in a timely manner. Disagreement over implications of ringfenced budgets (rfb) and staff transition unresolved between NHS SoTW and Sunderland City Council.

	skills and competencies in LA and PCT. Will there be criteria to assess if posts in the LA and PCT are similar in content/responsibilities? • *Development of a process to appoint senior staff – DPH and consultants- is an assessment process needed?* • *What will be the selection and appointment process for other transferring staff?* • *What will be the process to ensure that interview panel members and senior managers are up to date with diversity and equality considerations?* • *When will trainees on placement be identified to transfer to LA?* Locally consideration needs to be given to: • Will there be an induction programme for staff transferring into the SCC? • What will be the arrangements for shared learning, career opportunities and CPD in SCC to ensure revalidation of professional qualifications? • Engagement with the Public Health Specialist Trainee Scheme				Unions to be included not usually within Staff Side7-BMA?

4. Governance PL

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
4.A Develop and agree arrangements for accountability and performance monitoring arrangements for 2012/13	New arrangements for accountability and performance management will only be needed if functions transfer prior to 1/4/13. If it is agreed that some functions will transfer, one option to agree accountability and performance monitoring arrangements is a MoU • Sunderland Public Health Transition Board will make recommendations re if functions will transfer during transition year. (see 1A). If not, current arrangements will continue. If functions are to transfer, MoU to be developed • Terms of reference needed for Public Health Transition Board	MD/DH/ SR	MOU (if required) to be agreed 1 month prior to transfer Public Health Transition Board Terms of reference agreed Feb 2012		
4.B Agree and test arrangements for key public health functions during transition	Nationally mandated emergency planning arrangements will be implemented through Local Resilience Forums A regional factsheet has been produced (attached) and the HPA has summarised 12/13 arrangements Under current arrangements a lead DPH	LR/NC/ JJ/TC	Operating model developed including lead DPH arrangements June 2012 Exercise to test		LAs do not agree Lead DPH assignment/alignment?

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	will be nominated to LRF Health sub group and a process is needed for SCC to agree the lead DPH arrangements A summary of current arrangements for screening and immunisations produced by SHA is attached.		arrangements October 2012		
4.C Identify and agree arrangements for clinical governance arrangements during transition	Identified as work-stream in detailed plan. Currently out-with public health in PCT. During transition, arrangements will continue as current. An MOU may be developed should transfer of public health take place prior to Apr 13. An SLA with emerging organizations may be developed should staff supporting this function transfer. Options post transition currently being explored, preferred option is to commission this service from Commissioning Support Organisation. • Develop this element of the detailed plan • Define breadth of clinical governance in services to be commissioned by SCC • Establish if regional guidance will assist in developing local arrangements • Establish process for commissioners to be assured providers have appropriate	MD/CD/DH/NC	Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis MOU/SLA (if required) to be agreed 1 month prior to transfer Clinical governance option appraisal paper to be developed by September 2012 New arrangements developed and/or		Outcomes of Francis Enquiry may impact on this Can LA engage with NHSLA? Is funding available

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	clinical governance arrangements in place • Undertake option appraisal of post transition clinical governance arrangements and commission if appropriate.		commissioned March 2013		
4.D Agree risk sharing (LA/PCT) approach to transition	Risks identified and shared as part of the LA programme management process and the PCT Transition Process. Identification and mitigation of risk to be standing agenda item at transition meetings of LA and PCT. • Maintain risk register as part of the detailed plan (LA) • Update the NHS SOTW risk register to identify transition risks • Ensure involvement of legal services and audit services in the transition process	DH/CM/ MD/SR / JoJo/DS	PCT Public Health risk register to be maintained Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis		Lack of NHS.LA agreement over risk sharing re legacy issues
4.E Agree the approach to sector led improvement *(transformation)*	Transition plans aim to achieve transformational change in the delivery of public health services across Sunderland, through improved integration across functions, programmes and commissioned services with developing council services linked to the operating model. Additional work is needed in a range of areas (health improvement, health protection, health care	DH/NC/ IP/SR/NR /PC	Integrated model for commissioned services developed Apr 12 Integrated model for health improvement strategic influence		If EIA is not sufficiently robust then new model in relation to commissioned services may be challenged ?Could charges

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	quality) through the development of integrated programmes and commissioning.		developed Jul 12 Commissioning plan to achieve new model developed May 12		be introduced??
4.F Establish structures to ensure the active engagement of the LA in the PCT approach to transition	Public health transition is led by the Assistant CE in SCC with active engagement of broader team. Regular high level meetings between PCT cluster and 3XLAs and regular meetings of Sunderland public health team and council project team (see terms of reference of Sunderland Public Health Transition Board, NHS SoTW Directors Transition and Change Group and SOTW/LA High Level group). Plans developed jointly to ensure a good fit during transition and a number of sign-off processes have been agreed. • Complete detailed plan • Continue with PCT/LA and LA/PH meetings to oversee transition with robust terms of reference • SCC programme transition executive board to include DPH, DAS, DCS and Asst CE	SR/NR/ DH/NC	Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis Agree ToR of Sunderland Public Health Transition Board Feb 12 Agree ToR of LA/NHS SoTW group Mar 12 Composition of the programme board executive and governance journey confirmed by Mar 12		LA Chief Officers and Political Leadership may not support implementation timelines defined by DH

5. Enabling infrastructure GG

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
5.A Identify the capacity and capability to deliver the transition	Both this plan and the detailed plan identify leads for objectives. Transition Board meetings will provide a mechanism for the identification and addressing of capacity issues identified by work streams. • Ensure risks of capacity shortfall and actions to mitigate are identified on the risk register and regularly reviewed	NC/SR	Capacity issues standard agenda item for fortnightly Transition Board meetings		Either insufficient capacity to maintain progress on all fronts or risk to current work
5.B Identify any significant financial risks and develop a plan to resolve these	Financial risks for currently commissioned services are reviewed within NHS SOTW on a regular basis and actions taken to address these. The delayed publication of the 13/14 public health budget is a risk for services and staff. • Identify the infrastructure needed to support the public health function post transfer, e.g. IM&T, finance support, HR support, procurement support, governance support, performance management through the infrastructure work stream • Assess the size of the 13/14 indicative budget against 12/13 planned public health expenditure (including support	DH/NC/CM /SR/PC/ST	Ongoing management of financial risks during 12/13 Estimate of cost of required infrastructure Apr 12 to be reviewed Feb 13 Assessment of impact of 13/14 allocations on service delivery modelled Apr 12		If EIA/INRA is not sufficiently robust then prioritisation may be challenged

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	costs) • In absence of 13/14 baseline, model impact on staff, functions, programmes and commissioned services based on reduction of 10%, 20%, 30% and mandated services only • Undertake prioritisation process informed by JSNA, INRA and modelling of 12/13 indicative budget (see 1A) • Review priorities when 13/14 allocations are known		Indicative prioritisation of expenditure May 12. Final prioritisation of expenditure for 2013/14 Jan 13		
5.C Agree the arrangements for the handover of all agreed PH contracts	Contract details have been identified and shared with SCC. Commissioning Intentions (12/13) have identified the potential for notice to be given on all of these contracts. A prioritisation process will take place informed by the recently published 12/13 baselines and which will take account of transformational change and clearly identify contracts that will roll forward. It is anticipated that during 2012/13 there will be a need for the recommissioning of a number of services.	DH/LR/NC/ SR/PC	Assessment of impact of 13/14 allocation on service delivery Jan 2013 Proposed model for delivery of integrated health improvement services developed by		Legal issues in relation to transition of NHS contracts to LA contracts Litigation/clinical negligence issues Interaction of LA political process with prioritisation

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	• Assess impact of 13/14 pubic health budget alongside opportunities to transform and integrate services • The commissioning work stream of the detailed plan will identify the steps needed to achieve handover of contracts where appropriate.		April 12 Commissioning plan to achieve new model developed by end May 12		of previous NHS provided services
5.D Are all clinical and non-clinical risk and indemnity issues identified for contracts	• Risks are currently managed through NHS systems and processes. An additional risk is the lack of clinical governance structures in the LA.. There is also a lack of clarity as to whether LAs will be part of existing NHS indemnity arrangements (NHS Litigation Authority) in relation to PH contracts that will transfer. • Agree local approach to indemnity issues post April 2013pending any	DH/MD/CD /NC	Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis Agree local approach to post Apr 13 indemnity issues Feb 12		No agreement over legacy indemnity issues

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	national guidance February 2012 • Identify clinical risks for public health functions, programme and commissioned services transferring to SCC • Include definition of clinical governance (including medicines management) and indemnity post transition in detailed plan and risk registers • Undertake option appraisal of clinical governance arrangements post transition and commission if appropriate. • Undertake option appraisal for clinical and non clinical indemnity post transition • Agree local approach to legacy indemnity issues pending any national guidance February 2012		Clinical risks for PH functions, programmes and services mapped by Nov 12 Clinical governance option appraisal paper to be developed by June 2012 Indemnity option appraisal paper to be developed by Sept 2012 Approach to legacy indemnity issues agreed Feb 13 New arrangements developed		

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
			and/or commissioned March 2013		
5.E Develop and agree plan to ensure access to IT systems and data during transition and access to appropriate information and intelligence post transfer.	Current arrangements enable staff employed by the PCT to access NHS systems from council facilities. During transition access to information and intelligence support from the PCT structures will continue. There is currently no guidance on access to NHS information for the DPH post transfer. The intelligence and information element of the detailed plan needs to be completed and the options for intelligence and information support post		MOU to be agreed if required 1 month prior to transfer. Detailed plan agreed Information and Intelligence option appraisal		Information governance re access Lack of skilled resource and capacity to deliver information and intelligence out of data

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
	transition need to be considered. • Information and intelligence work stream of the detailed plan will scope the required support and options for delivery Sept 2012.		paper to be developed based on regional information and intelligence work Sept 2012 Scoping of infrastructure complete by Sept 2012 New arrangements developed and/or commissioned March 2013		
5.F Develop an agreed approach to facilities, estates	There are currently very few assets that sit with the public health team exclusively and no estates. The team currently has access to some office space within the council.		Assets identified Dec 2012 Approach to		

Objective	Progress and outstanding actions	Lead (PCT/LA)	Milestones	R/A/G	Risks
and asset registers	• Identify assets needed post transition as part of the Information and Intelligence work stream		asset transfer agreed Feb 13		
5.G Develop a legacy handover document	The public health team currently contribute to the emerging PCT legacy document. There is, however, a recognition that a more detailed document may be required in relation to public health services. • Agree format of PH legacy/handover document and issues log • Integrate development of document into work stream plans		First draft legacy document and issues log June 12		

6. Communication and Engagement GG

6.A Develop and agree an approach to communications and relationship building	A number of relationships amongst SCC/Public Health/CCG have been strengthened recently. Cross membership of the HWB/CCG and partnership arrangements for adults and children will help with communications and relationship building. • Develop the communications and engagement work stream of the detailed plan taking account of both current and emerging structures and organizations • Include communications and engagement in the service delivery work stream of the detailed plan.		Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis		Stakeholders may not agree to decisions within Transition Plan e.g. sourcing of core PH Offer to CCGs
6.B Develop and agree an approach to engagement of stakeholders	Early engagement of providers in relation to the transfer has begun through information in the PCT Commissioning Intentions and through contract meetings. There will be wider engagement following the development of proposals for an integrated model for health improvement services • Develop the communications and engagement element of the detailed plan including engagement with stakeholders in relation to the proposals for integrated health improvement services.		Agree v1.0 of detailed plan Mar 12. Review and refresh on a monthly basis Stakeholder events re integrated model completed Apr 12		

	• Include approach to engagement of stakeholders in the service delivery work stream of the detailed plan.				

Sunderland Public Health Transition Plan 2012/2013 - KEY

PCT		
Initials	**Name**	**Title**
NC	Nonnie Crawford	Director of Public Health
PL	Pam Lee	Public Health Consultant
GG	Gillian Gibson	Public Health Consultant
TD	Tony Douglas	Project Manager
BS	Ben Seale	Commissioning Manager
LR	Louise Robson	Chief Operating Officer
KH	Kate Hudson	Head Of Finance
DH	David Hambleton	Director of Commissioning
FAD	Faisal Al Durrah	Public Health Consultant
IP	Ian Pattison	Clinical Commissioning Group
DB	Debbie Burnicle	Commissioning Development
ML	Mark Lambert	Consultant in Public Health Medicine
MO	Mark Overton	Public Health Consultant
VT	Vicki Taylor	Director of Human Resources & Organisational Development
JL	Janine Lutz	Human Resources
MD	Moira Davidson	Director of Governance & Quality
CD	Carole Donaldson	Associate Director, Quality & Patient Safety
CM	Chris Macklin	Director of Finance

TC	Tricia Cresswell	Consultant in Health Protection – Health Protection Agency North East

LA		
Initials	**Name**	**Title**
SR	Sarah Reed	Assistant Chief Executive
CH	Claire Harrison	Senior Project Manager
KG	Karen Graham	Assistant Policy Lead for Health
NR	Neil Revely	Executive Director – Health, Housing and Adults
PC	Peter Coates	Programme Manager
JJ	Janet Johnson	Deputy Chief Executive
JoJo	John Jordan	Corporate Risk Manager
DS	Dave Smith	Chief Executive
ST	Sonia Tognarelli	Head of Financial Resources