NHS Nottinghamshire County

NHS Bassetlaw

Public Health Business Plan

October 2011 – March 2013

Healthy Lives, Healthy People, Healthy Nottinghamshire

Contents

1. Introduction

Key:

For the purposes of this document, the term “the NHS” refers to NHS Nottinghamshire County and NHS Bassetlaw.

Similarly, the term Local Authorities refers to Nottinghamshire County Council and all District and Borough Councils in Nottinghamshire County.

Definition of Public Health:

> *The science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.*
>
> *Faculty of Public Health*

1.1 For Nottinghamshire the Public Health function is provided primarily for a population of 776,600 (2009 ONS estimated figure) though there will be influences on both neighbouring populations and any visitors to the County.

1.2 The period from 2011 to 2013 is one of significant changes to the location and ways of working of Public Health services arising from the proposed legislation contained in the Health and Social Care Bill. The proposed roles are described in some preliminary detail in the various papers released by the Government and Department of Health (DH) – Healthy Lives, Healthy People. Subject to the passage of the Health and Social Care Bill, from April 2013, there will be a fundamental shift of responsibility when the Public Health (PH) function transfers from the NHS to Nottinghamshire County Council. Along with new commissioning responsibilities for Public Health, Local Authorities (LA) will need to embed PH into all Local Authority activities.

1.3 The key domains within Public Health are:

a. Health Improvement;
b. Health Protection; and,
c. Population Health Services

1.4 This Business Plan is concerned with 2 key actions:

a. Maintenance of local Public Health functions:
    - Leading the delivery of Public Health outcomes
    - Appropriate management of resources
b. Transition to the new working arrangements set out in the Transition Plan:
    - Leading and managing the transfer of Public Health functions, programmes and staff
    - Developing the PH role and commissioning support within Local Authorities at County, Borough Council (BC) and District Council (DC) levels
    - Developing the commissioning support role with Clinical Commissioning Groups (CCG)
    - Developing a meaningful interface with providers and the public
    - Developing appropriate interfaces with Public Health England (PHE) and the National Health Service National Commissioning Board (NHS CB)

1.5 The plan sets out the drivers and how Public Health will lead the transition of the service at a local level. It describes the current service and how Public Health will continue to deliver its statutory duties within the new commissioning environment.

1.6 Robust governance structures will be in place to ensure safe transition whilst maintaining a focus on the delivery of better health outcomes for the population of Nottinghamshire.

1.7 Public Health staff will be accommodated in Local Authority premises. This will involve many challenges with such things as information technology and new ways of working in a changed environment. Staff will be inducted into the NCC Local Authority mission values and principles, ways of working, culture, interface with members, report writing etc; all part of making the "one council" principle a reality. In conjunction NCC, staff will also be part of the induction programme to ensure they fully understand Public Health and the functions that are transferring. Appendix **A** includes more detail around the transition.

1.8 The funding in the Local Authority will be through a Public Health Grant. National discussions are still ongoing but are likely to be determined on current levels of expenditure matched to currently commissioned programmes and activities, including Public Health's role in Quality, Innovation, Productivity and Prevention (QIPP) and decommissioning programmes. Information on current expenditure on PH programmes is included in Appendix **B**. In preparation for shadow working from April 2012, the value of the grant should be released in December 2011. This information will be presented subject to ongoing review and change.

1.9 The interface with and active working with other organisations is key to the effectiveness of local Public Health functions and this will include direct links with Public Health England for some of the functions in Nottinghamshire. Other links will be with "Clinical Senates", NHS National Commissioning Board, Health Watch and with providers of services.

2. Review of Current Role and Functions

2.1 The Public Health function in the NHS is currently managed within a Public Health Directorate accountable through the Director of Public Health to the Boards of Nottingham/Nottinghamshire PCT Cluster and the South Yorks/Bassetlaw PCT Cluster. It is currently the responsibility of the PCT's to facilitate the optimisation of the health of its population whilst managing the healthcare system within financial constraints.

2.2 The PH function is at the heart of everything a PCT does. The specialist skills of PH staff are vital to securing effective commissioning and promoting population health to reduce future demand on services.

2.3 The core values of Public Health are:

- Effectiveness – getting the biggest positive impact on health;
- Localism – empowering local communities;
- Efficiency – getting the best value for money; and
- Equity and Comprehensiveness – reducing health inequalities and increasing fairness in the provision of services.

2.4 The PH function of a PCT plays a leading role in many of the organisations' essential roles. These include the determination of health needs of the population, the prioritisation of these needs, and the maximisation of return on the investment of the PCT in healthcare services, based on appropriate quality outcomes for patients and the public.

2.5 The PH function involves multi-sector and multidisciplinary working across the various health care sectors of primary care, secondary care and tertiary care. In

addition to PH leadership within health, work is undertaken at a local level with Local Authorities (LA) at tier 1 and 2 levels and voluntary and special interest groups. A significant amount of Public Health resource is provided to support Clinical Commissioning Groups, district LSPs and other local Partnerships to ensure improvements in the health of the population.

2.6 In Nottinghamshire County and Bassetlaw the Public Health workforce consists of 62 posts (2011/12).

2.7 The total programme expenditure for all PH programmes (including the PH staff) is detailed in Appendix B.

2.8 The functions of Public Health are to:

a. Undertake surveillance and assessment of the population's health and wellbeing
b. Monitor health status to identify community health problems;
c. Diagnose, investigate health problems and health hazards in the community
d. Inform, educate, and empower people about health issues;
e. Mobilise community partnerships to identify and solve health problems;
f. Develop policies and plans to support individual and community health efforts;
g. Enforce laws and regulations that protect health and ensure safety;
h. Assure a competent Public Health and personal health care workforce;
i. Evaluate effectiveness, accessibility, and quality of personal and population based health services;
j. Research for new insights and innovative solutions to health problems.
k. Demonstrate strategic leadership.

The Faculty of Public Health have developed core competencies for Consultant in Public Health that further define the functions and role. Further information can be found at http://www.fph.org.uk/ .

2.9 The PH teams have delivered on significant agendas over the last year. Appendix **C** provides the overview of some of the Public Health key successes in 2010 – 11. This is not an exhaustive list but illustrates the breadth of the PH function. Delivery has required new ways of working to support delivery along the whole of the commissioning cycle including writing service specifications and contracting.

3. Strategic Framework

3.1 The organisation and delivery of the Public Health function is determined within a framework of national legislation and guidance as well as local issues and policies. The interpretation of these and the identification of local needs will inform the development of local Public Health key priorities.

3.2 Legislative Framework

3.2.1 The White Paper *Healthy Lives, Healthy People: Update and way forward (HM Government 2011)* sets out the Government's response to a national listening exercise that included reviewing the Government proposals set out in *Healthy Lives, Healthy People: Our strategy for Public Health in England (HM Government 2010).* The Government proposals set out a step change in Public Health requiring reform with a new approach, reaching out to local communities.

3.2.2 The national vision is to create a Public Health system that will reach across and reach out – addressing the root causes of poor health and wellbeing, reaching out to individuals and families who need the most support, and be:

- **Responsive –** owned by communities and shaped by their needs
- **Resourced –** with ring-fenced funding and incentives to improve
- **Rigorous –** professionally-led, focused on evidence, efficient and effective
- **Resilient –** strengthening protection against current and future threats to health.

3.3 The reformed Public Health system involves Local Authorities taking on Public Health responsibilities including commissioning of a variety of services and delivery of mandatory functions. Appendix **D** describes the relationship between the NHS and Local Authority outlined in a Memorandum of Understanding (MOU). Information on transferred PH responsibilities is also included.

3.4 Simultaneously with the changes in the way Public Health is commissioned the White Paper on NHS reform *Liberating the NHS (Department of Health 2010)* is also being implemented, subject to the passing of the Health and Social Care Bill. This requires significant changes to local systems and relationships for delivering health outcomes.

3.5 Public Health England (PHE)

Nationally,

3.5.1 PHE will be established as an integrated Public Health delivery body. PHE's function will be to drive delivery of improved outcomes in health and well-being, and design and maintain systems to protect the population against existing and future threats. It aims to bring together in one organisation the Public Health skills, knowledge and capabilities that are currently distributed across a wide range of health organisations. More information can be found at http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249

3.5.2 As part of the implementation process the DH will produce a series of Public Health System Reform Updates to complete the operational design of the Public Health system. These will include the PH Outcomes Framework, PHE Operating Model, PH in local government and DPH post, PH funding regime and PH workforce.

3.6 NHS National Commissioning Board (NHS CB)

3.6.1 The NHSCB will be responsible for commissioning of services within the NHS, including the oversight of the CCGs.

3.6.2 The proposals for the NHS National Commissioning Board are subject to the successful passage of the Health and Social Care Bill and the decisions of the NHS CB once it is established. The NHS Future Forum report recommended that the NHS Commissioning Board should be established as soon as possible to ensure focused leadership during the transition. More information can be found at http://healthandcare.dh.gov.uk/the-role-of-the-nhs-commissioning-board/

4. Local Drivers

4.1 Health and Wellbeing Board

4.1.1 At the local level the whole system will be brought together by the Health and Wellbeing Boards in the Local Authorities. They will maximise opportunities for integration between the NHS, Public Health and social care, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population.

4.1.2 Health and Wellbeing Boards will provide the vehicle for local government to work in partnership with Clinical Commissioning Groups to develop comprehensive Joint Strategic Needs Assessments (JSNA) and a robust Joint Health and Wellbeing Strategy (JH&WS). These will set the local framework for commissioning of health care, social care and Public Health services, by taking into account wider ranging local interventions to support health and wellbeing across the life course (e.g. local planning and leisure policies and working with community safety partnerships, police and crime commissioners).

4.2 Local Resilience Forum

4.2.1 The Local Resilience Forum (LRF) operates across the whole of Nottinghamshire including Bassetlaw and the City to ensure the organisations fulfil their duties in relation to emergency preparedness, managing major incidents. There are also close working arrangements between the two PH directorates on health protection, including issues like infection control, blood borne viruses, Tuberculosis and Human Papilloma Virus programmes. The local Health Protection Unit of the Health Protection Agency currently covers the whole of Nottinghamshire, Derbyshire and Lincolnshire. It is planned that this joint working should continue, as the current systems work well. Overall the details on LRFs are currently being clarified at the national level.

5. Key Priorities

5.1 The key priorities for Public Health over the coming period are within agreed strategic and operational plans http://www.nottspct.nhs.uk/my-pct/strategies.html . Some will reflect national trajectories and targets that are performance monitored by East Midlands Strategic Health Authority. Key priorities include:

- Reducing health Inequalities
- Promoting urgent care systems to work effectively

- Supporting long term conditions
- Large scale prevention
- Primary Care
- Delivering high quality planned care
- Mental health wellbeing
- Making services safer
- Other local schemes

5.2 Public Health has been instrumental in delivering projects across Nottinghamshire for example within Productive Notts. Examples of key initiatives are summarised in Appendix **E**.

5.3 As well as the work with Productive Notts, The NHS has a comprehensive approach to health improvement and a reduction in health inequalities as part of current health strategies; this includes plans in relation to tobacco, smoking cessation, alcohol, obesity, heart and lung disease and cancer. There has been a particular focus on delivering reductions in health inequalities through primary care including the NHS health checks programme. Reducing health inequalities is also a key component of the primary care strategy and a major element of the induction programme for CCGs

5.4 The NHS has trajectories which are linked to the QIPP agenda and are regularly reported to PCT Boards where there is formal performance management of all targets. CCGs have been a fundamental part of the thinking behind all these policy areas and are fully signed up to their delivery.

6. Public Health Outcomes

6.1 The details of the national Public Health Outcomes Framework and the outcome measures to be adopted to track progress are to be published by the Government. This will incorporate a focus on the "wider determinants of health", which are the social, economic and environmental conditions that influence the health of individuals and populations, such as housing, educational attainment and financial position. There will also be a clearer alignment across the NHS, Public Health and Adult Social Care Outcome Frameworks.

6.2 Although the indicator set is under development, it is anticipated that measures of health inequality will be included, for example, measuring the gap between life expectancy between different socio-economic groups / males and females / regional inequalities.

6.3 It is likely that the Public Health outcomes framework will concern clinical end-points and process indicators (where a clinical end-point is inappropriate). Each indicator will need to be considered in terms of its potential impact on equality and diversity. More importantly, it will be the interventions deployed to improve health (as measured by the indicator set) that have the greatest potential to impact on reducing health inequalities. Any negative impacts will need to be mitigated at a local level through commissioning processes.

6.4 It is possible that indicators may be chosen which focus on specific groups e.g. cancer mortality for under 75 years of age. These indicators will only be selected where their inclusion can be justified by a strong evidence base and where the intention is to reduce specific inequalities in health.

For more information please see
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_123138.pdf .

7. Commissioning Development

7.1 Commissioning support for the Clinical Commissioning Groups is detailed in the memorandum of understanding (Appendix **F**). Public Health has a crucial and essential role in the commissioning of health services across the whole spectrum of health and its interface with social care and other providers.

7.2 The NHS will continue to have a critical part to play in securing good population health, and will work closely with local authorities to achieve the best possible health outcomes for local people. The NHS role in securing population health outcomes includes:

- The provision of accessible and high quality health care to meet the needs of the local population
- Ensuring that in delivering healthcare the opportunities to have a positive impact on Public Health are taken
- Delivery of specific population health interventions (e.g. childhood immunisations and national screening programmes)
- The NHS contribution to health protection and emergency response.

7.3 Where appropriate the NHS Commissioning Board will be asked to commission specific services funded from the Public Health budget and in agreement with the Clinical Commissioning Groups (CCG).

7.4 Locally there are six CCGs:

- Bassetlaw Commissioning Organisation
- Mansfield and Ashfield
- Newark and Sherwood Health
- Nottingham North and East
- Nottingham West
- Principia, Rushcliffe

Figure 2 shows a map illustrating the areas where 90% of patients registered with each CCG live. It shows that there are minimal differences between CCG populations and local authority boundaries.

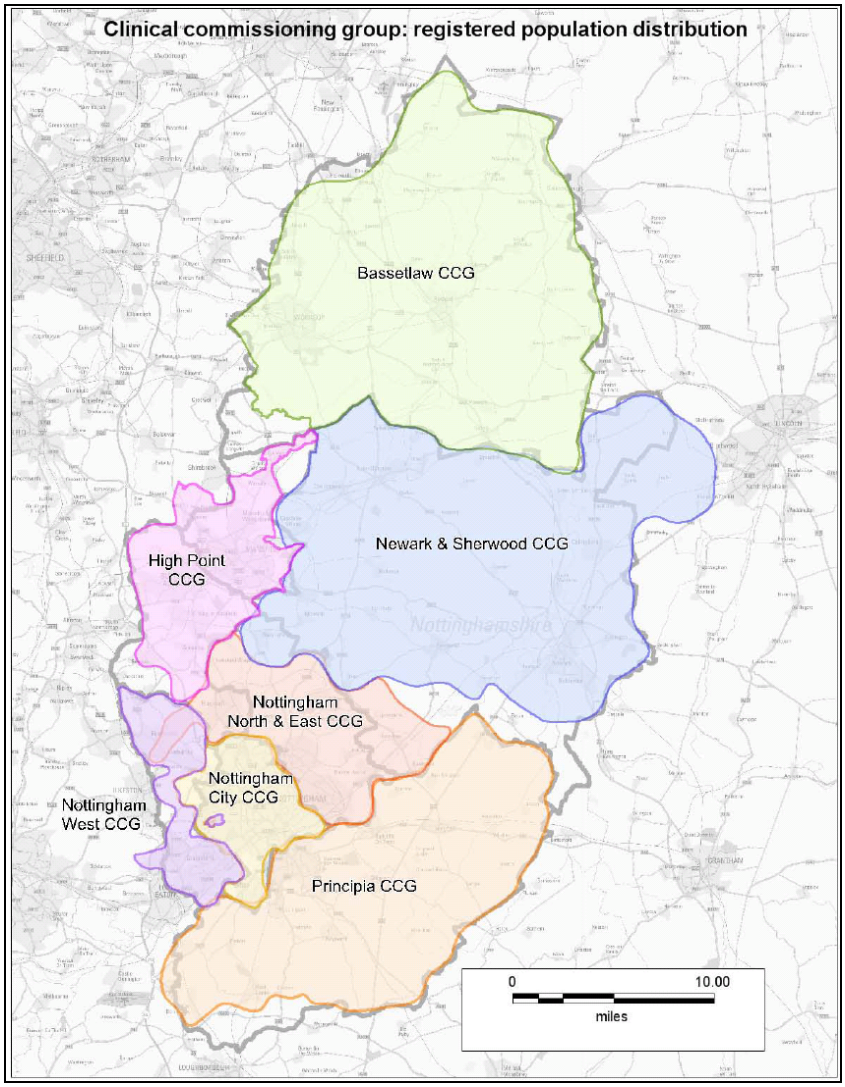

Figure 2: Map of 90% of patients registered with Clinical Commissioning Groups Bassetlaw, Newark & Sherwood Health, Principia (Rushcliffe), Nottingham North & East, Nottingham West and Mansfield & Ashfield.

8. Business Processes

8.1 Management Structure

8.1.1 The management structure will change from a NHS PCT based structure to a Local Authority based structure. The service will be lead by the Director of Public Health.

8.1.2 The effectiveness of the structure will require leadership on the key PH priorities and a workforce that is able to work generically across these priorities.

8.2 Finance

8.2.1 A fundamental plank of the national strategy is providing Public Health with dedicated resources. The plan is to strategically align resources to ensure focus on prevention, recognising that Public Health is a long-term investment, and that effective spend on prevention will release efficiency savings elsewhere, which can then be used elsewhere in the NHS and across government more widely.

8.2.2 The DH is committed to ensuring that local authorities are adequately funded for their new responsibilities and that any additional net burdens will be funded in line with the Government's New Burdens Doctrine. Public Health Grants to upper tier and unitary local authorities will be made for the first time in 2013-14 and DH intend to provide shadow allocations for 2012-13 by the end of this year. The Advisory Committee for Resource Allocation continues to consider what it will recommend as an appropriate allocations formula for the local authority grant.

8.2.3 Appendix B identifies the current commissioned Public Health programmes and activities with detail on the current investment. It provides detail regarding decommissioning and Public Health input to the QIPP plan. Additionally it identifies where some current Public Health funds are included as part of block funding for service areas with an understanding that this will remain in order to support authorisation and continuation of services.

Workforce and Training

8.3.1 The Department of Health (DH) is working with stakeholders to develop a Public Health workforce strategy as set out in the White Paper. The focus of the strategy will be on the specialist workforce, but it is clear that Public Health is everybody's business, so the strategy will be inclusive. It will:

8.3.1.1 Scope the current situation of Public Health workforces;

8.3.1.2 Consider the role and purpose of the Public Health workforce in the context of the White Paper, 'Healthy lives, healthy people: our strategy for Public Health in England';

8.3.1.3 Examine how best to transform the workforce to meet the challenges and opportunities of the future, but also offer career pathways to those with different entry points;

8.3.1.4 Set out how to deliver a high quality, sustainable, specialist workforce with the flexibility to move across employment sectors;

8.3.1.5 Look at the training and education opportunities to support wider Public Health

8.3.1.6 Review workforces (such as health visitors, school nurses, many allied health professionals and others) and the relationship between PHE and Health Education England; and,

8.3.1.7 Consider how best to build on and use workforce data effectively, not least for planning for the future.

8.3.2 The local workforce development plan is attached at Appendix **G** details how individuals and teams will be supported and developed through the changes.

8.3.3 From October 2011, Public Health Consultants (PHC) and their teams will move to be based in Nottinghamshire County Council premises; in a phased way. Workforce transition will be completed by March 2012 with full transfer of all duties and resources by March 2013.

8.3.4 Currently, those PH staff directly employed by NHS Bassetlaw will be transferring to the LA in the same way as NHS Nottinghamshire staff. Up to the end of March 2013 when the PCTs formally disband, they will continue to be managed and located as they currently are i.e. by one of the PHCs with lead responsibility in NHS Bassetlaw.

8.3.5 As well as fulfilling responsibilities on behalf of NCC and the B/DCs, each PHC will be assigned to a specified CCG. Additionally the PHC will lead on clearly defined policy areas. They and their teams will be easily accessible to ensure national policy is locally determined and commissioned. The memorandum of understanding provides more detail for CCGs and the Las.

Training

8.4.1 All PH directorates are expected to provide training for a variety of staff. They are also expected to ensure that all staff employed in their directorate maintain the requirements of continuing professional development (CPD) expected by their professional bodies. This is often addressed through a regular in-house educational session, as well as ongoing access to key external training opportunities, including those required to maintain competency in the training role.

8.4.2 In addition to employed staff, training is also provided to selected staff groups employed by external organisations. Staff specifically in training grades may be:

- Specialty Registrars, mostly employed by the SHA and will spend 2-3 years at a specific location;
- 2nd year Foundation Programme doctors, employed by local Acute Trusts, who will spend 4 months at a location; and,
- Undergraduate nurses, usually spending only 2-3 months at a location.

8.4.3 All staff in training grades will have a nominated educational/clinical supervisor, who requires dedicated time weekly to support the trainee. For Specialty registrars, the East Midlands Healthcare Workforce Deanery ensures the quality of the training location through annual monitoring of both the location and the performance of the trainee.

8.4.4 In addition, other staff in the PH team may be studying for a Masters degree, usually a Masters in Public Health (MPH). If the staff member has sought employer support for this, it may be given in time off for study or a contribution towards the costs of the degree, or both.

8.4.5 All PHCs are required to take part in a professional appraisal system in addition to their managerial appraisal. This is similar to other consultant specialties to meet national standards for revalidation as per GMC regulations. This process is co-ordinated across the East Midlands to ensure a standardised and efficient approach for all employers. Local PHCs will need to take part in this process both as appraisers and appraises.

8.5 Communications

8.5.1 A communication plan is in place to ensure that all staff and stakeholders are fully briefed and up to date with changes and wider health messages (Appendix **H**)

8.6 Information

8.6.1 The Public Health functions rely on good information and analysis. Requirements of the function include the development of Joint Strategic Needs Assessments. The opportunities gained by moving to the Local Authority should allow more connected and comprehensive information bases. However Information Governance issues need to be addressed to allow ongoing access to NHS data.

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8.7 Implementation

8.7.1 The implementation of this Business Plan will be monitored through a detailed implementation plan. This will update monthly at the PH Senior Management Team, chaired by the DPH who will report to the Transition Board.

Summary Implementation Plan 2011-2013

Appendix **I** provides a detailed implementation plan. This plan will be subject to review due to changing priorities to reflect the development of the Health & Wellbeing Strategy. An updated version of the plan is available from NHS NC Public Health Directorate.

The implementation broadly covers the two key actions of the business plan:

9.1 Maintenance of PH functions

- Leading the delivery of Public Health outcomes
- Appropriate management of resources

9.2 Transition

- Leading and managing the transfer of PH functions, programmes and staff
- Developing the PH role and commissioning support within Local Authorities at County and Borough/District levels
- Developing the commissioning support role with Clinical Commissioning Groups (CCG)
- Developing meaningful interface with other providers and the public
- Developing appropriate interfaces with Public Health England (PHE) and the National Health Service National Commissioning Board (NHSCB)

Glossary

A	
AAA (Screening)	Abdominal Aortic Aneurysm Screening
A&E	Accident and Emergency
B	
BC	Borough Council
BCO	Bassetlaw Commissioning Organisation
C	
CAHMS	Children and Adolescent Mental Health Services
CaSH or CASH	Contraception and Sexual Health
CC	Childrens Centre (as in Sure start Childrens Centres)
CCG	Clinical Commissioning Group
CHUMS	Care Homes Use of Medicine
COPD	Chronic Obstructive Pulmonary Disease
CPD	Continued Professional Development
CQC	Care Quality Commission
CQINN	Commission for Quality & Innovation
D	
DAAT	Drug and Alcohol Team
DC	District Council
DH	Department of Health
DPH	Director of Public Health
DRS	Diabetic Retinopathy Screening
DTaP/IPV/Hib	This is a 5 in 1 immunisation for infants consisting of: Diphtheria Typhoid & Polio, Inactivated Polio Vaccination and Haemophilius Influenzae type b
DV	Domestic Violence
E	
ED	Emergency Department
EDASS	Emergency Department Admission Support Service
EMPHO	East Midlands Public Health Observatory
EMSCG	East Midlands Specialist Commissioning Group
EOL	End of Life
ESD	Early Supported Discharge
F	
G	
GMC	General Medical Council
GP	General Practitioner
GP2DRS	GP Computer software programme to support DRS
GUM	Genitourinary Medicine

H	
Hep C	Hepatitis C
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prisons
HOS	Home Oxygen Service
HP	Health Protection
HPA	Health Protection Agency
HPV	Human Papilloma Virus
HR	Human Resources
HV	Health Visitor
HW	Health Watch
HWB	Health & Wellbeing Board
I	
IT	Information Technology
J	
JH&WS	Joint Health & Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
K	
KMH	Kings Mill Hospital
L	
LAA	Local Area Agreement
LA	Local Authority
LD	Learning Difficulty
LINks	Local Involvement Network
LOS	Length of Stay
LRF	Local Resilience Forum
LSP	Local Strategic Partnership
LTC	Long Term Condition
LTNC's	Long Term Neurological Condition
M	
MOU	Memorandum of Understanding
MPH	Masters in Public Health
MRSA	Methicillin-resistant Staphylococcus Aureus
N	
NCC	Nottinghamshire County Council
NCMP	National Child Measurement Programme
NDA	National Diabetes Audit
NHS	National Health Service
NHS NC	NHS Nottinghamshire County
NHS CB	NHS Commissioning Board
NHS/Nta	NHS National Treatment Agency for Substance Misuse
NICE	National Institute for Clinical Excellence
NNEC	Nottingham North & East Consortium (21 GP Practices)
NSF	National Service Framework
NTA	National Treatment Agency

O	
ONS	Office of National Statistics
P	
PBMA	Programme Budgeting and Marginal Analysis
PCT	Primary Care Trust
PEC	Professional Executive Committee
PH	Public Health
PHE	Public Health England
PHC	Public health Consultant
PID	Project Initiation Document
PMO	Programme Management Office
PNA	Pharmaceutical Needs Assessment
Q	
QIPP	Quality Innovation Prevention & Productivity
R	
RIF	Regional Innovation Fund
S	
SARC	Sexual Assault Referral Centre
SHA	Strategic Health Authority
SFHT	Sherwood Forest Hospital NHS Foundation Trust
SM	Substance Misuse
SS	Sure Start (as in Childrens Centres)
STAG	Strategic Tobacco Alliance Group
STI	Sexually Transmitted Infection
SQU	A National vital signs Indicator used to monitor performance
T	
TB	Tuberculosis
TOP	Termination of Pregnancy
TUPE	Transfer Undertaking Protection of Employment
U	
UNICEF	United Nations Childrens Fund
UNICEF BFI	UNICEF Breast Feeding Initiative
V	
V&I	Vaccination and Immunisation
W	
WTE	Whole Time Equivalent
X	
Y	
Z	

APPENDIX A – TRANSITION PLAN

Nottinghamshire County Council

Local Government & Health Transition Project Initiation Document (PID)

Pre-approval revision			
Date	Version	Author	Change Description
15.2.11	1.1	N Lane	Initial draft
	2.1	N Lane	Revised based on comments from CK, DP
7.3.11	3.1	N Lane	Based on comments from Improvement Office
15.3.11	4.1	N Lane	Revised based on comments from Local Government & Health Transitions Group
29.3.11	5.1	N Lane	Revised based on comments from CLT
Post-Approval revisions			
Date	Version	Author	Change Description
26.7.11	6.1	N Lane	Revised in line with amendments to HSCB

Introduction and Context

Purpose and Goals

This project relates to the implementation of the Health & Social Care Bill & associated legislation. The main goals of this programme are:

- to establish the Shadow Health & Wellbeing Board by April 2012
- to commission Local HealthWatch by October 2012
- *to commission complaints advocacy services from April 2013*
- to co-locate the Public Health function with local government by December 2011
- to implement robust local health protection arrangements within the new public heath structures by April 2013
- to establish effective working arrangements between the County Council and GP Consortia, including joint commissioning and exploration of the sharing of commissioning and infrastructure support

Within this over arching programme, 4 distinct projects have been identified:

Project 1 HWB: Establishment of the Shadow Health & Wellbeing Board to set the agenda for health improvement within the County and to promote joint commissioning through the Joint Commissioning Unit

Project 2 HW: Commissioning Local Health Watch to promote public involvement in health and care services and to provide advice and guidance to individuals and to c*ommission a local complaints advocacy service*

Project 3 PH: The co-location of public health in County Hall in preparation for the transfer of public health responsibilities to local government

Project 4 HP: Agreeing & embedding health protection arrangements for the county in preparation for the establishment of a joint Public Protection Unit.

In implementing this programme the Council will ensure that it is compliant with the new legislation and as a result will deliver organisational benefits and ensure better allocation of resources for the local population.

The Health and Wellbeing Board will provide leadership across Nottinghamshire in identifying health needs and also in developing a strategy to address these needs. The Board will be able to use the expertise of the clinical representatives, as well as the insight of elected members and HealthWatch to influence this strategy on behalf of the local people.

The Health and Wellbeing Board will require a unified approach across health and social care, resulting in more integrated commissioning between partner organisations led by the Joint Commissioning Unit within the Council.

This approach will lead to a coordinated and targeted approach to health needs, less duplication and ultimately better allocation of resources to meet identified and prioritized health needs.

Integration of public health within the Council will also improve coordination of services across health and social care. It will facilitate improved coordination with other services, maintained by the council which impact on health and wellbeing such as transport, leisure, housing and emergency planning.

Assumptions

The programme outline assumes that:

i. The Health & Social Care Bill will be passed

ii. The recommendations made in the Public Health White Paper Healthy Lives, Healthy People are implemented. A command paper was issued on 14 July 2011 which substantiates work to date and gives some clarity regarding the way forward. More detail is expected including a concordat which will cover arrangements for the transfer of public health staff into the local authority.

iii. The timescales for the plan have been extended and now cover changes scheduled until April 2013. Given these extensions the commissioning of complaints advocacy has now been included.

iv. In order to best manage the programme it will be phased. Phase 1 will focus on projects 1 & 3. Phase 2 will pick up projects 2 & 4, subject to guidance from the Department of Health regarding Local Health Watch & clarity regarding the location of the Health Protection Unit of Public Health England

v. Both the PCT Cluster & County Council support the delivery of the programme

vi. Resources will be allocated to the programme as required to deliver the outcomes locally & nationally

vii. Public Health staff are willing to relocate to County Hall and NCC will provide accommodation for transferring staff

viii. Suitable and sufficient resource is available from Public Health England to support the local service which will be required

The PID may need to be reviewed in light of changes to the legislation.

Key Programme Roles and Responsibilities

Within the overall programme there will 4 discrete projects as described above. Each of these projects will have a different project owner.

Project 1 HWB: David Pearson will be the Project Owner for the establishment of the Health & Wellbeing Board.

Project 2 HW: David Pearson will be the Project Owner for the establishment of Local HealthWatch.

Project 3 PH: Chris Kenny will be the Project Owner of the transfer of public health

Project 4 HP: Chris Kenny will be the Project Owner of the establishment of the health protection arrangements.

Project owners will have overall responsibility for:

- Monitoring the progress of the projects against the plan & ensuring that the plans meet the requirements of the legislation
- Reporting progress to the executive boards of the PCT Cluster & County Council.

Nicola Lane is the Project Manager & will be responsible for:

- Producing the PID, project plan, lessons learned & end project reports & ensuring that the risk, issue & quality logs are maintained
- Managing the transition plans & ensuring that each work stream is progressing to meet agreed milestones
- Providing a link between health & local government for this project & any associated issues.

Functional leads will be required to provide advice & support for each of the projects as required. See structure details in Appendix 1.

Programme Context

The Health and Social Care Bill was published in January 2011 and a White Paper followed proposing changes to the public health structures. Following public pressure a 'listening exercise' was conducted by the NHS Future Forum which has since reported and its recommendations accepted by the Department of Health. A response to the Public Health White Paper: Healthy Lives, Healthy People was issued on 14 July 2011. The outcome of both the listening exercise and the public health white paper response strengthen the role of the Health and Wellbeing Board and introduce some amendments to the PID, particularly in timescales. The board principles of the project plans remain unchanged. They remain:

The establishment of a **Health & Wellbeing Board (HWB)** within the county council. This Board will include:

- at least one elected representative
- the Director of Adult Social Services
- the Director of Children's Services
- the Director of Public Health
- a representative of Local HealthWatch
- a representative of each Clinical Commissioning Group within local authority area

In Nottinghamshire membership has also been extended to include 3 elected members from the majority group, and 2 from other parties, representatives from 2 of the 7 district/borough councils and a representative from the PCT Cluster.

This Board must prepare a Joint Strategic Needs Assessment (JSNA) & Health & Wellbeing Strategy (HWS) which will set the agenda for health improvement across the county. Clinical Commissioning Groups & the council must consider the strategy in their commissioning plans.

NCC has been accepted as an early implementer and the Board was established at a meeting of the Council on 31 March 2011. It met for the first time on 4 May 2011.

One of the key functions of the Health and Wellbeing Board will be to encourage and assist in joint commissioning arrangements. The newly established Joint Commissioning Unit within the Council will be vehicle for the delivery of these arrangements.

Local **HealthWatch (HW)** must be commissioned from October 2012. It will be responsible for involving people in the provision, scrutiny & commissioning of health & social care services. It will also provide people with advice & information to enable them to make choices about health & social care. Local HealthWatch may also make recommendation to the Care Quality Commission or via HealthWatch England regarding special reviews or investigation of local services.

Local authorities will also be responsible for commissioning complaints advocacy services from April 2013. This service is currently provided by the Independent Complaints Advocacy Service (ICAS) and is hosted by the Carers Federation in Nottinghamshire.

Public Health is currently a function of the NHS within the PCT Cluster. Within the proposal structure responsibility for public health will transfer to local authorities & consequently it is proposed that associated **public health staff should also transfer** to the County Council. Staff will initially relocated to County Hall while remaining employees of the PCT but a formal contractual transfer will follow prior to the dissolution of the PCTs in 2013. The Public Health Directorate has been undergoing a restructuring, including assignment of staff to other agencies. This is now being finalised & those staff who will relocate into the County Council are being identified.

Health Protection (HP) arrangements are currently coordinated between Public Health within NHS Nottinghamshire County (for the county & Bassetlaw) & NHS Nottingham City & the Health Protection Agency. Within the proposals the HPA will be abolished & it's duties assumed by Public Health England. As a consequence of the listening exercise the establishment of Public Health England has been delayed until April 2013.

It is likely that the Health Protection would become an integrated function of the County Council & the Public Health Service. Details of these arrangements have yet to be clarified.

Project Scope

General Programme

Programme In scope

Securing required resources to support all projects within this programme until March 2013.

Communications within the PCT, health services including Clinical Commissioning Groups, NCC & to the public around all 4 projects.

To represent Nottinghamshire at regional/national events regarding any projects within the programme.

Programme Out of Scope

On-going financial management of any element of the programme.

Financial savings resulting from any element of the programme.

On-going communications & engagement for the PCT or NCC.

Project 1 HWB

HWB In scope

To establish the shadow Health & Wellbeing Board within NCC structures.

Initial support to the HWB as required.

Acting as a point of contact for all stakeholders within Nottinghamshire for the HWB.

To act as point of contact for the Early Implementers Group & represent Nottinghamshire at events as required.

To support an integrated approach and to identify areas for joint and integrated commissioning.

HWB Out of scope

On-going administration of the HWB

Project 2 HW

HW In scope

To establish Local HealthWatch to be operational & commissioned by October 2012.

To prepare & agree service specifications as appropriate.

The commissioning of the complaints advocacy service from April 2013.

HW Out of scope

Performance monitoring of Local HealthWatch.

Management of TUPE transfer of staff into HealthWatch.

Project 3 PH

PH In scope

To manage the co-location of PCT Public Health into County Hall staff including coordination of all IT, facilities, HR & communications issues.

Coordination of required staff consultation & induction events.

PH Out of scope

Coordination of directorate restructuring.

Transfer of public health staff to other organisations.

The management of the TUPE transfer of PCT staff to NCC.

Project 4 HP

HP In scope

Ensuring that health protection arrangements are in place.

Co-location of HPA Staff

HP Out of scope

TUPE transfer of HPA staff

Programme Interdependencies

There are some interdependencies which are common across all projects, including:

1. The Health & Social Care Bill being passed & any amendments to that

2. The public health white paper not significantly altering the future plans for services

3. Other local & national bodies are established/authorised as planned & on schedule – Clinical Commissioning Groups, NHS Commissioning Board, HealthWatch England, Public Health England.

Other interdependencies are project specific:

Project 1 HWB	• Relies on the continued engagement of the Clinical Commissioning Groups & LINks/HealthWatch & the PCT Cluster. • The Joint Commissioning Unit is maintained within NCC to support future joint commissioning arrangements. • Agreement in principle can be reached between NCC & the Clinical Commissioning Groups regarding potential future pooled budget arrangements. • A programme of work is undertaken to refresh the JSNA and work to develop a health and wellbeing strategy within the first year of operation of the Board. • The national HR framework will support the proposed changes
Project 2 HW	• National HealthWatch to be established & provide leadership & guidance (proposed October 2012) • Transitional arrangements for LINks are agreed or a re-tendering exercise is successful for the formation of a Local HealthWatch organisation.
Project 3 PH	• The reorganisation of the PCT Public Health Directorate is completed & transferring staff are identified. • Accommodation within County Hall is available & terms can be agreed. • IT links can be maintained between the NHS/PCT network & the county council network. • That agreement can be reached between the PCT & NCC regarding the transferring staff.
Project 4 HP	• Specialist staff are available to support the required structures within PHE & NCC

Cost and Benefits Realisation

Project Costs

	Cost	Benefit
Project 1 HWB	The establishment of the board may requires some external facilitation - this cost would shared by PCT and NCC.	Smooth operation of Board & meetings. Early achievement of operational capability.
Project 2 HW	NCC to provide support to LINks to achieve transition into HW. There may be some re-tendering of host arrangements – this would be supported through NCC	Utilisation & development of current resource. Achievement of operational requirements of HW.
Project 3 PH	Relocation costs for staff furniture/belongings. To be paid by PCT Additional equipment required by staff to be funded by NCC. Establishing IT links- joint funding by NCC & PCT.	Support for NCC in transfer of public health responsibilities from the PCT to NCC. Legacy data & resources available within new organisation. Operational capability maintained. Transfer of equipment reducing costs to NCC. Required equipment available to achieve smooth transition into new host. Access into PCT network to maintain communications via PCT as employer. Maintain operational capacity during transition.
Project 4 HP	Additional relocation costs for staff to be met by HPA. Implementation and running costs of additional IT links to be funded by NCC & HPA. Additional accommodation to be provided by NCC.	Operational capacity maintained.

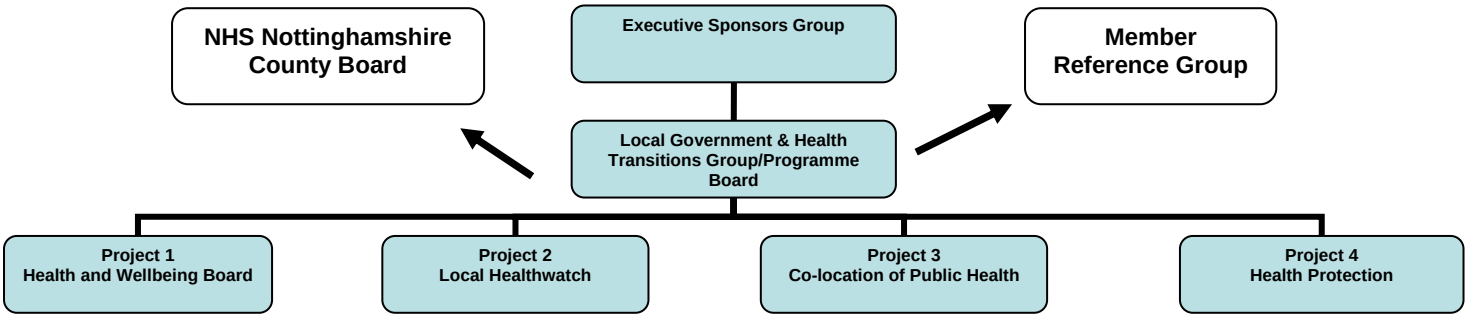
Project Benefits

Benefits Realisation Plan

This programme will not realise any immediate cost benefits, however there may be financial benefits in the future, across the health and social care community which arise from the joint commissioning work & the co-location of public health. A full benefits realisation plan would be subject to a separate plan & is not within the scope of this programme.

Project Structure and Governance

Project Governance Structure



A detailed governance document is attached as Appendix 2.

Risks

Project ref.	*Risk Title*	*Description*	*Mitigating Action*	*Type*	*Active / Closed*	Likelihood (1-5)	Impact (1-5)	*Risk Owner*
	Legislation is passed within the expected timescales	*The programme plan is based on the recommendations within the Health & Social Care Bill & The Public Health White Paper which are being amended. Definite dates are not available for the process to be finalised.*	*Monitoring the legislation & the responses to the consultations. Reviewing the Programme Plan & timescales in light of any amendments*	*Political*	*Active*	*3*	*3*	*David Pearson/Chris Kenny*
HWB.001	*Cultural change in establishing the HWB.*	*HWB requires commitment from GP consortia & elected members with possibly conflicting agendas.*	*Development programmes to be arranged for all groups.*	*Political Organisational*	*Active*	*2*	*4*	*David Pearson*
HW.001	*Lack of NCC management for LINks during transition*	*Current contacts within NCC leaving organisation or role being reallocated.* Operational & performance management contacts identified.	*Appropriate contact at NCC to be identified to ensure that performance is acceptable under current contract & that move to Local HealthWatch achieved.*	*Management*	*Closed*	*4*	*4*	*David Pearson*
PH.001	*Resistance to relocation of public health staff.*	*Consultation to be undertaken with staff & unions but there may still be unease about the move &*	*Early consultation with the staff & unions.*	*Human*	*Active*	*2*	*3*	*Chris Kenny*

		resistance to it.						
PH.002	*Incompatible IT systems*	*Not currently possible to connect into NHS systems via NCC.*	*Raised with NCC & PCT IT support.*	*Technical*	*Active*	*3*	*3*	*Chris Kenny*
PH.003	*Relocation of PH staff delayed*	*Details of move to be finalised pending restructuring, allocation of staff to other bodies & MALS. Consultation delayed until outcomes are known.*	*Draft structures being developed. Start consultation with all staff with final details to be agreed.*	*Management*	*Active*	*2*	*4*	*Chris Kenny*
PH.004	*Cultural shift required for transferring PH staff*	*Staff must understand structures within NCC & working arrangements on relocation to County Hall*	*Funding available from SHA for transfer process & induction*	*Management*	*Active*	*2*	*3*	*Chris Kenny*
PH.005	*Lack of agreement on accommodation*	*Details of arrangements for co-location to be agreed between PCT & NCC*	*Outline costs being prepared for agreement with PCT Board/ NCC Member Reference Group*	*Management*	*Active*	*2*	*5*	*Chris Kenny*
HP.001	*Inadequate health protection arrangements*	*Public Health England will need to be established & local Health Protection Units set up to respond to any local issues. Delays in setting up the service may leave NCC vulnerable in the event of a local incident.*	*Liaise with emerging PHE organisation & local contacts re Local Health Protection Units.*	*Infrastructure*	*Active*	*3*	*3*	*Chris Kenny*

Issues

Project Ref:	***Issue Title***	***Description***	***Action***	***Active / Closed***	***Issue Owner***
HWB.002	*NCC application for HWB early implementer status.* *Application accepted.*	*Expressions of interested required by DoH by 1 March 2011*	*Letters sent to district councils & pathfinder consortia re letters of support*	*Closed*	*David Pearson*
HW.002	*HealthWatch not established for October 2012*	*Hosting arrangements to be reviewed & contract extended. Risk of lack of interest in hosting & service not mobilised for operation by October 2012. Lack of clarity re funding/remit from DoH/CQC may delay re-tendering*	*Re-tendering of service ASAP. Contact with DoH HW lead.*	*Active*	*David Pearson*

Programme Plan

Overall Approach

Delivery

Implementation of the programme will involve 4 distinct projects. While the success delivery of the individual projects is not dependant on delivery of the other projects, the overall success of the programme is dependent on all these separate projects being delivered within agreed time, cost and quality parameters.

Phasing

In order to best manage the workload initial effort will focus on the establishment of the Health & Wellbeing Board & the co-location of Public Health. The date for establishment of HealthWatch & has been delayed until October 2012 & Public Health England will not be established until April 2013, delaying project 4 further.

Therefore Projects 1 & 3 have been prioritised as Phase 1 of the programme. Work is being undertaken on Project 2 and Project 4 will be the final phase of the programme.

Governance

Each project will be co-ordinated & lead by the Project Manager but ultimate authority will lie with the relevant Project Owner, who will be accountable to the Programme Board. Each project will be co-ordinated by the Project Manager but will be supported by functional leads from NCC, the PCT & the HPA as appropriate. *The multi-disciplinary transitions group will continue to monitor transitions & provide support to projects as required.*

Project Approaches

Project 1 HWB

- Representation of elected member and those from other statutory bodies to be agreed
- Agreement has been given by Council to establish the HWB as a committee of the council.
- Two meetings have taken place and a schedule of future agenda items is being developed. The Board has given agreement to a refresh of the JSNA & for the development of a Joint Health and Wellbeing Strategy.
- Working with the Service Director for Joint Commissioning to ensure that joint or integrated commissioning is considered across the Council and with GP Consortia at every opportunity
- Reporting arrangements into the Council will be clarified along with any further delegated roles which may be assigned to the Board.
- The Board's place within the Council's committee structure has been agreed. As the Board will be in shadow form only there will be no requirement to integrate the Board into formal PCT structures but reports are provided to the PCT Cluster Board for reference.

Project 2 HW

- HealthWatch will be commissioned by the Council from October 2012.
- It will be a 'body corporate' which will be commissioned directly & will be made up of volunteers & employed staff.
- Arrangements for the development of a service specification & procurement process are being agreed.
- There have been early discussions with the existing LINks & discussions have taken place regarding the planned process.

Project 3 PH

- A project group will be convened with representatives from both the PCT & NCC for HR, IT, finance & comms with an NCC lead for accommodation/facilities. Reports will be made back to PCT facilities to co-ordinate arrangements for leaving PCT premises.
- A national 'concordat' is awaited regarding the formal contractual aspects of the proposed legislation.
- Public Health Directorate structure to be agreed & staff to transfer to NCC to be identified.
- Agree a communications plan for the affected & remaining staff, PCT, NCC & other bodies e.g. GP Consortia
- Accommodation to be identified at County Hall & relevant IT links are being established.
- Security & information governance requirements to be identified & arrangements made to meet.
- Hardware, software & other equipment requirements of all staff to be identified & agreed. Asset transfers to be arranged if necessary or insurance arrangements to be made.
- Relocation programme to be established & individual moves identified.
- Removal contractor to be identified.
- Costs of move & on-going excess travel to be identified & arrangements made for payment.
- Induction events for affected staff to be agreed & run.
- Relocation programme to be implemented & resulting issues addressed as necessary.
- Management arrangements to be clarified for remaining PCT staff.

Project 4 HP

- Structures for Public Health England (PHE) & their proposed Health Protection Units are awaited. It is therefore proposed to delay initiation of this project until there is further clarity about PHE & allocation of staffing resources from the HPA.
- It is therefore proposed that this project should form the final phase of the programme, pending the availability of national & regional guidance.

Key Milestones and Deliverables

Milestones and key deliverables schedule

Project	Description	Start	End	Owner
1. HWB	Paper to Council & agreement to establish HWB Board		31 March 11	DP
	Shadow Board membership agreed	April 11	April 11	DP
	Date for shadow meeting to be agreed.	April 2011	April 2011	DP
	Communications plan to be developed for all stakeholders	March 2011	April 2011	DP
2. HW	Agree arrangements for implementation of HealthWatch – via LINks/hosting or re-tendering.	June 2011	Sept 2011	DP
	Confirm intentions for HealthWatch with existing providers	Sept 2011	Sept 2011	DP
	Draft & agree service specification for Local HealthWatch	Sept 2011	March 2012	DP
	Communications plan to be developed for all stakeholders	Sept 2011	Sept 2011	DP
	Commission Local HealthWatch	Oct 2012	Oct 2012	DP
3. PH	Agree staff to co-locate	July 2011	July 2011	CK
	Discussions with staff for relocation & formal notice of change	August 2011	Sept 2011	CK
	Establish IT links between NCC & PCT/NHS.	July 2011	Aug 2011	CK
	Staff inductions into NCC	Oct 2011	Oct 2011	CK
	Staff move to County Hall	Oct 2011	Dec 2011	CK
	Agree communications plan for all stakeholders	March 2011		CK
4. HP	Review existing arrangements	March 2012		CK
	Clarify responsibilities of NCC & PHE	March 2012		CK
	Identify required staff within new structure to deliver service	Sept 2013?		CK
	Consult with staff re change of role/base via current employers	January 2013		CK
	Relocate required staff to County Hall	March 2013?		CK
	Agree revised HP arrangements & procedures	March 2013?		CK
	Agree communications plan with all stakeholders	March 2012		CK

Project Initiation Checklist

Business Case

Has a Business Case been created (yes or no)?	*No*
Not required for this programme	*Not required*

Quality Plan

Has a Quality Plan been created (yes or no)?	*No – to be developed*
To be developed by April 2011	

Communications Plan

Has a Communications Plan been created (yes or no)?	*No – to be developed*
To be developed by April 2011	

Lessons Learned Log

Has a Lessons Learned Log been created (yes or no)?	*No – to be developed*
Project 1 HWB To be developed using evidence from other authorities & via the early implementer groups. Contact already made with neighbouring authority leads.	
Project 2 HW To be developed during phase 2 of programme implementation based on evidence from other areas, guidance from national HealthWatch.	
Project 3 To be developed using evidence from other authorities & via HR leads from both organisations from previous projects. Contact already made with neighbouring authority leads.	
Project 4 HP To be developed as & when the project is initiated.	

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Local Government & Health Transition
PID Sign-off Document
Appendix 1

Project:

Date of Issue:

Name	Signature	Project Role	Version	Date
David Pearson		Project Owner		
Chris Kenny		Project Owner		

Please select one of the three options:

No.	Approval / Rejection Options	Tick
1	I approve the PID	
2	I approve the PID but wish to make the following comments	
3	I reject the PID due to the following reasons	

No.	Concern to be resolved / Reasons for rejection
1	
2	
3	
4	
5	
6	
7	
8	

Note: All changes/reasons for rejection will be raised through the normal change/issue management process.

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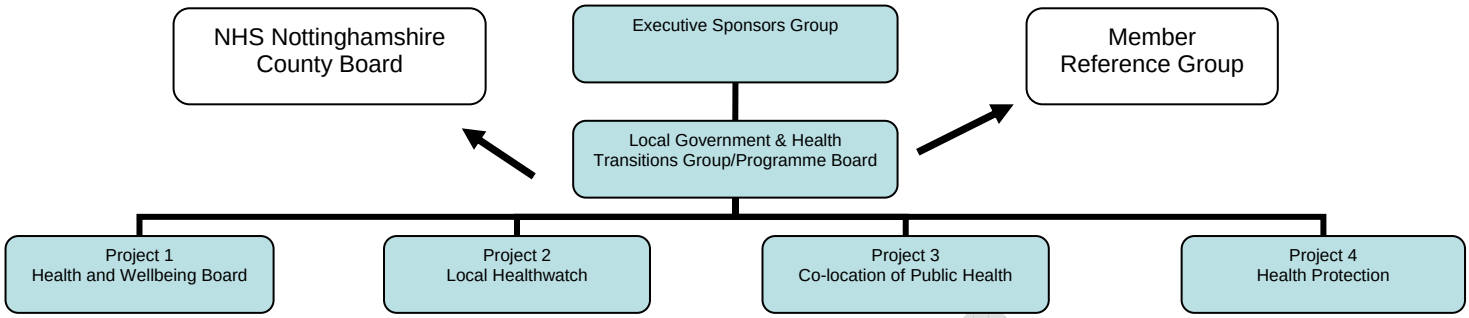
Appendix 2
Local Government and Health Transitions



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Executive Sponsors Group

Mick Burrows - Nottinghamshire County Council
David Pearson - Nottinghamshire County Council
Anthony May - Nottinghamshire County Council
Chris Kenny - NHS Nottinghamshire County

The programme plan will be discussed and approved on behalf of the Board by the Corporate Leadership Team.

The Board will have oversight of all projects within the programme.

Local Government and Health Transitions Group/Programme Board

A Group has been established to oversee the transitions. IT is made up of representatives from NHS Nottinghamshire County and Nottinghamshire County Council. Representatives from Bassetlaw District Council and Rushcliffe Borough Council have also been invited to represent the district councils.

David Pearson - Nottinghamshire County Council (Chair)
Chris Kenny - NHS Nottinghamshire County
John Tomlinson- NHS Nottinghamshire County
Nicola Lane - NHS Nottinghamshire County
Vicky Bailey – Principia
John True – Nottinghamshire County Council
Allen Graham – Rushcliffe Borough Council
David Hunter – Bassetlaw District Council

Project 1 – Health and Wellbeing Board

Project Owner	David Pearson
Project Manager	Nicola Lane

Specialist leadership will also be provided by:

Corporate Governance -	Karen Sullivan – NHS Nottinghamshire County Chris Holmes – Nottinghamshire County Council
Communications	Karlie Thompson – NHS Nottinghamshire County Peter Saunders – Nottinghamshire County Council
Joint Commissioning Unit	David Sykes - Nottinghamshire County Council

Project 2 – Local Healthwatch

Project Owner	David Pearson
Project Manager	Nicola Lane
Communications	Karlie Thompson – NHS Nottinghamshire County Peter Saunders – Nottinghamshire County Council

Support to be identified once national guidance is received and the project is initiated

Project 3 – Co-location of Public Health

Project Owner	Chris Kenny
Project Manager	Nicola Lane
Human Resources	Steve Wright - NHS Nottinghamshire County Mandy Steele/Tara Cook - Nottinghamshire County Council
Facilities	Sue Storey - Nottinghamshire County Council
IT	Nick Allars - Nottinghamshire County Council Andy Hall - NHS Nottinghamshire County
Communications	Karlie Thompson – NHS Nottinghamshire County Peter Saunders – Nottinghamshire County Council

Project 4 – Health Protection

Project Owner	Chris Kenny
Project Manager	Nicola Lane

Support to be identified once national guidance is received and the project is initiated

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APPENDIX B – PROGRAMME EXPENDITURE FOR ALL PUBLIC HEALTH PROGRAMMES

Organisation SHA Code:	Q33
Organisation Code:	5N8
Organisation Name:	Nottinghamshire County Teaching PCT

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	SIGN
Local Authority	**100**						
Public health leadership	**110**	2,323	0	**2,323**	(110)	0	+
Information & Intelligence functions	**120**	103	0	**103**	0	0	+
Nutrition, Obesity and Physical activity	**130**	56	1,378	**1,434**	0	496	+
Drug misuse	**140**	191	9,012	**9,203**	(2,252)	690	+
Alcohol misuse	**150**	47	1,518	**1,565**	0	9	+
Tobacco	**160**	59	1,569	**1,628**	0	591	+
Dental public health	**170**	0	89	**89**	0	0	+
Fluoridation	**180**	129	0	**129**	0	0	+
Children 5-19	**190**	0	4,010	**4,010**	(80)	0	+
NHS Health Check Programme	**200**	0	415	**415**	0	0	+
Misc health improvement and wellbeing	**210**	194	714	**908**	(27)	0	+
Sexual health (STI testing and treatment, contraception, abortion, prevention)	**220**	111	799	**910**	0	556	+
Total	**230**	**3,213**	**19,504**	**22,717**	**(2,469)**	**2,342**	+

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Commissioning Board	**240**						
Non-cancer screening	**250**	91	1,768	**1,859**	0	0	+
Cancer Screening	**260**	172	2,515	**2,687**	0	0	+
Healthy Start Vitamins	**270**	0	35	**35**	0	0	+
Children 0-5	**280**	0	8,776	**8,776**	(58)	0	+
Childhood immunisations	**290**	0	1,285	**1,285**	0	0	+
Targeted neonatal immunisation programmes	**300**	29	0	**29**	0	0	+
Seasonal flu and pneumoccal immunisation programmes	**310**	0	1,944	**1,944**	0	871	+
TD/IPV and HPV immunisation programmes	**320**	2	120	**122**	0	0	+
Contraception additional service - GP contract	**330**	0	233	**233**	0	0	+
Prison public health	**340**	0	1,087	**1,087**	0	0	+
Total	**350**	**294**	**17,763**	**18,057**	**(58)**	**871**	+
Public Health England	**360**						
Dental public health leadership	**370**	97	0	**97**	0	0	+
TOTAL	**380**	**3,604**	**37,267**	**40,871**	**(2,527)**	**3,213**	+

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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	SIGN
Child Health Information Systems	**390**	0	0	**0**	0	0	+
Preparedness, resilience and response for health protection incidents and emergencies	**400**	9	0	**9**	0	0	+
PCT support for surveillance and control of infectious disease	**410**	220	0	**220**	0	0	+
HIV treatment and care	**420**						
Safeguarding	**430**						
TOTAL	**440**	**229**	**0**	**229**	**0**	**0**	+

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Organisation SHA Code:	Q32
Organisation Code:	5ET
Organisation Name:	Bassetlaw PCT

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	SIGN
Local Authority	**100**						
Public health leadership	**110**	671		**671**	8		+
Information & Intelligence functions	**120**			**0**			+
Nutrition, Obesity and Physical activity	**130**		558	**558**			+
Drug misuse	**140**		971	**971**		229	+
Alcohol misuse	**150**		416	**416**			+
Tobacco	**160**		263	**263**			+
Dental public health	**170**			**0**			+
Fluoridation	**180**			**0**			+
Children 5-19	**190**		702	**702**			+
NHS Health Check Programme	**200**		123	**123**			+
Misc health improvement and wellbeing	**210**		59	**59**			+
Sexual health (STI testing and treatment, contraception, abortion, prevention)	**220**		836	**836**			+
Total	**230**	**671**	**3,928**	**4,599**	**8**	**229**	+

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Commissioning Board	**240**						
Non-cancer screening	**250**		151	**151**			+
Cancer Screening	**260**	40	551	**591**			+
Healthy Start Vitamins	**270**			**0**			+
Children 0-5	**280**		1,141	**1,141**			+
Childhood immunisations	**290**		54	**54**			+
Targeted neonatal immunisation programmes	**300**			**0**			+
Seasonal flu and pneumoccal immunisation programmes	**310**		188	**188**			+
TD/IPV and HPV immunisation programmes	**320**		102	**102**			+
Contraception additional service - GP contract	**330**			**0**			+
Prison public health	**340**		357	**357**			+
Total	**350**	**40**	**2,544**	**2,584**	**0**	**0**	+
Public Health England	**360**						
Dental public health leadership	**370**	8		**8**			+
TOTAL	**380**	**719**	**6,472**	**7,191**	**8**	**229**	+

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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	SIGN
Child Health Information Systems	390			0			+
Preparedness, resilience and response for health protection incidents and emergencies	400			0			+
PCT support for surveillance and control of infectious disease	410			0			+
HIV treatment and care	420						
Safeguarding	430						
TOTAL	440	0	0	0	0	0	+

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APPENDIX C - PUBLIC HEALTH KEY SUCCESSES 2010/11

Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
Public Health Functions		
Health Promotion	**Examples of Key Achievements across Nottinghamshire and / or Bassetlaw**	
Maternal and Childhood Screening programmes (including antenatal and neonatal screening e.g. neonatal hearing, Down's, Childhood screening programmes) Prevention of birth defects Cancer screening (of Cervix, Breast, Bowel) AAA screening	<u>Maternal and childhood screening</u> • Reconfiguration of laboratory providers for Infectious Diseases in Pregnancy Screening programme and blood grouping and Antibody testing in pregnancy complete. <u>Cancer screening</u> • Reconfiguration of cervical screening office function into Shared Business Family Health Services completed and reorganisation of cervical cytology laboratory services across Nottinghamshire, Derbyshire and South Staff to centralised laboratory at Derby Hospitals NHS FT. Sherwood Forest Hospital laboratory transferred February 2011, NUH June 2011. • Implementation of breast screening age extension across Nottinghamshire completed January 2011.	• Cost savings of approx £110, 000 per year achieved • Cost savings realised – uncertain of amount • VSA09 achieved
Diabetic Retinopathy Screening (DRS)	• Successful transfer of North Notts DRS programme team to Sherwood Forest Hospital Trust • Review and implementation of protocols, systems and dedicated clinics to improve quality assurance of North and City/South Notts DRS programmes • Review and refreshment of Programme Board Action Plans to provide oversight and monitoring of programme outcomes and standards, and workforce	Requirement to meet National Screening Committee Quality Assurance Standards Productive Notts work stream

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
	development and competence.	
COPD <u>Nottinghamshire County including Bassetlaw</u>	• Hosting of campaigns to raise awareness of COPD across Nottinghamshire County and Bassetlaw. The 'Love Your Lungs' campaign run by the British Lung Foundation in 2010 tested the lung function of 747 people at 5 events held across Nottinghamshire County. o 116 (15%) of those tested were advised to visit their GP for a follow up consultation. o 645 had never heard of COPD before. • Increased capacity in rehabilitation programmes in Bassetlaw.	
Health checks <u>Nottinghamshire County</u> <u>Bassetlaw</u>	• Implementation of the NHS Health checks programme and monitoring of key performance indicators identified as part of the national data set standards for health check assessment and lifestyle interventions. • By the end of March 2011, the majority of the 96 Nottinghamshire County GP practices were participating in the programme, which resulted in 30,740 eligible people from the 40 – 74 age group being offered a health check and 19,395 receiving a health check between April 2010 and March 11. • NHS Bassetlaw completed 6193 health checks during 2010-11 with participation from 11 GP practices.	The NHS Health checks are part of the drive towards a more preventative NHS and a drive to ensure that people from 40-74 age groups have the necessary information about their health in order to make important lifestyle changes and reduce their risks of developing diseases and long term conditions such as coronary heart disease, stroke, and diabetes and kidney disease. The programme is led through a multi-disciplinary task group in Nottinghamshire County. NHS Bassetlaw has implemented the health check programme fully since 2009.

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
Tobacco control Nottinghamshire County including Bassetlaw	• In 2010/11, 6,080 people from Nottinghamshire successfully quit smoking with support from their local NHS. This equates to 16 people every day kicking the habit. NHS Nottinghamshire County over-achieved its stop smoking target by 8% for 2010/11. It is the fifth successive year that the organisation has exceeded the target. • In 2010/11, 990 people from Bassetlaw successfully stopped smoking with support from the NHS Bassetlaw Stop Smoking service and local GP practices. This is an overachievement of 10%. In addition 178 homes in Bassetlaw have signed up to the 'Smoke Free Homes Initiative' • Hundreds of frontline staff across multi agency settings were trained in Brief Advice skills to support referral into stop smoking services. • 'Go Smoke free' was launched across Mansfield and Ashfield supporting people to maintain smoke free environments.	Smoking Cessation services are commissioned currently from four Providers-New Leaf Specialist services, Bassetlaw Stop Smoking Service, GPs and Pharmacists, in order to offer patient choice. The service support people to stop smoking, as part of the wider Tobacco agenda.
Obesity / diet / physical activity (adult and children), community nutrition Oral Health, including dental Public Health services Fluoridation promotion of community safety Workplace health	Bassetlaw: • A universal Obesity Prevention programme (change for life 0-11's) was introduced in 24 primary and 5 early years settings to establish healthy diets and adequate levels of physical activity in the population. • Nine Bassetlaw GP Practices delivered weight Management programmes and Bassetlaw Community Health established community weight management programmes (ZEST) in a range of community settings. • Bassetlaw's Well-being at work' workplace award	Local workplace health champions have been established and 'health trainer' and holistic brief

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
	scheme has been implemented in 14 local workplaces across the district. • A comprehensive programme of walks was delivered across the district including an annual walking festival – four walks per week led by local walks leaders a monthly buggy walk with an additional 7 walks held over the summer holiday period. Almost 6000 people participated in walks in Bassetlaw in 2010-2011.	intervention training programmes delivered to support workplace health and well being development. An annual awards ceremony has been held to celebrate good practice.
<u>Nottinghamshire County</u>	• Evaluation of exercise referral schemes in 5 districts across the County showed that the schemes increased participation in physical activity, improved health indicators such as blood pressure and reduced the risk of further health problems. • Community Nutrition services, commissioned across the County, contributed to reducing obesity and improving healthy weight by improving awareness, knowledge and confidence in adults and children to make positive dietary choices. • The National Child Measurement Programme (NCMP) delivered across the County since 2006 resulted in over 90% of reception year and year 6 children participating in the programme in 09/10.	QIPP Service Evaluation Reports Nottinghamshire NCMP annual reports The programme enables a better understanding of the prevalence of obesity in children to support the delivery of appropriately targeted interventions
<u>Nottinghamshire County including Bassetlaw</u>	<u>Oral Health Promotion</u> • The 'Incredible Mouth' Initiative promoted 3 key oral health messages on diet (including smoking cessation and alcohol), oral hygiene and regular dental care. Activity included brief interventions by	The aim of dental Public Health services is to address inequalities in oral health and access to oral health services, the main tools are Epidemiology (5 year-old survey 2011-12 and 12 year-old 2012-13) and Health Equity Audits.

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
	health professionals (Midwives, Health Visitors, School Nurses), preventive accredited dental practices (56/105 across Nottinghamshire working on the programme currently), community based work (including GPs, Pharmacies, Childrens' Centres), and resources for vulnerable adults and children (Champions and resource packs in Residential Care Homes and Special Schools) • Maintenance of water fluoridation schemes in Ashfield, Bassetlaw and Mansfield Districts and development of possible expansion of schemes across Nottinghamshire	
Medicines Management and Prescribing Nottinghamshire County	• Achievement of £3.2M efficiency savings from Primary Care prescribing as part of the QIPP challenge. • Improved management of the Area Prescribing Committee and recruitment of dedicated jointly funded medicines interface & formulary pharmacists for NUH & SFH has strengthened the implementation of medicines strategy within Nottinghamshire improving engagement and managing prescribing pressures. • Implementation of the Care Homes Use of Medicines (CHUMS) report including the review of community pharmacy care home advisory service. This was supported by training & education for pharmacy staff, homecare staff, carers and local authority staff on medicines use.	Part of the Prescribing Efficiency Plan 2010-11 More information available in the APC Annual Report More information available in the CHUMS Action Plan

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
Healthy Ageing	Health Ageing Initiatives in liaison with Nottinghamshire County Council, including, Support for LinkAge Plus projects. <u>Excess Winter Deaths</u> • Nottinghamshire Affordable Warmth Strategy has been produced to ensure work follows on from the end of the LAA. • Healthy housing was contracted to deliver training on fuel poverty and winter warmth to frontline staff in 3 southern boroughs	Opportunity Age Strategy
Health services		
Children and Young People (including CAMHS); Maternity (not screening), Healthy schools, Disabled children, Breast feeding, health visitors, safeguarding children Sexual Health (including sexual health services, GUM, Chlamydia testing, HIV, teenage pregnancy, SARC, TOP <u>Nottinghamshire County</u>	• Refresh of JSNA Children and Young People chapter, leading on Be Healthy section • Review of all non-NHS contracts, developed SLAs /service specifications. <u>Children with Additional Needs</u> • Pilot of Rapid Response Physiotherapy service • Data mapping for children and young people with palliative care. Bespoke data base (500 children) developed and hosted by NHIS (successful DH funding bids totalling £155,000.00) • Developed a Targeted mental health in Schools (TaMHS) Project • Multi-agency multi-disciplinary training programme for all universal staff (health visitors, school nurses, children's services staff, teachers) has been established to identify & address needs and ensure that they are referred when appropriate <u>Sexual Health</u>	QIPP saving £55,705.15 Admissions prevented, reduced Length Of Stay (LOS), estimated £77,792.00 savings Mental health services are also directed at particular hard to reach groups. For example, public mental health for children and young people include a dedicated training programme related to children and young people issues and targeted mental health services in schools: Part of QIPP – savings to be realised 2012/13

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
	• Procured Pre-termination Assessment and Early Medical Abortion in a community setting • Chlamydia screening programme decommissioned, new integrated pathway agreed and implemented. • Increased provision of LARC within primary care • Children & Young People CASH service established within West Notts College	QIPP
Long Term Neurological conditions (LTNC's) Nottinghamshire County Including Bassetlaw	• £150,000 funding secured from 2 voluntary sector agencies for two specialist nurses to develop a community rehabilitation service for the county. • A comprehensive scoping exercise of current LTNC related services undertaken, which will inform an integrated patient pathway to be included on the 'Nottsinfoscript' (information prescription) website, this will facilitate condition specific 'fluid' patient pathways. • Service reviews undertaken, with the intention to align current services to more effectively meet local health needs/service requirements.	Development and introduction of data information packs for all LTCs developed to monitor performance against key indicators at PCT and Practice Based Commissioning/Clinical Commissioning Group level for admissions and readmissions, LOS, outpatient activity A wider network of LTNC related leads has been coordinated to ensure effective service alignment and communication.
Diabetes Nottinghamshire County Including Bassetlaw	• 'Think Glucose' programme introduced with acute trusts to reduce LOS for people with diabetes in hospital. • Diabetes education for staff and patients reviewed and commissioned to meet NICE requirements • DESMOND service continued in Bassetlaw	Productive Notts Plan 100% participation achieved by Notts GP practices in National Diabetes Audit (NDA) due to public health coordination, facilitation and support for including development of guidance and instruction/installation of software where required.
Older People	Care Homes	QIPP

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
Nottinghamshire County Including Bassetlaw	• Launch of The Good Practice Guidance developed for care homes and primary care at the care homes forum and to GP practices • Nurse Practitioners appointed within GP practices in the North to work specifically within care homes Falls • Delivery of falls awareness training programme to care home staff in Partnership with social care • Emergency Department Admission Support Service (EDASS) implemented–in KMH – to Identify high risk fallers who have attended ED. • Bassetlaw introduced social foot care scheme and revised serviced specification for community falls team. • Bassetlaw work undertaken with care homes to reduce falls	QIPP New posts appointed to in NNEC Primary Care falls team
Dementia Nottinghamshire County Including Bassetlaw	• Business Plan developed for Memory Assessment Services approved in summer 2011. • Mental Health Intermediate Care Service extended to Newark and Sherwood following closure of friary ward at Newark Hospital, commenced 1 April 2011.	Dementia Strategy Implementation Plan 2010/11 Dementia Awareness Training included in CQUIN for Acute Trusts for 50% of staff to receive training in 2011/12.
COPD	• Ongoing implementation of the COPD Pathway led to improved quality services for patients across Nottinghamshire. • Implementation of a Home Oxygen Validation pathway and the East Midlands Recommendations for Home Oxygen Service (HOS) has achieved improved quality and reduced cost.	£141K QIPP savings.

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
Hear Failure	• Review of the Nottinghamshire Echocardiography Services, including a minimum dataset of information to enable quarterly performance monitoring of provider services to support the timely diagnosis of the condition. • National and local cost modelling analysis undertaken to support the inclusion of the B-type natriuretic peptides (B-NP) test to enable early diagnosis of heart failure within the pathway.	Nottinghamshire Coronary Heart Disease (CHD) Network devised guidelines `Nottinghamshire Heart Failure Lights - the Management of heart failure' to facilitate the implementation of the Heart failure pathway. New key performance indicators identified that monitor the pathway components that cover prevention, diagnosis, condition management, complex/crisis avoidance management and End of Life (EoL) specialised intervention treatments.
End of Life	• Hospice at home, hospice day care and pilot carer support short breaks services were reviewed and commissioned to ensure that the same criteria and standards are used across Nottinghamshire. • A 24/7 care coordination and end of life care registration service was developed and initiated. • In partnership with Nottingham University, public health organised a well-attended public event as part of an ongoing initiative to break the taboo of talking about death and dying and raise awareness of advance care planning.	QIPP Unplanned Care work stream Service provides practical, emotional, spiritual and social support, including practical training in personal care for unpaid carers. Unpaid carers provide a significant proportion of care for people dying at home and mainstream short breaks services are often not suitable. Care coordination and locality registers are a cornerstone of the national and local end of life care strategy, providing reassurance for patients and carers, improving care delivery and averting crises that can lead to an unwanted hospital admission at the end of life.
Mental Health / LD (adults and older people but not CAMHS); public mental health services All aspects of substance misuse (including former DAAT	<u>Nottinghamshire County</u> • The 'Books on Prescription' initiative provided support for people with common mental health problems, such as anxiety and depression.	This is delivered in partnership by NHS Nottinghamshire County, Nottinghamshire County Council and Let's Talk Wellbeing. 'Books on Prescription' supports the 'watchful waiting'

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
role); offender health, prison health, violence prevention (including Domestic violence),	▪ All County community substance misuse services were reviewed and new models of delivery commissioned from the 1 April, in line with the Governments recent Drug Strategy and focus on a recovery orientated system.	phase of services, which is the first approach to active treatment of mild to moderate mental health conditions. Books are 'prescribed' free of charge by the patient's GP, and collected by the patient from a participating library. Book collections are available in almost every library in Nottinghamshire County, except mobile libraries. Patients do not have to be a library member to access the scheme.
<u>Nottinghamshire County including Bassetlaw</u>	▪ Awareness raising/developing training for GPs, hospital staff at NUH, Sherwood Forest and Bassetlaw Hospital, care home and home care staff ▪ DH Learning Disability screening questionnaire was implemented across 3 Nottinghamshire prisons.	
<u>Bassetlaw</u>	• Alcohol pathways (in line with NICE Guidance) were commissioned across the Bassetlaw community, primary care, probation and HMP Ranby aiming to improve access to alcohol intervention and treatment and reduced alcohol related hospital admissions. • In partnership with Bassetlaw District Council, Police, Housing and Bassetlaw Drug and Alcohol Services a Safer Neighbourhood project was implemented targeting hard to reach groups from the community of Sandy Lane Worksop.	All Bassetlaw health, social, police, fire and ambulance have access to alcohol training awareness and education. Bassetlaw Primary Care Drug treatment provision is working in line with NHS/NTa Building Recovery in Communities recommendations.
Health protection		
Vaccination and Immunisation programmes (including	<u>Childhood Immunisation and Vaccination</u> ▪ Nottinghamshire County achievement levels of	A turnaround plan has been agreed and

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
childhood V+I, seasonal flu, Pneumococcal, HPV) Integrated Pollution Prevention and Control Health Protection, including management of incidents and emergencies Emergency Planning, Pandemic Flu <u>Nottinghamshire County</u> <u>Nottinghamshire County including Bassetlaw</u>	Primary immunisations in 2010/11 were: 96%, DTap/IPV/Hib 96%, MenC 95.6%, PCV 96%. ▪ Bassetlaw achievement levels of Primary immunisations in 2010/11 were: DTap/IPV/Hib 94.7%, MenC 93.6%, PCV 90.9%96% <u>HPV</u> ▪ Nottinghamshire County HPV uptake rates achieved target of 90% for year 8 girls, Dose 1: 94.8% (3379) Dose 2: 93.4% (3331) Dose 3: 90.3% (3218) ▪ Bassetlaw HPV uptake rates achieved target of 90% for year 8 girls, , Dose 1: 100.0% (698) Dose 2: 90.5% (632) Dose 3: 90.3% (630) <u>Seasonal flu campaign</u> ▪ The Nottinghamshire County seasonal flu campaign achieved 74.4% >65 yrs (target 75%), 52% <65yrs (target 60%), Pregnant women 47.8%, Pregnant Women at risk 68.2%. Carers 45.6% (no target) HCW 31.2% (no target). ▪ The Bassetlaw seasonal flu campaign achieved 73.0% >65 yrs (target 75%), 52.6% <65yrs (target 60%), Pregnant women 43.5%, Pregnant Women at risk 50.0%, HCW 15.5% (No target). Carers 2010/11 45.5% (no target) <u>Infection Control</u> ▪ Detailed prompt investigations of community acquired MRSA bacteraemia cases were undertaken as per national requirements, and follow-up measures actioned. ▪ TB policy and service specification implemented in	implementation is in progress to improve performance across all target population groups, this has included the lowering of SHA targets rates for 11/12. Infection Control work includes surveillance and monitoring of healthcare acquired infections across Nottinghamshire and the promotion of best practice through provision of specialist knowledge, advice, and education to 109 GP surgeries, 89 Dental practices, 67 contracted Care Homes, 131 Pharmacies, 67 Optometrists. The service also manages outbreaks and provides support to individual patients with infection that is potentially a risk to others e.g. *clostridium difficile*/MRSAs. Emergency Planning includes coordination of effective PCT response to multi agency major incidents.

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
	the north of the county. ▪ Surveillance and monitoring of HCAI and the promotion of best practice through provision of specialist knowledge, advice, and education to 109 GP surgeries, 89 Dental practices, 67 contracted Care Homes, 131 Pharmacies, 67 Optometrists <u>Emergency Planning</u> ▪ Updated Cluster On Call and Major Incident Handbook, with wallet size guidance for On Call Directors and Managers published in 2010/11.Training delivered to all Directors on Strategic Gold Rota. ▪ Secured agreement of GP practices to update their Business Continuity Plans	
Accidental injury prevention <u>Nottinghamshire County</u>	▪ The First Contact Scheme continued to identify fallers and direct people to the falls services and GP for follow up. ▪ The falls programme developed good practice guidance for care homes and primary care, which includes guidance on falls. Partnership working with social care and health also delivered training on falls in care homes.	Falls prevention is an import programme to help reduce the adverse health and social care consequences of falls or fractures in the elderly population. Falls teams are in place in all Clinical Commissioning Groups. In addition, there is an Emergency Department Admission Support Service (EDASS) in Kings Mill Hospital (KMC) to identify people with a high risk of falling who have attended and are discharged home from A&E.
Appropriate management of resources		
PH input into NHS Nottinghamshire County financial assurance, including planned care and non elective care Programme budgeting	• PH led the delivery by primary and secondary of reductions in low priority procedures, thereby freeing up savings in excess of £1M for more valuable treatments and services. Further savings due this year. • Walk-in-Centre review undertaken releasing up to	Productive Notts priorities

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Action	Key Achievements in 2010/11	Supporting information i.e. linked to plans such as QIPP/Productive Notts
	£900K for QIPP. • Utilisation review undertaken with potential to release up to £3.9M. Virtual Community Wards being implemented across all CCGs.	
PH leadership and transition <u>Nottinghamshire County including Bassetlaw</u>	• The Health & Local Government Transition Board and transition project plan were established. • The Health and Wellbeing Board was established. • The Director of Public Health was invited to become a new member of the NCC Corporate Leadership Team.	Changes to PH Leadership & Transition is directed through the publication of healthy Lives: Healthy People and the forthcoming legislative changes in the Health & Social Care Bill.

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APPENDIX D – LOCAL AUTHORITY MEMORANDUM OF UNDERSTANDING

NHS Nottinghamshire County and NHS Bassetlaw
Public Health Directorate

NHS Nottinghamshire County Public Health Directorate – Nottinghamshire County Council, Borough & District Councils within Nottinghamshire
Memorandum of Understanding

Author[1]	Cathy Quinn, Associate Director of Public Health, NHS Nottinghamshire County (NHS NC) & NHS Bassetlaw
Date	October 2011
Introduction	1. The purpose of this Memorandum of Understanding (MOU) is to establish a framework for relationships between NHS Nottinghamshire County (NHS NC) & Bassetlaw Public Health Directorate, and Nottinghamshire County Council (NCC,) Gedling Borough Council, Ashfield District Council, Bassetlaw District Council, Broxtowe Borough Council, Mansfield District Council, Newark & Sherwood District Council and Rushcliffe Borough Council for 2011/12 and beyond, subject to further national and regional guidance in advance of a formal transfer of staff to NCC and services in 2013. Public health science functions are described in Appendix 1. 2. This MOU is supported by a NHS NC Business Plan and MOU's with NHS NC and Clinical Commissioning Groups (CCGs). ***NB: Within this document, the term Borough Councils & District Councils (BCs & DCs) is used to refer to the following organisations: Gedling Borough Council, Ashfield District Council, Bassetlaw District Council, Broxtowe Borough Council, Mansfield District Council, Newark & Sherwood District Council and Rushcliffe Borough Council.*** ***The term Local Authorities (LA) is used to refer collectively to tier 1 and tier 2 authorities.*** ***This MOU is not intended to form a legally binding agreement, but aims to clarify the expectations relating to the transfer of the Public Health function with NCC, BCs & DCs.***
Context	3. Since 1974, within the NHS, specialist public health staff have assumed the lead for the three core public health responsibilities on behalf of the NHS and local communities: • Health improvement e.g. lifestyle factors and the wider determinants of health. • Health protection e.g. preventing the spread of communicable diseases, the response to major incidents, and screening

[1] With thanks to Worcestershire PCT and Dr Robert Wilson at Lincolnshire PCT whose document formed the basis of this MOU.

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- Health Services e.g. input to the commissioning of health services, evidence of effectiveness, care pathways.

4. With the implementation of the Health and Social Care Bill 2010, primary responsibility for health improvement and health protection will transfer at the national level from the NHS to Public Health England (PHE), and at local level from PCTs to upper tier and unitary Local Authorities. Nottinghamshire County Council will also have new commissioning responsibilities which are described in Appendix 1.

5. Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to Clinical Commissioning Groups.

6. The PH management structure will change from an NHS PCT based structure to a Local Authority based structure in NCC, with retained leadership by a Director of Public Health. Developing the PH role and commissioning support within Local Authorities at County, Borough Council (BC) and District Council (DC) levels will be the main objective whilst maintaining a focus on the delivery of better health outcomes for the population of Nottinghamshire. The challenge/opportunity will be ensuring that the benefits from PH leadership in a range of areas such as health intelligence, needs assessment, clinical effectiveness, health protection, implementation of health improvement are not weakened or lost during the transfer of services.

7. Some public health tasks are delivered most effectively and efficiently at a county-wide level e.g. screening or emergency planning, and as such will be delivered by teams that may work across existing boundaries. Public Health will deliver the following for the local CCGs:
   - Coordination of Health Protection planning and response,
   - Implementation of health improvement initiatives, and
   - Provision of PH intelligence, rigorous framework for clinical effectiveness, and sustainable approach to prioritisation.

8. Public Health support is aligned to specific commissioning priority areas. This includes PH support to future strategic commissioning arrangements with the Local Authorities (LA) as indicated in Appendix 1.

9. The new functions, through Regulations, will require NCC to take action to protect the local population's health, and provide Clinical Commissioning Groups with population health advice. The capacity that is available in PH will be mapped to the needs of the service, LA & CCGs.

10. PH will work with LA & CCGs to agree outputs/outcomes that are measurable against key deliverables.

11. The Department of Health (DH) is committed to ensuring that LA is adequately funded for their new responsibilities and that any

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additional net burdens will be funded in line with the Government's New Burdens Doctrine. The Advisory Committee for Resource Allocation is currently considering what it will recommend as an appropriate allocations formula for the local authority grant. Public Health grants to upper tier and unitary local authorities will be made for the first time in 2013-14 and DH intend to provide shadow allocations for 2012-13 by the end of 2011.

Local Strategic Planning

12. The organisation and delivery of public health services is determined within a framework of national legislation and guidance as well as local issues and policies. The interpretation of these and the identification of local needs will inform the development of local public health key priorities.

13. The NHS will continue to have a critical part to play in securing good population health, and through Public Health will work closely with LA to achieve the best possible health outcomes for local people. Where appropriate the NHS Commissioning Board will be asked to commission specific services funded from the public health budget and in agreement with the CCGs.

15. Public Health will be a locally-led system with responsibility and power transferred to a local level, allowing local services to be shaped to meet local needs whenever possible. Public Health teams will also work locally with the Borough Councils (BCs) & District Councils (DCs) within Nottinghamshire to agree and implement national priorities at a local level and to maximise use of resources across the area. BCs & DCs will also be represented at the Health and Wellbeing Board.

The Director of Public Health will:

- Act as the principal adviser on health to elected members and officials.
- Work to ensure that public health is embedded across the work of the Local Authorities delivering key existing & new public health functions.
- Sponsor action to facilitate working across structures on such issues as consultation, guidance, training and health protection.
- Act as a statutory member of the Health and Wellbeing Board.
- Act as the strategic link between PHE on behalf of NCC, BC, & DCs within Nottinghamshire.
- Produce regular reports on the health of the population.
- Ensure PH leadership is provided to Local Strategic Partnerships and other Partnership arrangements.
- Support Public Health specialists to come together with other health and care experts in new clinical senates, hosted by the NHS Commissioning Board, to advise on how to make patient care fit together seamlessly.

NCC Corporate Leadership Team will:

- Support the development of working relationships & structures to allow the Director of Public Health to fulfil their role defined in the Public Health business plan.

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- Take action to ensure integration of Public Health into NCC strategies.

BC & DC Leadership Teams will:

- Support the development of working relationships to ensure integration of Public Health into local strategies.

Health improvement

14 The Health and Social Care Bill will give the LA statutory duties to improve the health of the population from April 2013. CCGs will also be given duties to secure improvement in health and to reduce inequalities utilising the role of health services, which will require action along the entire care pathway from prevention to tertiary care. Therefore, Nottinghamshire County Council (NCC), BCs & DCs within Nottinghamshire and the 6 County CCGs have a collective interest, and are likely to have individual and collective responsibility for health improvement, both during the transition period and subsequently. For 2011/12:

The Public Health Directorate will:

- Refresh its delivery and lead role in current strategies and action plans to improve health and reduce health inequalities, with input from NCC, BCs & DCs and CCGs.
- Maintain and refresh as necessary, metrics to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of key NHS and LA strategies.
- Support primary care with health improvement tasks appropriate to its provider healthcare responsibilities - for example by offering training opportunities for staff, targeted behaviour health change programmes and services.
- Lead health improvement partnership working between NCC, BCs & DCs, CCGs, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention.
- Embed public health work programmes around improving lifestyles into frontline services towards improving outcomes and reducing demand on treatment services

NCC will:

- Contribute to strategies and action plans to improve health and reduce health inequalities.
- Contribute to the maintenance of metrics to allow the progress and outcomes of preventive measures to be monitored
- Build up knowledge of the range of PH health improvement services and the associated expenditure in preparation for transfer of accountability for the PH grant.
- Review the integration of LA services with PH to maximise their collective contribution to disease prevention – for example by taking every opportunity to address smoking, alcohol, and obesity in their interactions and by optimising management of long term conditions.
    - Ensure primary and secondary prevention is incorporated within commissioning practice including review of provider contracts where appropriate
    - Commission to reduce health inequalities and inequity of

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access to services
- Support and contribute to locally driven public health campaigns

BCs & DCs will:
- Contribute to strategies and action plans to improve health and reduce health inequalities.
- Contribute to the maintenance of metrics to allow the progress and outcomes of preventive measures to be monitored
- Ensure PH is incorporated within commissioning practice including review of provider contracts where appropriate
- Commission to reduce health inequalities and inequity of access to services
- Support and contribute to locally driven public health campaigns

Health protection

15. The Health and Social Care Bill will be followed by regulations which are likely to give Local Authorities and the Director of Public Health a series of responsibilities in respect of health protection, on behalf of Public Health England. These are likely to include ensuring that plans are in place to protect the health of the local population in relation to infectious diseases, environmental hazards and emergency preparedness.

16. The Bill also gives CCGs a duty to ensure that they are properly prepared to deal with relevant emergencies. The Secretary of State retains emergency powers to direct any NHS body to extend or cease functions, and is likely to discharge these through Public Health England.

17. Therefore, to ensure robust health protection arrangements for 2011/12:

The Public Health Directorate will:
- In conjunction with NCC, BCs & DCs lead on and ensure that local strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, other outbreaks of infectious diseases, chemical incidents, natural disasters & emergencies.
- Work with PHE providing assurance on the local public health & NHS contribution to health protection and emergency response
- Ensure that local plans are adequately tested.
- Ensure adequate advice is available to the clinical community via PHE and any other necessary route on population health interventions, protection and infection control issues, e.g. delivery of childhood immunisations and national screening programmes
- Ensure that the CCGs have access to local plans and an opportunity to be involved in any exercises.
- In conjunction with NCC, BCs & DCs within Nottinghamshire, ensure that any preparation required – for example training, access to resources - has been completed.
- Ensure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements.

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NCC will:

- Engage in the joint leadership of health protection to ensure that local strategic plans are in place for responding to the full range of potential emergencies
- Coordinate the Local Resilience Forum (LRF) operating across the whole of Nottinghamshire including Bassetlaw and the City
- Jointly lead and attend emergency planning exercises.
- Ensure that the BCs & DCs have access to local plans and an opportunity to be involved in any exercises.
- Assist with co-ordination of the response to emergencies, through local command and control arrangements.

NCC, BCs & DCs will:

- Familiarise themselves with strategic PH plans for responding to emergencies.
- Engage in health protection to ensure that local strategic plans are in place for responding to the full range of potential emergencies
- Ensure that LA provider contracts include appropriate business continuity arrangements.
- Ensure that LA services have business continuity plans in place to cover action in the event of the most likely emergencies.
- Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and through action by LA services.

Population Healthcare/Health Services

18. The Health and Social Care Bill establishes Health and Wellbeing Boards as the primary mechanism of ensuring the responsibilities around health improvement and health and social care provision to identify the needs of the population and ensure that these are to be addressed through CCGs, public health and social care commissioning plans and activities. CCGs are established as the main local commissioners of NHS services and gives them a duty to continuously improve the effectiveness, safety and quality of services.

19. Public Health specialist staff currently provide a range of support for specific NHS commissioning functions (Appendix 2); the requirement for this support will not diminish, and DH guidance indicates that this support should be obtained from an appropriately skilled local Public Health specialist team. The commissioning functions required of LA & CCGs include significant Public Health functions to be maintained in order to perform competently (Appendix 3).

20. The expectations for 2011/12 should be that:

The Public Health Directorate will:

- Lead the future development of, and provide professional support for, the Health and Wellbeing Board (HWB).
- Provide specialist public health expertise, advice and analysis on the breadth of health policy areas to the HWB, NCC, BCs, DCs, CCGs and to the NHS Commissioning Board (for primary care and other directly commissioned services,) including working up a more defined specification for comprehensive public health

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support.

- Refresh the Joint Strategic Needs Assessment (JSNA,) in conjunction with LAs and CCGs, to re-assess the health needs of the local population. The production of the JSNA will be complemented by a programme of targeted needs assessments (e.g. health of prisoners, and the pharmaceutical needs assessment).
- In consultation with the local population and in conjunction with LAs and CCGs, develop the Health and Wellbeing Strategy (HWS), ensuring national PH policy is translated into local practice. Make the best use of evidence-based interventions so that health improvement is maximised and inequalities are minimised, ensuring PH issues at local level (district, locality, and neighbourhood) have sufficient focus and attention.
- Utilise the Outcomes Frameworks to support the development of the HWS.
- Support the development of public health skills for LA and CCG staff.
- Lead the co-ordination of appropriate health commissioning work between the NHS, PHE and LA at a local level. Promote and facilitate joint working between LA, CCGs and wider partners to maximise health gain through integrated commissioning practice and service design
- Ensure that services are commissioned (NCC, BCs, DCs or CCG) to meet local need, so that NHS, Public Health and Social Care outcomes are maximised. This will also include the appropriate decommissioning of services that do not demonstrate effectiveness in meeting the identified need.
- Ensure the reduction of health inequalities is prioritised in the commissioning of services, including utilising health equity audit
- Support commissioners in developing evidence based care pathways, service specifications and quality indicators to improve patient outcomes. Undertake reviews of the evidence of effectiveness, predictive modelling of effects, and supporting documentation to aid clinicians in decision-making.
- Set out the contribution that interventions make to defined outcomes (modelling) and the relative return on investment across the portfolio of commissioned services
- Design monitoring and evaluation frameworks, collect and interpret results
- Providing a legitimate context for setting priorities using 'comparative effectiveness' approaches and public engagement and identify areas for disinvestments including using programme budgeting and marginal analysis (PBMA) in this process.
- Support clinical validation of data where necessary for commissioning purposes

NCC will:

- Host the Health and Wellbeing Boards to maximise opportunities for integration between the NHS, public health and LA, promoting joint commissioning, and driving improvements in the health and wellbeing of the local population.
- Promote internal working relationships and act as sponsor to provide the vehicle for local government to work in partnership with commissioning groups to develop a comprehensive Joint

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Strategic Needs Assessment and robust Joint Health and Wellbeing Strategy for commissioning of health care, social care and public health services.

- Take an active part in the development of the JSNA and Health & Wellbeing Strategy for Nottinghamshire.
- Encourage staff to collaborate and develop specialist PH skills, including service planning, efficiency, audit, and evaluation to promote joint commissioning of health & social care prior to the mandate being set in 2013 in the Health and Social Care Bill.
- Support the continued delivery of PH support to CCGs to assist in effective commissioning of healthcare services.
- Support a process for defining public health support to commissioners beyond 2013
    - Utilise specialist public health skills to target services at greatest population need and towards a reduction of health inequalities
    - Contribute intelligence and capacity to the production of the JSNA

BCs & DCs will:

- Participate in the Health and Wellbeing Boards to maximise opportunities for integration between the NHS, public health and LA.
- Take an active part in the development of the JSNA and Health & Wellbeing Strategy for Nottinghamshire.
- Encourage staff to collaborate and develop specialist PH skills, including service planning, efficiency, audit, and evaluation to promote joint commissioning of health & social care prior to the mandate being set in 2013 in the Health and Social Care Bill.

Workforce, Training & Integration into LA

21 The transfer of the Public Health function to Nottinghamshire County Council and the development of new commissioning structures in the NHS will require the Public Health team to establish new ways of working, whilst ensuring that the public health activities and responsibilities continue to be delivered.

22 From October 2011, PH Consultants and their teams will move to be based in Nottinghamshire County Council premises; small numbers of staff will move over time rather than altogether. Workforce transition will be completed by March 2012 with full transfer of all duties and resources by March 2013. The location for PH staff within Bassetlaw will remain unchanged until review in March 2012.

21. In addition to the physical transfer of staff and managing accommodation and information technology issues, the transition will include induction of staff within the local authority, covering the mission values and principles of NCC, ways of working, culture, interface with members, report writing etc; all part of making the “one council” principle a reality. In conjunction, NCC staff will also be part of the induction programme to ensure they fully understand Public Health and the functions that are transferring.

Specifying the quality of the public health team

22. As part of the transition, a communication plan and local workforce development plan have been developed to define the

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activities, training and education that will be on offer to staff to aid the transition into a new organisation and way of working.

23. All PH directorates are expected to provide training for a variety of staff. This also includes PH trainees and doctors who are employed by other agencies. They are expected to ensure that all staff employed in their directorate maintain the requirements of continuing professional development (CPD) expected by their professional bodies. This is addressed through a regular in-house educational session, as well as ongoing access to key external training opportunities, including those required to maintain competency in the training role. Therefore all PH consultants are required to allocate time to cover their training commitment as Educational/Clinical supervisors

24. The Department of Health (DH) is working with stakeholders to develop a public health workforce strategy as set out in the White Paper, Healthy Lives Healthy People. The focus of the strategy will be on the specialist workforce, but it is clear that public health is everybody's business, so the strategy will be inclusive. It will scope the current situation of public health workforces, *e*xamine how best to transform the workforce to meet the challenges and opportunities of the future and ensure a high quality, sustainable, specialist workforce with the flexibility to move across employment sectors

25. The Public Health directorate, PCT cluster and NCC will ensure that an appropriately skilled public health workforce will be maintained and supported to allow delivery of the technical and leadership skills required of the function.

26. The specialist staff will, as necessary, contribute to the developing commissioning support arrangements and link geographically to support functions at different population levels which may be wider than a local LA / CCG base, including working with PHE and the NHS CB as required as part of the overall support function for the CCG and health community.

Wider working arrangements

27. The Public Health directorate, NCC and CCGs will determine the level of integration for procurement with LA and CCGs including the following scenarios:
    - PH complete the total commissioning function for areas of responsibility outlined in Healthy Lives, Healthy People
    - PH request CCGs undertake procurement
    - PH request LA to undertake procurement
    - CCGs and LA work to handover health commissioning for PH functions e.g. sexual health services

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Appendix 1: New Responsibilities for Local Authorities

New Responsibilities for Local Authorities as set out in Healthy Lives, Healthy People NHS White Paper
Tobacco Control
Alcohol and Drug Misuse services
Obesity & Community Nutrition initiatives
Increasing Levels of Physical Activity in the local population
Assessment and Lifestyle interventions as part of 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
Promotion of community safety, violence prevention and response
Local initiatives to tackle social exclusion

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Appendix 2: Public Health Lead areas

Lead (*and support staff)*	**Area**
Chris Kenny, Director of Public Health	Health and Wellbeing Board and Strategy Safer Nottinghamshire Partnership Safeguarding Improvement Board
John Tomlinson, Deputy Director of Public Health *Lindsay Price* *Helen Scott* *Heather Lindsay* *Jenny Charles-Jones* *Jo Hopkin* *PH I&I (county wide)* *David Gilding* *Kristina McCormick*	**Nottingham West and Nottingham North and East CCGs with the following county lead areas:** Long term conditions (diabetes, retinopathy screening, health checks, Renal and COPD) Tobacco control End of Life AAA screening Information and Intelligence (EMPHO, Dr Foster etc) Evidence for CCG authorisation JSNA Sustainability agenda **Provider Interface with Nottingham University Hospitals and County Health Partnership**
Barbara Brady *Tammy Coles* *Lynn Robinson* *Nick Romilly* *Jade Poyser* *Tristan Poole* *Tanya Makins* *Jenny Ward* *(Sarah Theaker SpR)*	**Mansfield & Ashfield CCG and Ashfield & Mansfield District Councils with the following county lead areas:** Obesity / diet / physical activity (adult and children), community nutrition Oral Health, including dental public health services Fluoridation Mental Health / LD (adults and older people but not CAMHS); public mental health services All aspects of substance misuse (including former DAAT role); offender health, prison health, violence prevention (including Domestic violence), promotion of community safety Workplace health **Provider Interface with Sherwood Forest Hospitals NHS Foundation Trust (and Nottinghamshire Healthcare Trust led by City PH)**
Jonathon Gribbin *Libby Lomas* *Sue Coleman* *Kathy Holmes* *Jill Burn* *Debbie Brown* *Rachel Toplis* *Wendy Walker* *Sally Bird*	**Principia, Rushcliffe CCG and Rushcliffe, Broxtowe and Gedling Borough Councils with the following county lead areas:** PH input into NHS financial assurance, including planned care and non elective care Programme budgeting Integrated Pollution Prevention and Control Health Protection, including management of incidents and emergencies Community Infection control including TB strategy, Blood borne viruses Emergency Planning Pandemic Flu
Kate Allen *Tracy Burton* *Sally Handley* *Ann Berry* *Sarah Everest* *David Pearce (SpR)*	**Newark and Sherwood Health CCG and Newark & Sherwood District Council with the following county lead areas:** Children and Young People (including CAMHS); Maternity (not screening), Healthy schools, Disabled children, Breast feeding, health visitors, safeguarding

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	children, Sexual Health (including sexual health services, GUM, Chlamydia testing, HIV, teenage pregnancy, SARC, TOP) Maternal and childhood Screening programmes (including antenatal and neonatal screening e.g. neonatal hearing, Down's, Childhood screening programmes) Prevention of birth defects Cancer screening (of Cervix, Breast, Bowel)
Penny Spring *NHS NC Staff:* *Iolanda Shaker* *Gina Policelli* *NHS Bassetlaw staff:* *Cheryl George* *Susan March* *Helen Houghton* *Sonya Clark* *Jenny Harding* *(Dean Wallace SpR)*	**Bassetlaw CCG and Bassetlaw District Council with the following county lead areas:** Accidental injury prevention Vaccination and Immunisation programmes (including childhood V+I, seasonal flu, pneumococcal, HPV)
Mary Corcoran *Gill Oliver* *Nikki Hughes* *Cheryl George (PT)* *Vicky Wright* *(Shade Agboola SpR)* *(Shazia Ahmad SpR)*	**The following county lead areas:** Older People (including Stroke, osteoporosis, falls); excluding Older Persons Mental Health, but including Dementia; seasonal mortality NSF Long Term Neurological Conditions, including physical disability and sensory impairment Continuing Care Cancer policy; prevention and early diagnosis EMSCG PH support for regional Cardiovascular Network
Cathy Quinn *Nicola Lane*	**Link to Local Authorities** All NHS and PH outcomes (coordinating role) Health and Wellbeing Strategy Principal liaison role with LA members Pharmaceutical Needs Assessment Support for other Consultants on specific projects
Tracy Gaskill	**Link to CCGs** PH Business Plan MOU between PH and the CCGs PH development PH communication Management of all admin staff PH business management (CMO cascades, PH standards, PH part of Assurance framework, PH Risk Register) NICE Guidance – coordination of PH implementation Support for Consultants on specific projects
Vanessa McGregor	Health protection – detail to follow

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Appendix 3: Public Health functions to support NHS & LA commissioning

Public health support for NHS commissioning
1. Public health information and analysis
• Use and interpretation of the data to assess the health needs of populations and how they can be best met using evidence based interventions • In collaboration with the CCGs and local authorities, oversee the production and development of the Joint Strategic Needs Assessment and in line with national guidance • Support commissioning practice towards the reduction of local health inequalities and the specific needs of vulnerable and marginalised groups • Analysis and utilisation modelling of service activity including health equity audit • Predictive modelling of activity against outcomes • Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups. • Identification of service and organisational outcome measures towards the improvement of the public's health and achievement of indicators within the NHS and public health outcomes frameworks
2.Clinical Commissioning and service planning
2.1 Clinical effectiveness • Critical appraisal of the research and application to support the CCG in developing evidence-based care pathways, service specifications and quality indicators to improve patient outcomes as required and in particular in the absence of NICE or other national guidance • Establishing and evaluating indicators and benchmarks to map service performance • Identify and assess population impact of implementing NICE guidance/guidelines • Support the CCG in the identification, assessment and implementation of national policy and best practice guidelines e.g. national service frameworks, national strategies • Design monitoring and evaluation frameworks, collect and interpret results • Predictive modelling of activity against outcomes for locally designed and populated care pathways. **2.1 Quality improvement** • Support the CCG work programme on the quality improvement and QIPP agenda • Provide public health input to the development of quality indicators • Support the development of public health awareness and competencies of the CCG • Facilitate and provide support towards the CCG strategy for health improvement and disease prevention
3.Prioritisation and resource allocation
• Apply health economics and a population perspective to provide a legitimate context and technical evidence-base for the setting of priorities • Identify the contribution that interventions make to defined outcomes and the relative return on investment across the portfolio of commissioned services • Identify areas for disinvestment and enable the relative value of competing demands to be assessed • Critically appraise the evidence and provide clinical support to appropriately respond to individual funding requests
3. Engagement - Public and Partners
• Through objective analysis, providing the impartiality necessary to communicate and defend difficult decisions to the public

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• Support the CCG to progress joint commissioning and provision plans with the local authorities and other statutory and non statutory organisations to maximise health gain through commissioning practice and service design
4. Objective independence
• Providing through the JSNA or other technical material, and in an independent role, to act as broker in relation to deciding on competing demands for funding as required. Protecting the ability of GPs to act, and to be seen to act, in the best interests of their individual patients.
5 **Research, innovation and teaching**
• To provide a professional source of expertise for research and evaluation of local health care as required and to contribute to innovation and development of locally sensitive solutions to help meet healthcare need. • To provide teaching and support for the use of public health science skills in the appropriate functional domains of CCG responsibility
6. Health Protection
• To provide local leadership and support for key NHS health protection functions: o Childhood vaccination o Adult vaccination including influenza immunisation programmes o Blood borne virus prevention and case identification (Hepatitis B, C and HIV) o Tuberculosis strategy and disease prevention • To provide support for the CCG in all dealings with local health protection issues handled by Public Health England including infectious and non-infectious hazards • To provide leadership and co-ordination for a health community approach to Emergency Planning and Response

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APPENDIX E – KEY EFFICIENCY INITIATIVES

Project/ Initiative name	Summary description of the aims of the project/ initiative, plus any dependencies with other projects/ themes
COPD	Savings are being achieved through the implementation of a standardised COPD pathway to ensure that all patients receive the right care in the right place from the right person. The COPD Pathway is commissioned to standards and outcomes releasing providers from the barriers of location and profession. Once an assessment of achievement of level one savings has been performed, the opportunity for level two savings will be scoped. Links to Emergency Care plans.
Diabetes	The implementation of the standardised diabetes pathway, based on national guidelines to ensure all patients receive the right care in the right place from the right person. The Nottinghamshire wide Diabetes Network provides the strategic lead and co-ordination for the implementation of the agreed pathways and services. Links to Emergency Care
Dementia and Mental Health in Acute Settings	Figures suggested by the Alzheimer's Society indicate that 60% of hospital beds are occupied by older people and that 60% of those people will have a mental health problem. This aims is to reduce length of stay by 10%, saving an estimated 26,280 bed days through the implementation of an Acute Care Liaison Team.
Procedures of Low Clinical Value	Savings are being achieved by improving the equity in access and the impact of healthcare procedures commissioned in Nottingham, in order to release funds for more beneficial activity. The initial focus has been to define thresholds for treatment to underpin policies covering low priority procedures and it is planned these policies will be incorporated in contracts with provider organisations. Once an assessment of achievement of level one savings has been performed, the opportunity for level two savings will be scoped. This work is linked to Orthopaedics, Planned and Emergency Care.
Prescribing	To reduce the cost of prescribing from the local implementation of medicines efficiency projects. The Area Prescribing Committee oversees the implementation of local projects and also supports collaborative work, such as the rational use of lipid lowering drugs and use of atypical antipsychotic medicines. In addition, the following project is being taken forward under Productive Notts: Special Pharmaceuticals - The aim of the project is to slow the growth in costs of prescribing 'specials' through a co-ordinated, planned approach across Productive Notts. It is proposed that local prescribers & dispensers be encouraged to make rational cost effective choices through a locally agreed mechanism. This project is linked to the procurement work stream.

TE Theme, or LHE Programme or Workstream name	Description of the vision for this service area	Financial opportunity
Clinical Services Review	To move clinical care for patients in Doncaster and Bassetlaw towards a new vision. This vision if for modernised, high quality services that will be delivered first time in local hospitals and the community for our population. It is the primary Quality initiative in NHS Bassetlaw's QIPP programme.	To be determined through development of Business Cases
Making Urgent Care Systems work	To manage demand on services to reduce A&E attendances and admissions along with improvements in the patient experience	£4.5m
Supporting Long Term Conditions (LTC)	To improve the quality of life for patients with a LTC and reducing the number of emergency admissions	£2.9m
Large Scale Prevention	A targeted approach by primary care to improve the quality of life for patients, support early detection and reduce admissions	£2.1m
Primary Care	The commissioning of high quality, value for money services in Primary Care.	£1.3m
Delivery High Quality Planned Care	To manage demand on services to reduce unnecessary planned care, reduce length of stay to a minimum and move to top quartile performance	£10.6m
Mental Well Being	To review services to ensure appropriate provision and value for money	£1.9m
Making Services Safer	No specific schemes	X
Non-clinical services and cross cutting	To secure value for money across a range of service areas	£16.7m
Specialised Services	To secure value for money across a range of specialised service areas	£1.8m

APPENDIX F – CLINICAL COMMISSIONING GROUP MEMORANDUM OF UNDERSTANDING

NHS Nottingham City, NHS Nottinghamshire County and NHS Bassetlaw Public Health Directorates

Public Health Directorates – Clinical Commissioning Groups Memorandum of Understanding

Author[2]	Dr Chris Packham, Executive Director of Public Health, NHS Nottingham City Ms Alison Challenger, Consultant in Public Health, NHS Nottingham City Tracy Gaskill, Associate Director of Public Health, NHS Nottinghamshire County (NHS NC) and NHS Bassetlaw
Date	August 2011
Introduction	12. The purpose of this Memorandum of Understanding (MOU) is to establish a framework for relationships between NHS Nottingham City and NHS Nottinghamshire County (NHS NC) Public Health Directorates and the Clinical Commissioning Groups (CCG) for 2011/12 and beyond subject to further national and regional guidance. Public health science functions are described in Appendix 1 and CCG functions in Appendix 2. 13. To reflect the differences in organisational form this MOU is supported by a NHS NC Business Plan and NHS NC local MOU (Appendix 3).
Legal status	This MOU is not a legally binding document but aims to clarify the expectations of all parties during the transition of Public Health to Local Authorities
Context	14. Since 1974, within the NHS, specialist public health staff have assumed the lead for the three core public health responsibilities on behalf of the NHS and local communities: • Health improvement e.g. lifestyle factors and the wider determinants of health. • Health protection e.g. preventing the spread of communicable diseases, the response to major incidents, and screening • Health Services e.g. input to the commissioning of health services, evidence of effectiveness, care pathways. 15. With the implementation of the Health and Social Care Bill 2010, primary responsibility for health improvement and health protection will transfer at the national level from the NHS to Public Health England, and at local level from PCTs to Local

[2] With thanks to Worcestershire PCT and Dr Robert Wilson at Lincolnshire PCT who developed previous versions of this document

Authorities. Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to Clinical Commissioning Groups. The challenge/opportunity will be ensuring that CCGs access and benefit from PH leadership in a range of areas such as health intelligence, needs assessment, clinical effectiveness, health protection, implementation of health improvement

16. Some public health tasks are delivered most effectively and efficiently at a county-wide level e.g. screening or emergency planning, and as such will be delivered by teams that may work across existing boundaries. Public Health will deliver the following for the CCGs
    - Coordination of health protection activities including NHS resilience planning and response,
    - Implementation of health improvement initiatives, and
    - Provision of PH intelligence, rigorous framework for clinical effectiveness, and sustainable approach to prioritisation.

17. Public Health support is aligned to specific commissioning priority areas as indicated in Appendix 1. This includes PH support to future joint commissioning arrangements with the Local Authority (LA). The capacity that is available in PH will be mapped to the needs of the CCGs.

18. PH will work with CCGs to agree outputs/outcomes that are measurable against key deliverables

Health improvement

19. The Health and Social Care Bill will give the Local Authority statutory duties to improve the health of the population from April 2013. CCGs will also be given duties to secure improvement in health and to reduce inequalities utilising the role of health services, which will require action along the entire care pathway from prevention to tertiary care. Therefore, Nottingham City Council, Nottinghamshire County Council, the 6 County CCGs and Nottingham City CCG have a collective interest, and are likely to have individual and collective responsibility for health improvement, both during the transition period and subsequently. For 2011/12:

The Public Health Directorate will:

- *Refresh its delivery and lead role in current strategies and action plans to improve health and reduce health inequalities, with input from the CCG.*
- *Maintain and refresh as necessary metrics to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of key NHS and LA strategies.*
- *Support primary care with health improvement tasks appropriate to its provider healthcare responsibilities - for example by offering training opportunities for staff, targeted behaviour health change programmes and services.*
- *Lead health improvement partnership working between the*

CCG, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention. Embed public health work programmes around improving lifestyles into frontline services towards improving outcomes and reducing demand on treatment services

CCGs will:

- *Contribute to strategies and action plans to improve health and reduce health inequalities.*
- *Ensure that constituent practices maximise their contribution to disease prevention – for example by taking every opportunity to address smoking, alcohol, and obesity in their patients and by optimising management of long term conditions.*
- *Ensure primary and secondary prevention is incorporated within commissioning practice*
- *Commission to reduce health inequalities and inequity of access to services.*
- *Support and contribute to locally driven public health campaigns*

Health protection

20. The Health and Social Bill will be followed by regulations which are likely to give Local Authorities and the Director of Public Health a series of responsibilities in respect of health protection, on behalf of Public Health England.

21. The Bill gives CCGs a duty to ensure that they are properly prepared to deal with relevant emergencies. The Secretary of State retains emergency powers to direct any NHS body to extend or cease functions, and is likely to discharge these through Public Health England.

22. Therefore, to ensure robust health protection arrangements for 2011/12:

The Public Health Directorate will:

- *Lead on and ensure that local strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, major incidents and provide assurance to NHS East Midlands and in time PHE regarding the arrangements*
- *Ensure that these plans are adequately tested.*
- *Ensure that the CCG has access to these plans and an opportunity to be involved in any exercises.*
- *Ensure that any preparation required – for example training, access to resources - has been completed.*
- *Ensure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements.*
- *Ensure adequate advice is available to the clinical community via the Health Protection Agnecy and any other necessary route on health protection and infection control issues.*

The CCGs will:

- *Familiarise themselves with strategic plans for responding to emergencies and prepare for possible holding responsibility for this function with PH and PHE only leading the response to incidents which impact on Public Health e.g. pandemic's and*

other infectious disease outbreaks

- *Participate in exercises when requested to do so.*
- *Ensure that provider contracts include appropriate business continuity arrangements.*
- *Ensure that constituent practices have business continuity plans in place to cover action in the event of the most likely emergencies.*
- *Assist with co-ordination of the response to emergencies, through local command and control arrangements.*
- *Ensure that leadership and resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and through action by constituent practices.*
- *Develop and test their own business continuity plans*

Population healthcare/Health Services

23. The Health and Social Care Bill establishes CCGs as the main local commissioners of NHS services and gives them a duty to continuously improve the effectiveness, safety and quality of services. The Health and Well-being Boards have been established as the primary mechanism of ensuring the responsibilities around health improvement and health and social care provision to identify the needs of the population and ensure that these are to be addressed through CCGs, public health and social care commissioning plans and activities.

24. Public health specialist staff currently provide a range of support for specific NHS commissioning functions (Appendix 1); the requirement for this support will not diminish, and DH guidance indicates that this support should be obtained from an appropriately skilled local public health specialist team. The functions required of CCGs include domains where significant public health science skills are required to perform competently (Appendix 2).

25. The expectations for 2011/12 should be that:

The Public Health Directorate will:

- *Provide specialist public health advice to the CCG including working up a more defined specification for comprehensive public health support.*
- *Assess the health needs of the local population, and how they can best be met using evidence-based interventions*
- *Ensure the reduction of health inequalities are prioritised in the commissioning of services, including utilising health equity audit*
- *Support the Clinical Commissioning Groups in developing evidence based care pathways, service specifications and quality indicators to improve patient outcomes*
- *Set out the contribution that interventions make to defined outcomes (modeling) and the relative return on investment across the portfolio of commissioned services*
- *Design monitoring and evaluation frameworks, collect and interpret results*
- *Providing a legitimate context for setting priorities using 'comparative effectiveness' approaches and public engagement and identify areas for disinvestments including using programme*

budgeting and marginal analysis (PBMA) in this process.

- *Support clinical validation of data where necessary for commissioning purposes*
- *Support the CCGs in the achievement of the indicators in the NHS outcomes frameworks for Domain One – preventing people from dying prematurely*
- *Promote and facilitate joint working with local authority and wider partners to maximise health gain through integrated commissioning practice and service design*
- *Support the clinical effectiveness and quality functions of the CCGs including input into assessing the evidence e.g. NICE guidance*
- *Support the CCGs in agreeing commissioning intentions*
- *Support the development of public health skills for CCG staff*
- *Lead the development of, and professional support for, the Health and Wellbeing Boards.*
- *Through the Joint Strategic Needs Assessment (JSNA), refresh the needs assessment of the population and ensure that this is relevant to the County. The production of the JSNA will be complemented by a programme of targeted needs assessments (e.g. health of prisoners, and the pharmaceutical needs assessment). CCGs will be co-participants n the production of the JSNA.*
- *Lead production of the Joint Health and Wellbeing Strategy and ensure that the CCG is fully involved in the production of this strategy*
- *Lead the co-ordination of appropriate health commissioning work between the NHS, PHE and LA at a local level.*
- *Work on care pathways, including review of the evidence of effectiveness, predictive modelling of effects, and supporting documentation to aid clinicians in decision-making..*
- *Provide specialist technical reports and support in relation to named patient funding requests.*

CCGs will:

- *Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.*
- *CCGs to publish the commissioning intentions in line with PH priorities including the areas outlined in Healthy Lives Healthy People Update and way forward (DH 2011)*
- *Support a process for defining public health support to CCGs beyond 2013*
    - *Utilise specialist public health skills to target services at greatest population need and towards a reduction of health inequalities*
    - *Contribute intelligence and capacity to the production of the JSNA*

Specifying the quality of the public health team	26. NHS Nottingham City and Nottinghamshire County will ensure that an appropriately skilled public health workforce will be maintained and supported to allow delivery of the technical and leadership skills required of the function. This will include: 27. All public health specialists to be subject to all existing NHS clinical governance rules, including those for continued professional development. 28. All PH Consultants are required to take part in a professional appraisal system in addition to their managerial appraisal. This is similar to other consultant specialties to meet national standards for revalidation as per GMC regulations. This process is co-ordinated across the East Midlands to ensure a standardised and efficient approach for all employers. Local PHCs will need to take part in this process both as appraisers and appraises. 29. The specialist staff will, as necessary, contribute to the developing Commissioning Support arrangements and link geographically to support functions at different population levels which may be wider than a local CCG / LA base, including working with PHE and the NHS CB as required as part of the overall support function for the CCG and health community.
Wider working arrangements	30. Determine the level of integration for procurement with the LA and CCGs including the following scenarios: • PH complete the total commissioning function for areas of responsibility outlined in Healthy Lives, Healthy People • PH request CCGs undertake procurement • PH request LA to undertake procurement • CCGs and LAs work to handover health commissioning for PH functions e.g. sexual health services

Appendix 1: Public health functions to support NHS commissioning

Public health support for NHS commissioning
1. Public health information and analysis
• Use and interpretation of the data to assess the health needs of populations and how they can be best met using evidence based interventions • In collaboration with the CCGs and local authorities, oversee the production and development of the Joint Strategic Needs Assessment and in line with national guidance • Support commissioning practice towards the reduction of local health inequalities and the specific needs of vulnerable and marginalised groups • Analysis and utilisation modelling of service activity including health equity audit • Predictive modelling of activity against outcomes • Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups. • Identification of service and organisational outcome measures towards the improvement of the public's health and achievement of indicators within the NHS and public health outcomes frameworks
2.Clinical Commissioning and service planning
2.1 Clinical effectiveness • Critical appraisal of the research and application to support the CCG in developing evidence-based care pathways, service specifications and quality indicators to improve patient outcomes as required and in particular in the absence of NICE or other national guidance • Establishing and evaluating indicators and benchmarks to map service performance • Identify and assess population impact of implementing NICE guidance/guidelines • Support the CCG in the identification, assessment and implementation of national policy and best practice guidelines e.g. national service frameworks, national strategies • Design monitoring and evaluation frameworks, collect and interpret results • Predictive modelling of activity against outcomes for locally designed and populated care pathways. **2.1 Quality improvement** • Support the CCG work programme on the quality improvement and QIPP agenda • Provide public health input to the development of quality indicators • Support the development of public health awareness and competencies of the CCG • Facilitate and provide support towards the CCG strategy for health improvement and disease prevention
3.Prioritisation and resource allocation
• Apply health economics and a population perspective to provide a legitimate context and technical evidence-base for the setting of priorities • Identify the contribution that interventions make to defined outcomes and the relative return on investment across the portfolio of commissioned services • Identify areas for disinvestment and enable the relative value of competing demands to be assessed • Critically appraise the evidence and provide clinical support to appropriately respond to individual funding requests
5. Engagement - Public and Partners
• Through objective analysis, providing the impartiality necessary to communicate and defend difficult decisions to the public

- Support the CCG to progress joint commissioning and provision plans with the local authorities and other statutory and non statutory organisations to maximise health gain through commissioning practice and service design

6. Objective independence

- Providing through the JSNA or other technical material, and in an independent role, to act as broker in relation to deciding on competing demands for funding as required. Protecting the ability of GPs to act, and to be seen to act, in the best interests of their individual patients.

5 **Research, innovation and teaching**

- To provide a professional source of expertise for research and evaluation of local health care as required and to contribute to innovation and development of locally sensitive solutions to help meet healthcare need.
- To provide teaching and support for the use of public health science skills in the appropriate functional domains of CCG responsibility

6. Health Protection (subject to change as still being finalised at the DH)

- To provide local leadership and support for key NHS health protection functions:
    - Childhood and adult vaccination programmes including seasonal flu
    - Blood borne virus prevention and case identification (Hepatitis B, C and HIV)
    - Tuberculosis strategy and disease prevention
    - Outbreak management
- To provide support for the CCG in all dealings with local health protection issues handled by Health Protection Agency including infectious and non-infectious hazards
    - To provide leadership and co-ordination for a health community approach to Emergency Planning Resilience and Response
- To provide support for the CCG in all dealings with local health protection issues handled by the Health Protection Agency including infectious and non-infectious hazards
- To provide leadership and co-ordination for a health community approach to Emergency Planning and Response

Appendix 2: Clinical Commissioning Group functions

GPCC functions **[NHS (2011). The functions of CCGs (working document – note DH agreement of detail especially around emergency planning)**
1. General
• To exercise their functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience. • To co-operate with local authorities and participate in their Health & Wellbeing Boards. • To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available. • To have regard to the need to reduce inequalities in access to healthcare and healthcare.
2. Planning services
• Assessing people's healthcare needs and identifying likely trends in healthcare needs, building on the JSNA. • Identifying inequalities in access to healthcare services, quality and outcomes. • Working with the Directors of Public Health and their teams, to take account of public health advice in the development of commissioning plans. • Redesigning services and/or pathways to deliver improved outcomes and better meet patients' needs. • Determining the nature, volume and range of services that will need to be available locally to meet needs. • Identifying which services will be most effective and cost effective and planning both new investments and disinvestments, drawing on evidence and experience. • Consulting with the public, and working with local Healthwatch and local authorities. • Involving group's representative of patients and carers in the planning of services.
3. Agreeing services
• Developing service specifications and incorporating them into contracts • Making arrangements for managing individual funding requests, • Determining arrangements for making decisions on the funding of specific treatments including high-cost drugs and new interventions.
4. Monitoring services
• Working with clinicians and patients to review the effectiveness of services and improve patient pathways. • Using the Commissioning Outcomes Framework and other intelligence to benchmark • Improvements in quality and outcomes.
5. Improving the quality of primary care
• Drawing on comparative practice level information to understand the relationship between patient needs, practice performance and wider quality and financial outcomes.
6. Specific duties of co-operation
• Working with Directors of Public Health and their teams to identify opportunities to work better together to improve people's health and wellbeing.

Appendix 3

NHS Nottinghamshire County and NHS Bassetlaw Public Health Directorate
(NB: Business Plan to follow)

Clinical Commissioning Groups (CCG) **Memorandum of Understanding for the following CCGs** **Bassetlaw; Mansfield and Ashfield; Principia Rushcliffe; Nottingham West; Nottingham North & East and Newark & Sherwood Health**	
Author	Tracy Gaskill, Associate Director of Public Health, NHS Nottinghamshire County (NHS NC) and NHS Bassetlaw
Acknowledgements	Dr Robert Wilson, Consultant in Public Health Medicine, NHS Lincolnshire, originator of the paper.
Date	21 August 2011
Legal status	This MOU is not a legally binding document but aims to clarify the expectations of all parties during the transition of Public Health to Local Authorities
Introduction	1. The purpose of this Memorandum of Understanding is to detail the local relationship between NHS NC's Public Health Directorate and NHS NC's Clinical Commissioning Groups (CCG) for 2011/12 with the three priorities: a) Securing authorisation b) Financial recovery (Quality, Innovation, Productivity and Prevention QIPP) c) Developing longer term arrangements from April 2013 onwards (Please see cluster PH MOU for CCGs)
Context	2. CCGs will need to build a track record of delivery e.g. QIPP, primary care and partnerships in readiness for authorisation, that will enable them to take on the full range of functions in April 2013 3. In 2011/2012 public health advice and support will be provided to each CCG. It is envisaged that a similar level of support will be provided in future years (Appendix 1). In the interim a Public Health Business Plan will be in place for October 2011 – April 2013 that will ensure PH delivery of the key functions, ensure authorisation and lead financial recovery 4. Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to CCGs. Most of the public health staff currently employed by NHS NC will work from Nottinghamshire County Council (NCC) premises from October 2011 and have contracts of employment by April 2013. 5. Currently, at a senior level, NHS NC employs a Director of Public Health (a joint appointment with Nottinghamshire County Council) and public health consultants; the public health directorate also supports a number of staff in more junior positions, plus PH registrars.

	6. Some public health tasks lend themselves better to work at a more local level e.g. input to healthcare commissioning. Within current staffing levels it is envisaged that each CCG in NC will have a named public health consultant contact, who will do work for the benefit of that CCG. CCGs will also benefit from work done by more junior staff, and from work that is done at a county-wide level. 7. Each consultant has lead policy area and will continue to work with GP clinical leads to develop plans on a county wide basis for these areas whilst ensuring CCGs input into the planning and implementation at a local level (Annex 1)
Authorisation ***Strong clinical and professional focus which brings real added value*** ***Clear credible plans to deliver QIPP*** ***Collaborative arrangements for commissioning***	The most important issue in 2011/12 is CCG authorisation. 8. The size of the public health team and the approach taken to discharging public health responsibilities will need to be prioritised so that CCGs can access and benefit from the resources of the wider PH function. Local authorities already employ staff who deliver some front-line public health functions (e.g. within leisure, planning, environmental health etc.) 9. Equally it is likely that there will be a greater emphasis in the future on commissioning health improvement programme delivery from the voluntary sector and social enterprises. Both consortia and local authority public health teams will need to be aware of development needs of these new front-line providers. ***Over the next 12 months the Public Health Directorate will*:**; • Provide key evidence and documentation for example and including reviews, annual plans, wellbeing strategies, joint commissioning plans, local health improvement strategies and partnership arrangements • Provide understanding on PH's role with JSNAs and how CCGs maximize their input and contribution to development of strategy • Provide crucial input from the health intelligence staff and clarity over the different options for accessing these technical public health skills for commissioning • Target programmes to deliver reductions of inequalities as well as maximum health gain • Advise on behaviour change techniques • Provide training in public health awareness and development of core public health skills across commissioners and providers in the new system by using imaginative new ways • Develop care pathways that represent best-value care. • Focus attention on individuals who are at highest risk of adverse health events to ensure the right things happen for them at the right time (whether through self-care, informal care or medical care). • Co-production of health through community development initiatives (e.g. partnerships for older people, maximizing the move to personalised health care, accessing effectively a range of "any qualified providers" locally, partnerships with other primary care contractors). • Proactively share information about performance to highlight variation between practices and GPs, and relative strengths and

	weaknesses of practices. • Produce information on different population levels for commissioning health care – locally as well as across groups – depending upon the service commissioned. • Provide a profile of the local (practice and resident) populations to identify those at highest risk of admission; comparisons across practices • Interface with future arrangements run from the NHS Commissioning Board for the commissioning of specialized services and for screening. • Give advice on how to use and interpret comparative analyses such as the NHS Atlas of Variations and the Spend and Outcome tool • Advise on areas for disinvestment • Provide the evidence-base and rationale for specific points on patient pathways across the health (and social care) spectrum to deliver best value • Provide key indicators and quality targets for inclusion in service specifications. • Use evidence on cost and clinical effectiveness to challenge secondary care clinicians • Advise on prioritisation processes and providing ethical frameworks to enable CCGs to take tough commissioning decisions • Provide technical input to the commissioning of high risk areas such as screening programmes. • Evaluate services and share good practice • Point to examples of effective initiatives for co-production of health and examples of good practice to inform local commissioning of services. ***The CCGs will:*** • Take responsibility for service transformation to improve outcomes and reduce health inequalities • Contribute to the health and wellbeing agenda and strategy with Clinical Leaders as active members of the Health and Wellbeing Board • Harness public health skills to aid front-line delivery amongst community pharmacists, optometrists, dentists, health visitors, practice nurses, and allied professionals • Undertake and commit to a programme of training • Commit to working with PH to understand information and it's application to commissioning • Use information and PH skills to commission best value, effective services Take responsibility for ongoing practice based surveillance, risk communication and best use of information and intelligence to ensure delivery of the health protection function
Financial Recovery	10. Financial recovery remains a top priority for CCGs. 11. The PH resource is not expected to change over the next 18 months but has been identified as being ring fenced before moving to the Local Authority. 12. The table 1 below indicates the areas of spend with more detail available in the Business Plan

	Table 1 Public health leadership Information & Intelligence functions Nutrition, Obesity and Physical activity Drug misuse Alcohol misuse Tobacco Dental public health Fluoridation Children 5-19 NHS Health Check Programme Misc health improvement and wellbeing Sexual health (STI testing and treatment, contraception, abortion, prevention) Non-cancer screening Cancer Screening Healthy Start Vitamins Children 0-5 Childhood immunisations Targeted neonatal immunisation programmes Seasonal flu and pneumococcal immunisation programmes TD/IPV and HPV immunisation programmes Contraception additional service - GP contract Prison public health Dental public health leadership 13. In order to achieve delivery PH will play a central role in commissioning and decommissioning ***The Public Health Directorate will:*** • Continue to lead and support plans for delivering NHS NC's Quality, Innovation, Productivity and Prevention (QIPP) financial recovery plan • Lead and contribute to the unplanned and planned care commissioning programmes, for example low priority procedures and utilisation reviews in secondary care and mental health services • Provide information and intelligence on clinical effectiveness, evidence to support rational sustainable prioritisation helping CCGs achieve financial balance and authorisation ***CCGs will:*** • Locally lead the QIPP financial recovery plan • Use PH resources in the commissioning and decommissioning of services with the exception of resources already identified as moving to the LA in 2013. These will continue to be managed by Public Health.
Health improvement Health protection Health services *(Please also refer to Cluster MOU*)	14. In addition to the Cluster PH MOU for CCGs: ***The Public Health Directorate will:*** • Appoint DPH or his/her rep as standing member of CCG board or appropriate committees • Produce a Business Plan for the period of 2011 – 2013 to ensure transparency over the responsibilities and functions during transition, for all stakeholders • Represent the PCT and CCGs on the Community Safety

	Partnerships and District/Borough Local Strategic Partnerships • Public Health will retain overall responsibility for delivery of the core functions as outlined the command paper *Healthy Lives, Healthy People Update and way forward (DH 2011)* • Produce CCG and County level information for the HWB Board where possible • Produce key topic and papers for HWB Board for commissioning consideration and action ***The CCGs will:*** • Determine the process for taking over the commissioning duties associated with the commissioning of health services currently undertaken by PH • Ensure Clinical Leadership and active involvement in preparing information for the HWB Board • Ensure Clinical Leads or their approved clinical deputy for each CCG attend every HWB Board to provide health population information and challenge • Provide timely responses to the recommendations from the HWB Board
Dispute Resolution	15. In the event of a dispute in the delivery of this agreement, formal notice should be given to the Director of Public Health (DPH). Resolution will be lead through the DPH, with escalation to the PCT Board as required.

Annex 1: Lead areas

Lead (*and support staff)*	**Area**
Chris Kenny, Director of Public Health	Health and Wellbeing Board and Strategy Safer Nottinghamshire Partnership Safeguarding Improvement Board
John Tomlinson, Deputy Director of Public Health *Lindsay Price* *Helen Scott* *Heather Lindsay* *Jenny Charles-Jones* *Jo Hopkin* *PH I&I (county wide)* *David Gilding* *Kristina McCormick*	**Nottingham West and Nottingham North and East CCGs with the following county lead areas:** Long term conditions (diabetes, retinopathy screening, health checks, Renal and COPD) Tobacco control End of Life Information and Intelligence (EMPHO, Dr Foster etc) Evidence for CCG authorisation JSNA Sustainability agenda **Provider interface with Nottingham University Hospitals and County Health Partnership**
Barbara Brady *Tammy Coles* *Lynn Robinson* *Nick Romilly* *Jade Poyser* *Tristan Poole* *Tanya Makins* *Jenny Pilmore* *(Sarah Theaker SpR)*	**Mansfield & Ashfield CCG and Ashfield & Mansfield District Councils with the following county lead areas:** Obesity / diet / physical activity (adult and children), community nutrition Oral Health, including dental public health services Fluoridation Mental Health / LD (adults and older people but not CAMHS); public mental health services All aspects of substance misuse (including former DAAT role); offender health, prison health, violence prevention (including Domestic violence), promotion of community safety Workplace health **Provider Interface with Sherwood Forest Hospitals NHS Foundation Trust (and Nottinghamshire Healthcare Trust led by City PH)**
Jonathon Gribbin *Libby Lomas* *Sue Coleman* *Kathy Holmes* *Jill Burn* *Debbie Brown* *Rachel Toplis* *Wendy Walker* *Sally Bird*	**Principia, Rushcliffe CCG and Rushcliffe, Broxtowe and Gedling Borough Councils with the following county lead areas:** PH input into NHS financial assurance, including planned care and non elective care Programme budgeting Integrated Pollution Prevention and Control Health Protection, including management of incidents and emergencies Community Infection control including TB strategy, Blood borne viruses Emergency Planning Pandemic Flu
Kate Allen *Tracy Burton* *Sally Handley* *Ann Berry* *Sarah Everest* *David Pearce (SpR)*	**Newark and Sherwood Health CCG and Newark & Sherwood District Council with the following county lead areas:** Children and Young People (including CAMHS); Maternity (not screening), Healthy schools, Disabled children, Breast feeding, health visitors, safeguarding children, Sexual Health (including sexual health services,

	GUM, Chlamydia testing, HIV, teenage pregnancy, SARC, TOP) Maternal and childhood Screening programmes (including antenatal and neonatal screening e.g. neonatal hearing, Down's, Childhood screening programmes) Prevention of birth defects Cancer screening (of Cervix, Breast, Bowel) AAA screening
Penny Spring *NHS NC Staff:* *Iolanda Shaker* *Gina Policelli* *NHS Bassetlaw staff:* *Cheryl George* *Susan March* *Helen Houghton* *Sonya Clark* *Jenny Harding* *(Dean Wallace SpR)*	**Bassetlaw CCG and Bassetlaw District Council with the following county lead areas:** Accidental injury prevention Vaccination and Immunisation programmes (including childhood V+I, seasonal flu, pneumococcal, HPV)
Mary Corcoran *Gill Oliver* *Nikki Hughes* *Cheryl George (PT)* *Vicky Wright* *(Shade Agboola SpR)* *(Shazia Ahmad SpR)*	**The following county lead areas:** Older People (including Stroke, osteoporosis, falls); excluding OPMH, but including Dementia; seasonal mortality NSF Long Term Neurological Conditions, including physical disability and sensory impairment Continuing Care Cancer policy; prevention and early diagnosis EMSCG PH support for regional Cardiovascular Network
Cathy Quinn *Nicola Lane*	**Link to Local Authorities** All NHS and PH outcomes (coordinating role) Health and Wellbeing Strategy Principal liaison role with LA members Pharmaceutical Needs Assessment Support for other Consultants on specific projects
Tracy Gaskill	**Link to all CCGs** PH Business Plan MOU between PH and the CCGs PH development PH communication Management of all admin staff PH business management (CMO cascades, PH standards, PH part of Assurance framework, PH Risk Register) NICE Guidance – coordination of PH implementation Support for Consultants on specific projects
Vanessa McGregor	Health protection – detail to follow

APPENDIX G – WORKFORCE DEVELOPMENT PLAN

Public Health Workforce Development Plan
October 2011 – March 2013
Working Document[3]

Introduction

This Workforce Development Plan has been developed to support staff through the changes to Public Health as it prepares to transfer from the NHS to the Local Authority (LA).

The interventions have been identified to ensure that staff are equipped to take on new ways of working and to move into a new culture taking on new roles and responsibilities. The overall ethos behind the plan is to build staff confidence and to identify and affirm existing strengths and skills.

It is recognised that there will be key phases where staff will need more focused support when preparing to transfer to new bases or when teams need additional support to reprioritise their activities or adjust their approach to ensure priorities and goals are achieved.

Target audience

Public Health and Local Authority staff

Interventions:

Title	Activity / Purpose	Target audience	Owner	Date
Induction and welcome	To introduce the teams from PH and LA. Welcome staff to the LA Develop an understanding of the LA structure and ways of working	Consultants and their teams LA officers and their teams	Cathy Quinn	From 19 September (Mon/Weds)
Team development	To develop ways of working with new team members Agreeing priorities for delivery Agree training and workforce needs for 12/13	DPH and his team Consultants and their teams	Tracy Gaskill	From 14 Oct – 19 December 2011
Indicative workforce programme – to be confirmed after team development sessions				
The role of Public Health within the Local Authority	To develop an in-depth understanding of the role of PH within the LA contained within the memorandum of	Consultants and their teams LA officers and	Cathy Quinn	From January 2012

[3] Please note this document will be amended constantly to reflect the training and workforce needs of the team

	understanding	their teams		
The role of Public Health within the NHS and Clinical Commissioning Groups	To develop an in-depth understanding of the roles and responsibilities PH with each CCG contained within the memorandum of understanding	Consultants and their teams. Chief Operating Officers	Tracy Gaskill	From January 2012
Financial assurance: supporting cultural change	To maintain support to NHS and LA delivery of financial targets.	Consultants and their teams	Tracy Gaskill	From January 2012
Leading and supporting cultural change and health and well-being	To support individuals and teams in responding positively to change and establishing new ways of working	Consultants and their teams LA officers and their teams	Tracy Gaskill	From January 2012
Programme Management Office (PMO)	To ensure delivery of targets and priorities by developing in depth understanding and skills in project management	Consultants and their teams	Tracy Gaskill	From January 2012

Performance and Development Reviews

This Workforce Development Plan is based on the existing commitment that all staff have Performance Review and Development meetings. In a period of considerable change it is as important, if not more so, that all staff have up to date Performance and Development Reviews, firstly, to ensure that individuals and teams are supported and focused during transition; and secondly, to ensure that there is a smooth handover of objectives and development needs to the new employer.

There is a requirement for all staff to have had a one to one with their Line Manager by 1 October 2011 to discuss individual training needs and agree directorate and personal objectives.

Communications

The successful execution of the plan is dependent on effective and timely communication. A communications work plan has been developed and will run concurrently with this plan.

Costs / Resources / capacity issues

It is anticipated that NHS workforce development resources will be severely stretched from 1 April 2011 with the loss of members of the team to new organisations or as part of the voluntary and compulsory redundancy schemes.

The Associate Director of Public Health Development will lead the delivery of the plan working with all PH consultants and line managers both in the NHS and LA.

APPENDIX H – COMMUNICATION PLAN

Public Health

Communications Work Plan
1 August 2011

Contents:

Key to colours used:

	Red rated – should have raised an exception report at some stage and forwarded to the accountable officer
	Amber rated – of concern but corrective action in place to ensure meet deadlines
	Green rated – on track

Version record:
V1.0 issued 08.08.2011
Document owner: Tracy Gaskill, Associate Director of Public Health Development

This document should be read alongside the Local Government & Health Transition Communications & Engagement Planner (available from NHS Nottinghamshire County Communication and Engagement Team).

1. **Communication with Staff**
   Lead manager: Tracy Gaskill, Associate Director of Public Health Development

Activity	Milestones or targets	Lead officer	Start date	End date	RAG rating
Director of Public Health meetings with all staff	Staff are aware of transition and options for choosing base and new ways of working (building on consultation with all staff see Appendix 1)	Tracy Gaskill	01.08.11	01.10.08	**G**
One to one meetings with all staff to determine personal needs and commence PDR process	To ensure staff have their needs identified and, if possible, met. To set objectives in line with the PCT and LA strategy and to develop new ways of working. Please refer to Workforce Development Plan	Line Managers	01.08.11	10.09.11	**A**
Presentations to Staff Side	To agree involvement and present emerging themes from one to ones Meet bi-monthly or as required	Tracy Gaskill	September 11	March 13	**A**
Use existing internal news channels and supervision structures to disseminate information	Ensure all staff are aware of the transition plan, including national policy and local implementation and key developments including governance arrangements and Human Resources changes	Line Managers	06.06.2011	ongoing	**G**
Induction pack to all staff	To ensure that all staff have written information on LA policies and procedures	Nicola Lane	21.09.11	31.10.11	**A**
Senior Management	Monthly meeting with updates from	Jo Stewardson	August 2011	Ongoing -	**A**

Activity	Milestones or targets	Lead officer	Start date	End date	RAG rating
Team and Team Briefing	line managers on staff engagement and communication Team brief issued to all staff and stakeholders 24 hours after the meeting - capturing all key points			monthly	
Policies and procedures alignment to LA	Awaiting national HR Framework Memorandum of Understanding to be issued to all staff	Nicola Lane	01.10.11	March 2012	**R**
Programme Management Office (PMO)	Establish PMO for all consultants and portfolios reporting to LA and NHS	Tracy Gaskill	01.04.12	Ongoing	**R**

2. Communication with Local Authority Senior Officers and Elected Members

Lead Manager: Cathy Quinn, Associate Director of Health and Wellbeing (HWB)

Activity	Milestones or targets	Lead officer	Start date	End date	RAG rating
Director of Public Health member of Corporate Leadership Team	Awareness of policy directives and Public Health England	Cathy Quinn	03.08.11	March 2012	**A**
Health and Wellbeing Board (HWB)	Governance and meetings arranged to take over statutory reporting for Public Health with communication to stakeholder in written and electronic formats	Cathy Quinn	03.08.11	Ongoing	**A**
Introduction meetings with elected members, managers and practitioners in the county council & seven districts ensuring they are aware of and understand PH transition, role of HWB & strategy development	Elected members, managers and practitioners across Nottinghamshire understand the implementation plan, role of HWB & are aware of the development of the Health & Wellbeing strategy (HWS).	Cathy Quinn	20.09.11	March 2012	**A**
Regular briefings with elected members managers and practitioners as required	Elected members across Nottinghamshire understand the HWB implementation plan and are involved in the development of the HWS.	Cathy Quinn	03.12.11	Ongoing	**A**

3. Communication with NHS and health partners

Lead manager: Tracy Gaskill, Associate Director of Public Health Development

Activity	Milestones or targets	Lead officer	Start date	End date	RAG rating
Publish news items from SMT team brief	To ensure awareness across the community of public health transition and functions	Tracy Gaskill	June 2011	July 2011	G
Consultants in Public Health aligned to Clinical Commissioning Groups	At least monthly attendance at various forum in the CCG	Consultants	01.08.11	Ongoing	A
PH consultant policy leads	Consultants meetings with secondary and primary care clinical leads to ensure key messages on transition are understood and clear links are forged to deliver on policy agenda	Consultants	03.09.11	Ongoing	A
PH leadership and engagement within Clinical Commissioning Group Boards & Executives	Meeting with Chief Operating Officers and CCG Board to outline developments and identify priorities or challenges	Tracy Gaskill	03.09.11	March 13	A
PH leadership and engagement with Clinical Executives	Meeting with Medical and Clinical Directors across all sectors	Chris Kenny	03.09.11	March 2012	R

Activity	Milestones or targets	Lead officer	Start date	End date	RAG rating
Transfer of PH functions	Meeting with PCT directorate leads for: Information and Performance Contracting and Procurement Finance Communications Workforce and HR Governance and Quality DPH member of Transitional Governance Project Board	Chris Kenny	03.09.11	March 13	**A**

4. Communication with the Public
Lead Manager: Cathy Quinn, Associate Director of Health and Wellbeing

Activity	Milestones or targets	Lead officer	Start date	End date	RAG rating
Briefings with public within county council & districts on specific topics as needed	To inform the public of key policy areas and their role in a securing a healthier Nottinghamshire	Cathy Quinn	01.11.11	Ongoing	**R**
County Council newsletters	To update Nottinghamshire residents in public health developments	Cathy Quinn	01.04.12	Ongoing	**R**

Progress report

Since January monthly team briefs have been issued to all staff detailing the transition and policy updates. Line managers have cascaded this to monthly team meetings and held one to ones, with transition and new ways of working being a standing item for discussion.

August 2011

During August 2011 the Director of Public Health held four briefing sessions and all available staff attended at least one. This discussed transition and new ways of working. At the same time, line managers held one to ones with their staff and identified any individual needs regarding terms and conditions. In September the PH Senior Management Team collated the views to determine the next stage of communication. These findings will be presented the findings to staff side for consideration and comment.

Appendix 1

Public Health Consultation with Staff

As part of the 30 day consultation on the restructure of NHS Nottinghamshire County all public health staff attended briefing meetings with the Director of Public Health and had one to ones with their line manager. Meetings were held during May and questions and answers collated and issued to all staff as below:

Suggestions for Titles	Public Health Manager and Senior Public Health Manager Alternatives suggested: Public Health Associate, Worker, Practitioner Should there be one title for all, irrelevant of grade for flexibility?
Voluntary Redundancy Scheme	Can the timescale be stretched so staff can make an informed decision after slotting in has happened?
Accommodation	The County Council are currently reducing their number of buildings. With regard to PH moving into a CC building, either County Hall at West Bridgford for the south and Meadow House in Mansfield for the north is being proposed. Anyone requiring a move of base will receive protected mileage for 4 years.
Bassetlaw	Bassetlaw PH staff are not included within the numbers on the structure. Bassetlaw staff are line managed by a member of staff employed by NHS Nottinghamshire County. Bassetlaw staff will possibly be seconded into PH within the Council.
DAAT	The members of staff currently working within the DAAT are included within the numbers on the structure. DAAT will be fully integrated into PH in the future and will not be separate.
WTE vs Headcount	The numbers on the PH structure are head count not WTE. It is assumed that if you work part time now, you will continue to work part time in the new structure if your post is included. If moved over to GP consortia, this information needs to be clarified as their structures are listed as WTE posts.
Locality Work	This will not continue in the future as there will not be a sufficient number of staff to continue this.
Downgrading	There is a minimal amount of downgrading of posts within PH.
Partnership working	This will continue
Slotting in	The consultation period ends on Tuesday 7th June. The PH SMT are meeting on Wednesday 8th June and will discuss the posts that are able to slot in.
Job descriptions	Within PH these will remain the same apart from slight tweaks to include some commissioning elements.
Additions to PH	Infection Control and Emergency Planning will be part of Public Health as they are moving from Governance.
Number of consultants – Thought of as top heavy	This is to remain the same as guidance has been given from a national level to not lose any consultants during this restructure.
HPA Consultant	There is no clarity on where this consultant will sit at local level.
Current number of posts	Do not focus on the number of posts currently in place and what there is in the future; other opportunities will become available throughout the other organisations.
Response to PH White Paper	A command paper is due to be issued on 12 July.

APPENDIX I - IMPLEMENTATION ACTION PLAN (2011 – 13) Subject to Further Amendment

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
Maintenance of PH Functions				
Health Promotion				
Maternal and childhood Screening programmes (including antenatal and neonatal screening e.g. neonatal hearing, Down's, Childhood screening programmes)	Establish Strategic Commissioning Group to oversee all programmes and developments Review newborn blood spot screening programme	KA KA	Mar 2012 Mar 2012	Ideally requires national solution due to risks in these programmes.
Prevention of birth defects	Implement NSC FASP 18 – 20 week foetal anomaly scan standards	KA	Mar 2012	Sonographer capacity to deliver Standards being reviewed to identify areas of compliance and non compliance
Cancer screening (of Cervix, Breast, Bowel)	NHSCSP – complete lab reorganisation. Implement HPV triage. Implement HPV test of cure. Implement bowel cancer screening age extension.	 KA KA KA	 Mar 2012 Mar 2013 Mar 2012	Lab transfers complete –staff restructure to take place. HPV triage – meetings planned with labs, awaiting technology assessment to progress Cancer Reform Strategy national directive to extend age up to 75 years.

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
AAA screening	Implement AAA Screening as per NHS Operating Framework	KA	Oct 2011	Implementation must commence immediately otherwise key dates will be missed and it be deferred for a year
Diabetic Retinopathy Screening	Ongoing monitoring of the Diabetic Retinopathy screening service, inc. quality assurance standards and reporting to meet national standards / achievement of 100% of population eligible screening are screened. Undertake monitoring and audit of equipment, grader/screener performance. Implement the new version of software including GP2DRS. On completion of DRS service review provide report of outcomes with recommendations for future commissioning.	JT JT JT JT	Ongoing Mar 2012 Mar 2012 Jan 2012	Ongoing monitoring of the DRS programmes is required to ensure all eligible patients are screened and national quality assurance standards and targets are met GP2DRS is a nationally developed and approved automated software package to transfer the data for all patients with diabetes from the GP practice to DRS programmes in a more efficient, effective way and ensuring the database is as up to date an accurate as possible The report will provide recommendations to inform future commissioning when PCTs cease to exist in 2013

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
Health Check Programme	Implement action plan in Nottinghamshire County to complete full roll out by 2014 – 15 (Years 3-5) of the health check programme for the remainder of the eligible population aged 40 – 74. Monitor the key performance indicators identified for the health check programme as part of the national data set standards in terms of the health check assessment and lifestyle interventions. All practices participating in NHS Bassetlaw. Actions include supporting practices to improve on take up rates, carrying out audit of process, particularly in terms of recording and which groups are not accessing the checks. Review use of TCR tool.	JT JT JT / PS	Mar 2013 Mar 2012 Mar 2012	Mandatory national programme. Requirement to meet SHA and DH Performance monitoring targets. Focussed approach to continue until Mar 2012. Thereafter full roll out expected between April 12 to Mar 15.
Obesity / diet / physical activity (adult and children), community nutrition Oral Health, including dental Public Health services Fluoridation promotion of community safety Workplace health	Ongoing implementation of the agreed children and adult obesity pathways, including: • Implementation of the national NCMP programme • Achievement of coverage targets Achieve sign up from at least 10 new organisations to 'Well-being at Work' identifying 30 health champions, and	BB / PS PS	Review Mar 2012 Mar 2012	Dependant on CCG willingness as obesity budget currently in scope of CCGs, although in future will be part of PH allocation.

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	develop a workplace specific website.			
Tobacco	Develop and Implement the multi-agency Tobacco Strategy, including: • Planning and commissioning the four week quitter target 2011/12 • Performance monitoring of providers inc. QIPP/CQUIN • Normalising smoke free lifestyles e.g. 'Go Smoke free' • Communication • Education and brief intervention training of smoking cessation service providers.	JT	Review Mar 2013	Trajectory and target agreed by SHA. Providers commissioned to deliver target. Monthly monitoring established through the four week quitter group. Lead the Joint county and city group, the Strategic tobacco alliance group (STAG), the Smoking at time of delivery group, the children and young peoples smoking and tobacco group.
Healthy Ageing	Support the development of healthy ageing and promotion of independence agenda across the county, including Excess Winter Deaths work on Healthy Housing and Nottinghamshire Affordable Warmth Strategy.	MC	Mar 2013	Early Intervention and Prevention Board set up
Health Services				
Children and Young People (including CAMHS); Maternity (not screening) Healthy schools	<u>Maternity & Newborn</u> Breastfeeding UNICEF BFI (Quality Standard) to be transferred to providers	KA	Mar 2012	National standard accreditation of providers – in progress

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
Disabled children Breast feeding Health Visitors Safeguarding children Sexual Health (including sexual health services, GUM, Chlamydia testing, HIV, teenage pregnancy, SARC, TOP	Work with providers to increase breast feeding prevalence at 6-8 weeks Increase number of women booked for maternity care by 12 weeks gestation to ensure optimum care/ reduce complications	KA KA	Mar 2013 Mar 20 13	Vital Sign Indicator SQU19 – in progress Vital sign SQU12 – in progress
	<u>CAMHS Strategy</u> Complete and implement through Joint Strategic Commissioning Group	KA	Mar 2012	In Progress
	<u>Community Paediatrics</u> Complete community paediatric service reviews across Nottinghamshire.	KA	June 2012	In Progress
	<u>Health Visitor Implementation Plan</u> Develop creative commissioning solutions to deliver the HV Implementation Plan. Undertake partnership work to jointly commission Family Nurse Partnership.	KA	Mar 2013	In Progress
	<u>Disabled children</u> Complete and implement Joint Commissioning Strategy - Disability & Special Educational Needs Implement successful pilot projects – rapid access physiotherapy, integrated community nursing.	KA KA	Mar2012 Mar/Apr 2012	In Progress

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	Sexual Health Work with providers to ensure Integrated Sexual Health Service Offer Termination of Pregnancy: Review provision to ensure QIPP target is realised and ensure equitable and early access. Chlamydia**:** Ensure opportunistic testing is occurring within core clinical services. (GPs/ CaSH/GUM)	KA KA KA	Mar 2013 Mar 2013 Mar 2013	Work towards National Strategy QIPP Vital sign
Long Term Neurological Conditions	Launch & implement the integrated LTNC pathway, including: • specialist nurses utilisation & integration • Review of LTNC related services and tariffs • Development of wider LTNC related network	MC	Review Mar 2012	
Long term conditions: Diabetes	Coordinate the Nottinghamshire Diabetes Strategic Network and implement the action plan including: • Data collection, presentation, monitoring and performance management against key indicators at PCT and PBC/CCG level • Launch joint diabetes guidelines • Implement care pathway to ensure specialist time is appropriately utilised,	JT	Mar 2013	Ongoing Ensure consistent equitable management of care for all patients with diabetes in line with national guidance in both primary and community care

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	reducing out-patient 1st to follow-up ratio and LOS. Co-ordinate the Bassetlaw Diabetes network and implement action plan including • Review paediatric services and implementation of enhanced tariff • Increase levels of community support • Improve prescribing practice • Improve access to structured education programme for both Type 1 and Type 2 and enhance self care • Improve inpatient care through Think glucose and patient passport	JT / PS	Mar 2013	
Heart Failure	Develop & Implement the Nottinghamshire Health Failure pathway, including: • Business case and pathway for BNP test business case. • Pilot study to review the Integration of Heart failure Rehabilitation with Pulmonary rehabilitation • Monitoring of the key performance indicators to support the reduction of admissions and readmissions to hospital and improve the quality of care for people with heart failure.	JT	Mar 2013 Mar 2012 Jan 2012-April 2012 Ongoing	B-type natriuretic peptides (B-NP) is an approved test for diagnosing heart failure.

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	• Increase access to rehabilitation for heart failure patients including physical activity.	JT / PS	Mar 2012	
COPD	Coordinate the multi-agency COPD Network and implement the COPD pathway including: • Monitoring of the key performance indicators • Monitoring of Home Oxygen Service (HOS) inc Serious Untoward Incidents • Co-ordination of LTC Programme • Plan, commission and performance monitor relevant non NHS Contracts • Co-ordinate the Bassetlaw Network and implement the action plan including further improvements to rehabilitation services, build on the Know It Check it Treat it campaign carried out to identify people with COPD, improve quality of COPD care within primary care through support for spirometry training	JT JT / PS	Mar 2013 Mar 2013	Local groups established in each CCG. Monthly monitoring by PMO. Ongoing monitoring by the COPD Strategic Network HOS Validation & Concordance processes established. Regional Recommendations agreed locally. Procurement for regional contract ongoing.
Older People	Implement the Older People work programme including: • Review of reablement options for older people • Appropriate balance of residential and	MC MC	Mar 2012 Apr 2012	Evaluation of current re-ablement schemes underway and due by March 2012. Actions to be agreed following results of the Utilisation Review - Draft results

Action	Key Actions for 2011-13	Lead	Date	Comments/progress

	community intermediate care provision
	• Implement NICE guidance related to falls and osteoporosis
	  • Identification of fallers by ED
	  • Training to care homes in partnership with NCC
	
	Submit application for RIF for ESD for Hip Fractures
	
	• Develop robust plans for coordinated community services to care homes for CCGs.
		
		MC
		
		MC
		
		MC
		
		MC
			
			Mar 2012
			
			Mar 2013
			
			Review Mar 2012
			
			Sept 2012
				expected end November 2011
				
				Awaiting confirmation from NHIS that this has been made available. Risk that ED staff won't actively identify patients.
				
				Training session have been well attended and well evaluated

End of Life Care	Implement the End of Life Care (EoLC) pathway including: • Review of existing and pilot services • Implementation of new policy for EoLC registration and re-launch coordination services • Pilot EoLC cohort pathways modelling tool. • Ongoing implementation of "Let's Talk" initiative.	JT JT JT JT JT	Mar 2013 Mar 2013 Apr 2012 Apr 2012 March 2014	In progress Proposal tabled for December 2011 PEC Commenced October 2011 (Newark & Sherwood, Principia) Compassionate Communities scoping exercise commenced October 2011, for completion Jan 2012
Mental Health / LD (adults and older people (not CAMHS); Public mental health services	Complete MH in-patient rehabilitation utilisation review and support implementation of subsequent recommendations, including development of patient care pathway and associated service specifications.	BB	Nov 12	In progress

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	Develop MH strategy for Nottinghamshire.	BB	June 12	To commence shortly, with work with City colleagues to ensure consistency.
	Complete autism needs assessment and secure support for recommendations	BB	Nov 11	In progress
	Support the implementation of the improvement plan for LD, including increased uptake of LD annual health checks in the community.	BB	Mar 2013	
All aspects of substance misuse (SM) (including former DAAT role); Offender health, prison health Violence prevention (including Domestic violence),	Establish substance misuse services in the 3 prisons based on SM needs assessment as per NTA timescales	BB	June 2012	In progress
	Undertake comprehensive SM needs assessment for treatment/recovery and harm minimisation services in the community and implement recommendations	BB	Commence Jan 2012	Ongoing
	Commission integrated community based SM services for adults	BB	Sept 2012	In Progress
	Ongoing contractual management of SM contracts.	BB	Nov 2011	In progress
	Develop and deliver rolling programme of HNA for the prisons including taking	BB	April 2012	Analytical capacity is critical for this

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	forward associated recommendations. (need to ensure Autism and LD included in this, and subsequent HNAs to include SM) Work with NCC to align approach to Domestic Violence.	 BB	 Apr 2013	
Health Protection				
Vaccination and Immunisation programmes (including childhood V+I, seasonal flu, pneumococcal, HPV)	Ongoing implementation of Vaccination & Immunisation programme to improve performance & achieve herd immunity, including: • Commissioning of school based school leaver immunisation programme to improve uptake rates. • Programme to encourage GP practices to support vaccination uptake improvement. • Season flu campaign including Health Care Worker uptake. • HPV vaccination programme • Implementation of a social marketing programme	PS	Mar 12	Some segments of the population reluctance to immunise children
Health Protection, including management of outbreaks of infectious disease Community Infection control including	Maintain plans and capacity to respond to outbreaks through transition period. Monitor the implementation of the TB policy and ensure recently implemented	JG JG	Mar 2012 Mar 2012	

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
TB strategy, Blood borne viruses Pandemic Flu Integrated Pollution Prevention and Control	service specification delivers intended outcomes. Address opportunities highlighted by the East Midlands Hep C Working Group and the Nottinghamshire wide Hepatitis Group	 JG	 Mar 2012	
Emergency Planning	Review and Implement the Emergency Planning programme including: • Development of Nottinghamshire wide emergency plans (inc. Bassetlaw and City.) • Review and testing of command and control systems. • Maintenance of training	JG	Mar 12	City and County teams have merged for emergency planning. Emergency Plans must include actions identified from risk assessments at national/sub-national and local levels in line with future DH guidance (post October 2011), including health implications of severe weather, major fires, significant transport incidents, industrial action and civil unrest.
Appropriate management of resources				
Budget management and setting baseline for PH grant	Map & review expenditure related to PH programmes including baseline submission to SHA Manage the PH budget and monitor expenditure and QIPP savings.	CK CK	Sep 2011 Mar 2012	
PH input into NHS QIPP initiatives beyond CCGs: Planned & unplanned care Programme budgeting	Develop and monitor policies to secure evidence-based affordable clinical thresholds (e.g. PLCV, cosmetics)	JG	Mar 2012	

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
	Provide public health input to acute provider contracts, in response to assessed need.	JG	Mar 2012	
Information and Intelligence (EMPHO, Dr Foster etc)	Undertake review of PH information requirements and implement findings.	JT	Mar 2012	
JSNA	Review of JSNA for Nottinghamshire.	JT	Mar 2012	
Transition				
Transfer of PH function to LA	Implement PH transition plan	CQ/ TG	Nov 2011	
	Review requirements for PH support functions including performance monitoring of targets, contracts management and integrate these within the Local Authority as appropriate.	CQ / TG	Mar 2013	
PH business management (CMO cascades, PH standards, PH part of Assurance framework, PH Risk Register)	Develop and implement PH Business Plan including: • Monitoring of implementation plan • Maintenance of risk register • Development & review of MOU with CCGs and LA • Implementation of workforce plan • Implementation of communication plan	TG TG/CG	Mar 2012 Nov 2011	

Action	Key Actions for 2011-13	Lead	Date	Comments/progress
All NHS and PH outcomes (coordinating role)				
Health and Wellbeing Board (HWB)	Develop & review the forward programme and development needs for the HWB.	CQ	Mar 2013	
Health and Wellbeing Strategy (HWS)	Develop HWS for Nottinghamshire	CQ	Mar 2012	Update report to go to November HWB
Support for other Consultants on specific projects	Review mental health services and make recommendations for implementation	TG	Nov 2011	
	Develop commissioning policy for fertility preservation	CQ	Mar 2012	
NICE Guidance – coordination of PH implementation	Establish process for the co-ordination of PH NICE guidance including consultation, dissemination and implementation planning.	TG	Mar 2012	
Pharmaceutical Needs Assessment (PNA)	Review PNA and publication of supplementary statement.	CQ	Feb 2012	