Public Health Transition in Bath & North East Somerset

Appendices for the Assurance Plan

22 March 2012

Appendix 1 – Summary of key public health transition policy papers

NB: This summary was formally reported to the Health and Wellbeing partnership Board, Change Programme Board and Public Health Transition Group and more informally circulated amongst a wider range of partner departments and organisations during January and February 2012.

January 2012 update, Based on Latest Department of Health guidance
http://healthandcare.dh.gov.uk/public-health-system/

Headlines

Local authorities will take the local lead for:
- improving health
- coordinating local efforts to protect the public's health and wellbeing
- ensuring health services effectively promote population health

Public Health England will:
- deliver health protection and intelligence services
- support the public through social marketing
- lead for public health by building the evidence base and relationships
- support the development of the specialist and wider public health workforce

NHS will:
- continue to play a full role in providing care, tackling inequalities and ensuring every clinical contact counts

Chief Medical Officer will:
- continue to provide independent advice to the Secretary of State for Health and the Government on the population's health

Department of Health will:
- set the legal and policy framework, secure resources and make sure public health is central to the Government's priorities.

Public Health in Local Government

The Government is returning responsibility for improving public health to local government due to their population focus, ability to shape services to meet local needs, ability to influence wider social determinants of health and ability to tackle health inequalities. Their aim will be to create healthier communities.

Having taken on the key role in promoting economic, social and environmental wellbeing at the local level, local government is ideally placed to adopt a wider wellbeing role.
In all they do, local authorities will want to ensure the health needs of disadvantaged areas and vulnerable groups are addressed, as well as giving consideration to equality issues. The goal should be to improve the health of all people, but to improve the health of the poorest, fastest.

The role of the Cabinet lead for health within the council is critical, but there needs to be a much broader engagement in this agenda among all local political leaders.

DH will publish a Public Health Workforce Strategy, accompanied by a formal public consultation. This will include options for how public health knowledge can best be embedded across the wider workforce. The new arrangements will provide opportunities and challenges for employers, including the wider local authority workforce.

Mandatory steps

DH set out some areas that require greater uniformity of provision or are a duty delegated by the Secretary of State for Health to local government and therefore need to be mandated. These are:

- a duty to ensure there are plans in place to protect the health of the population
- ensuring NHS commissioners receive the public health advice they need
- appropriate access to sexual health services
- the National Child Measurement Programme
- NHS Health Check assessment.

The net result of these steps will be that local authorities have key responsibilities across the three domains of public health – health protection, healthcare public health and health improvement.

Although there had been signals to mandate elements of the Healthy Child Programme 5-19, this is not going to happen for 2013. Consideration is being given to the future models of delivery.

The role of the Director of Public Health

Each authority, acting jointly with the Secretary of State for Health, must appoint an individual to have responsibility for its new public health functions, known as the Director of Public Health. That individual could be shared with another local authority where that makes sense.

New guidance on appointments to existing Director of Public Health vacancies and transfer to local government, has been published by DH and LGA.
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132048.pdf
Subject to Parliament, DH will add Directors of Public Health to the list of statutory chief officers in the Local Government and Housing Act 1989. After Royal Assent, DH intend to issue statutory guidance on the responsibilities of the Directors of Public Health, in the same way that guidance is currently issued for Directors of Children's Services and Directors of Adult Services.

DH say that the organisation and structures of individual local authorities is a matter for local leadership, by that they are clear that these legal responsibilities should translate into the Director of Public Health acting as the

lead officer in a local authority for health and championing health across the whole of the authority's business.

DH would expect there to be direct accountability between the Director of Public Health and the local authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.

The Director of Public Health will be the person elected members and other senior officers will consult on a range of issues, from emergency preparedness to concerns around access to local health services. He/she will be able to promote opportunities for action across the "life course", working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues.

The Director of Public Health will work with local criminal justice partners and the new Police and Crime Commissioners to promote safer communities. And he/she will engage with wider civil society to enlist them in fostering health and wellbeing.

In short, the Director of Public Health will be a critical player in ensuring there are integrated health and wellbeing services across the locality. With regard to the ring-fenced grant, formal accountability rests with the Chief Executive of the local authority, but we would expect day-to-day responsibility for the grant to be delegated to the Director of Public Health.

Commissioning responsibilities

Local authorities will be responsible for commissioning the services below. The list is not exclusive. Local authorities may choose to commission a wide variety of services under their health improvement duty.

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes

- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

DH are now proposing that abortion should remain within the NHS and be commissioned by clinical commissioning groups. A consultation on this revised recommendation starts soon. Responsibility for sexual assault services, including SARCs, rest with the NHS Commissioning Board.

Early diagnosis programmes for cancer will be a responsibility of both Public Health England and the NHS Commissioning Board.

The NHS Commissioning Board will be accountable for delivery of the national screening and immunisation programmes. Public Health England will provide public health advice on the specification of national programmes, and also a quality assurance function with regard to screening. Directors of Public Health will provide challenge and advice to the NHS Commissioning Board on its performance, for example through the joint strategic needs assessment and discussions at the health and wellbeing board.

Only some of the above services are to be mandated (see previous section above).

The commissioning of other services will be discretionary, guided by local results from the Public Health Outcomes Framework, the local joint strategic needs assessment and the joint health and wellbeing strategy.

Children under five

In the first instance, the NHS Commissioning Board will lead the commissioning of public health funded services for children under five, including health visiting, the Healthy Child Programme and Family Nurse Partnership.

DH aim to unify responsibility for these services within local government by 2015 when the increased health visiting workforce and new health visiting service model and the Healthy Child Programme offer to families should be in place.

In line with this direction of travel, we are also transferring responsibility for commissioning effective Child Health Information Systems to the NHS Commissioning Board, also to be funded by the public health budget.

This decision will be reviewed in 2015 to determine longer-term plans. We will engage further on the detail of these proposals, particularly in respect of transition arrangements and the best way to begin to involve local authorities in local commissioning of these services in partnership with the NHS.

In the meantime, Public Health England will retain a close interest in the specification of Child Health Information Systems, to ensure public health requirements, such as accurate and effective collection on the delivery of childhood immunisations, are met.

Emergency preparedness

New guidance on the Local Resilience Forum (LRF) is provided, with a lead Director of Public Health from a local authority within the LRF area coordinating the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area.

Public Health England will continue to provide the health protection services, expertise and advice currently provided at an LRF level by the Health Protection Agency.

The NHS Commissioning Board will appoint a lead director for NHS emergency preparedness and response at the LRF level, and provide necessary support to enable planning and response to emergencies that require NHS resources.

Local Health Resilience Partnerships (LHRPs) will bring together the health sector organisations involved in emergency preparedness and response at the LRF level. LHRPs will consist of emergency planning leads from health organisations in the LRF area and will ensure effective planning, testing and response for emergencies.

The lead director appointed by the NHS Commissioning Board and the lead Director of Public Health will act as co-chairs at the LHRP during emergency planning. Resources will be required to support the LHRP to provide continuous readiness.

DH will publish further details on the new system. DH will also produce operational guidance to support incident management at a local level, which will cover the working relationship between the NHS, Public Health England and the local authority.

Population healthcare advice to the NHS

Clinical commissioning groups (CCGs) will require a range of information and intelligence support via local authorities, other commissioning support organisations and potentially Public Health England. It is important to note that although there are some similarities in the nature of these services they will have a different focus (for example on strategic population issues on the one

hand and more clinical processes and activity on the other). These should be complementary.

Local authority public health advice to CCGs is proposed in 6 key ways:

- Strategic planning: assessing needs
- Strategic planning: reviewing service provision
- Strategic planning: deciding priorities
- Procuring services: designing shape and structure of supply
- Procuring services: planning capacity and managing demand
- Monitoring and evaluation: supporting patient choice, managing performance and seeking public and patient views

More specific guidance on public health contribution to CCGs is provided at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131902.pdf

Public Health England – Operating Model

Public Health England will have three main business functions:

1. Delivering services to national and local government, the NHS and the public
2. Leading for public health
3. Supporting the development of the specialist and wider public health workforce.

Working with local authorities

Local authorities, supported by their Directors of Public Health, are the local leaders for public health. Public Health England will not duplicate the work that they do. Instead, Public Health England will be the expert body with the specialist skills to support the system as a whole. Public Health England will carry out functions and activities that would not be practicable to replicate in each local authority. Public Health England will support local authorities in their new role by providing services, expertise, information and advice in a way that is responsive to local needs. It will support local authorities to ensure action taken is on the basis of best available evidence of what works.

Working with the NHS Commissioning Board

Public Health England will provide a public health service to the NHS Commissioning Board to support the commissioning and delivery of health and wellbeing services and programmes. Public Health England will be providing public health and population healthcare advice to the NHS Commissioning Board. It will work with the NHS Commissioning Board to ensure that the prevention of ill health and promotion of good physical and mental health and wellbeing are addressed systematically across services and care pathways. Further work will be done in 2012 to establish and publish the arrangements of how Public Health England and the NHS Commissioning Board will work together.

Public Health England's structure will have three elements:

- A national office, including national centres of expertise.

- Four hubs, coterminous with the four sectors of the NHS Commissioning Board and Department for Communities and Local Government resilience hubs, covering London, the South of England, Midlands and East of England and North of England.

- Units that deliver its locally facing services and act in support of local authorities, other organisations and the public in their area. When appropriate, units will provide coordination across several local authorities in managing incidents and outbreaks. DH clarify that Directors of Public Health are the local leaders for public health and provide a core offer to the NHS.

  Early in 2012 Public Health England will be seeking the views of local authorities, health and wellbeing board early implementers and local partners on how Public Health England can best prove its responsiveness and expert contribution to localities.

  Public Health England expect to appoint a Chief Executive designate in April 2012 to further develop and implement the operating model for Public Health England through 2012/13. Public Health England will assume full powers in April 2013.

Public Health Human Resources Concordat

PCTs and local authorities will be responsible for developing public health transition plans and consulting with their constituent trade unions and staff on these and the associated workforce plans. Key guidance and support are being developed at national level, which outline the human resources (HR) processes and expectations on PCTs, councils, NHS and local government trade unions in managing this important change.

The Public Health HR Concordat, developed by the Department of Health with NHS Employers and the Local Government Association, and in partnership with NHS and local government trade unions, has been published. This provides a best practice framework.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131111

The Concordat is followed by more detailed transition guidance as follows:

- PCT Transition Planning Guidance
- Local Government Transition Guidance. This is aimed at HR specialists in councils who will be managing the staff transfers. This will be available in January 2012.

Sender guidance is also being developed by the Department of Health, providing practical advice, templates and guidance for sender organisations to

implement the People Transition Policy(s) at local level. Items particularly relevant for primary care trusts and councils to use will be signposted.

A Public Health Workforce Strategy will also be published in early 2012, accompanied by a formal public consultation. The strategy will seek to ensure the development and supply of a future professional public health workforce for all sectors.

Public Health Outcomes Framework for England, 2013-2016

A new public health outcomes framework has been published. This still requires technical development during 2012/13 and so for that transition year the NHS Operating Framework for 2012/13 provides the headline performance measures required for public health. The public health outcomes framework is summarised below. There are clearly intended overlaps with NHS and Social Care outcomes and commissioning areas.

High level outcomes

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities.

1. Improving the wider determinants of health

- Children in poverty
- School readiness
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness *and or disability* in settled accommodation
- People in prison who have a mental illness or significant mental illness
- Employment for those with a long term health condition including those with learning difficulty / disability or mental illness
- Sickness absence rate
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime
- Re-offending
- The percentage of the population affected by noise
- Statutory homeless
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- Social connectedness
- Older people’s perception of community safety

2. Health Improvement

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- Child development at 2-2.5 years
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- Emotional wellbeing of looked after children
- Smoking prevalence – 15 year olds
- Hospital admissions as a result of self harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health check programme – by those eligible
- Self reported wellbeing
- Falls and injuries in the over 65s

3. Health Protection

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board approved sustainable development management plans
- Comprehensive, agreed, inter-agency plans for responding to public health incidents

4. Healthcare public health and preventing premature mortality

- Infant mortality
- Tooth decay in children aged five
- Mortality in causes considered preventable

- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable diseases
- Excess under 75 mortality in adults with serous mental illness
- Suicide
- Emergency readmissions within 30 days of discharge from hospital
- Preventable sight loss
- Health related quality of life for older people
- Hip fractures in over 65s
- Excess winter deaths
- Dementia and its impacts

Appendix 2 Terms of Reference - PH Transition Group

NB: These were formally agreed in June 2011 by the Public Health Transition Group and have been accepted by the Partnership Board for Health and Wellbeing.

1. Purpose

The purpose of this group is to oversee the transition of public health responsibilities from B&NES Primary Care Trust in its current form to B&NES Council and, where appropriate, to the GP Commissioning Consortium and the PCT Cluster. The group will also identify and manage risks or barriers that could negatively affect the transition. This work will include the following:

Coordination of the transition of public health responsibilities

- Propose timescales for different aspects of the transition (eg. Functions, governance, transfer of staff, budgets, etc) and seek agreement though the appropriate PCT and Council decision making processes.
- Develop a business continuity plan to ensure stability for the existing public health programmes during the period of transition.

Capacity, capability and design of future public health programmes

- Support the recruitment of a new Director of Public Health.
- Identify future public health responsibilities of existing and new organisations.
- Design a model for future public health arrangements in B&NES, showing how public health could work in the new organisational forms.
- Identify existing resources that will transfer or contribute to these arrangements.
- Identify potential gaps in resources or guidance.

Finance and resources

- Identify historic NHS and council spend on public health work streams and advise both organisations on recommended spend in future, in line with guidance as this emerges, taking in to account local financial position.
- Agree a process for identification and final sign off of budgets, spend and financial accountabilities of key partners in relation to public health programmes.
- Scope the implications for finance, HR, management, IT support and advise on the necessary capability and capacity.

Communications and marketing

- Coordinate reports to the executive teams of the Council, the PCT and the GP Consortium.
- Oversee the coordination of a consultation response to the Department of Health for the Public Health White Paper and associated documents
- Scope the implications for communications support and advise on the necessary capability and capacity.

Information and intelligence

- Scope implications for intelligence support and advise on the necessary capability and capacity.

Workforce

- Identify staff that will be involved in the public health transition process.
- Identify workforce development needs within and outside of public health to enable an optimal transition of roles.
- Develop a HR framework for secondment and transition of staff.
- To oversee the HR framework and to ensure appropriate consultation with appropriate employee/union representatives.

2. Membership

Name	Role or representation
Ashley Ayre (Chair)	Strategic Director, People and Communities, Council
Ed MacAlister-Smith	PCT Cluster CEO
Dr Pamela Akerman	Acting Joint Director of Public Health
Cllr Simon Allen	Cabinet Member for Wellbeing
Ros Brooke	Non-executive Director, Trust Board, NHS B&NES
David Trethewey	Divisional Director, Policy and Partnerships, Council
William Harding	Head of Human Resources, Council
Suzanne Tewkesbury	PCT Cluster Director of HR, Governance & Comms
Ian Orpen	GP Commissioning Consortium Chair
Paul Scott	Assistant Director of Public Health (Project Lead)
Denice Burton	Assistant Director – Health Improvement
Sarah James	Deputy Director of Finance, PCT Cluster
Tim Richens	Divisional Director, Finance, Council
Dr Mark Evans	Acting Unit Director, Health Protection Agency

The group will seek representation and advice as required from HR, finance, IT, communications, Council Legal Services and other key colleagues.

3. Meeting frequency

Meetings will be held 6 weekly during 2012/13.

4. Constitution, reporting arrangements and links

The group has no executive powers but will report monthly to the Change Programme Board of B&NES Council.

5. Interfaces

The group needs to relate to the Commissioning Support Unit scoping project, the emerging arrangements for the PCT Cluster and the GP Consortium.

6. Administration

Agenda and papers to be sent out one week before the meeting. Minutes of the meeting to be sent within one week of the meeting.

7. Review

The terms of reference will be reviewed in April 2012.

Appendix 3 B&NES - Public Health Transition – Draft Outline Plan.

Version 1, February 2012. Author: **Paul Scott**. Accountable Director: **Pamela Akerman**

Transition Issue	Accountable Director	Operational Lead	Commentary on current position
1 Ensuring a robust transfer of systems and services			
1.1 Is there an understood and agreed (PCT cluster/LA) set of arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013?	CEOs of Council and Cluster, DPH and SD People and Communities	Paul Scott	Local Transition Plans had been agreed locally but the publication of new papers by the Department of Health in December 2012 have implications that mean we will need to review local arrangements and reconsider local transition plans.
1.2 Is there a clear local plan which sets out the main elements of transfer including functions, staff and commissioning contracts for 2013/14 and beyond?	Functions – DPH Staff – HR Director of Council / Cluster Contracts – DPH	Denice Burton, Paul Scott Steve Graham Denice Burton, Paul Scott	Following the publication of key guidance by DH in the last month, a plan will now be produced. This process is part of a bigger local process looking at the transfer of all PCT staff and the commissioning stock take of contracts.
1.3 Are there locally agreed transition milestones for the transition year, 2012/13?	CEOs of Council and Cluster, DPH and SD People and Communities	Paul Scott	The key milestones have been set out clearly nationally. Many of the key issues are already underway and we are now awaiting the shadow budget to enable concrete plans to be developed.

			The B&NES Public Health Transition Group is overseeing this process.
1.4 Is there a clear local plan for developing the JSNA in order to support the H&WB strategy?	DPH and DD Policy & Partnerships	Jon Poole, Paul Scott	This process is well underway. There is a dedicated JSNA governance group with membership from CCG, Council and PCT. The work is well integrated with the H&WB Strategy process and includes members who are working on both projects. We anticipate a final JSNA document will be signed off by H&WB Partnership Board in April 2012, with a web-portal launch and a public engagement event. This will also give rise to a clear ongoing work programme that work sit alongside further H&WB Strategy work and future prioritisation and review processes.
1.5 Is there a clearly developed plan for ensuring a smooth transfer of commissioning arrangements for the services described in *Healthy Lives, Healthy People* that Local Authorities will be responsible for commissioning?	DPH	Denice Burton, Paul Scott	Following the publication of key guidance by DH in the last month, a plan will now be produced. This process is part of a bigger local process looking at the transfer of all PCT staff and the commissioning stock take of contracts.
1.6 Is there a clearly developed plan for ensuring a smooth transfer of those PH functions	DPH, SD People and Communities, HR Director	Denice Burton, Liz Price, Paul Scott	We will be working with local, regional and national partners to produce an assurance plan ready for March 2012.

and commissioning arrangements migrating to NHS CB and PHE?			
1.7 Is there local agreement on the delivery of a core offer providing LA based public health advice to Clinical Commissioning Groups?	DPH, CCG Chair, Cluster Director of Commissioning Development, DD Service Development, HR Director	Mike Bowden, Steve Graham, Ian Orpen, Paul Scott	These discussions have begun and the recent DH guidance has been a helpful resource to guide this. We anticipate having an agreement on the core offer ready for March 2012.
2 Delivering public health responsibilities during transition and preparing for 2013/14			
2.1 Is it clear how future mandated services and steps are to be delivered during transition and in the new local public health services:	CEOs of Council and PCT, with DPH		Following the publication of key guidance by DH in the last month, a plan will now be produced. We are also working closely to integrate these transitions processes in to the broader organisational changes occurring in the council and health service as they go through their own reorganisation. This provides a more robust footing for the future, but does mean plans are still in production as partners develop their own processes and structures for commissioning and delivery. We anticipate having an agreement on these programmes ready for March 2012.
a. Appropriate access to sexual health services,	DPH, CCG Chair	Daniel Messom	
b. Plans in place to protect the health of the population,	DPH and DD Risk & Assurance	Chris Williams	
c. Public health advice to NHS commissioners,	DPH, CCG Chair, Director of Commissioning Development	Mike Bowden, Paul Scott	
d. National Child Measurement Programme,	DPH	Denice Burton	
e. NHS Health Checks assessment?	DPH	Daniel Messom	

2.2 Is there clarity around the delivery of critical PH services/programmes locally, specifically: screening programmes; immunisation programmes; drugs & alcohol services and infection prevention & control?	Screening/immms: DPH and SD People and Communities Drugs and alcohol: DPH and SD People and Communities Infection control: DPH and Cluster Nursing Director	Liz Price, Paul Scott Pamela Akerman, Jane Shayler Pamela Akerman, Mary Monnington	
3 Workforce			
3. Have the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat?	HR Directors for Council and Cluster	Steve Graham and William Harding	Local commissioning staff, managers, executives and boards have been briefed regularly about updates nationally and locally for the public health transition. Informal conversations have occurred with the relevant Trade Union representatives, but as we have not yet reached the point of defining new structures or terms and conditions of transfer, we have not had more formal consultations. We are in the process of matching people to functions and identifying the destination of those functions. The recent HR Concordat has been shared with

			key officers and processes are underway to clarity the workforce elements of the overall public health transition process.
4 Governance			
4.1 Does the PCT cluster with LA have in place robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate?	DPH, HR Director, DD Legal and Democratic Services	Steve Harman, Paul Scott, Derek Thorne, Jeff Wring	Internal accountability and performance monitoring has been going through transition within the PCT cluster and the council and public health is part of that process. Arrangements for these functions in 2012/13 are the subject of forthcoming meetings and will be agreed by March 2013.
4.2 Are there robust arrangements in place for key public health functions during transition and have they been tested e.g. new emergency planning response to include: a. Accountability and governance, b. Details of how the DPH, on behalf of LA, assures themselves about the arrangements in place, c. Lead DPH arrangements for EPRR and how it works	CEOs of Council and PCT Cluster, with DPH and DD Risk and Assurance	Chris Williams	These arrangements are being developed locally alongside the still emerging national arrangements. Roles and responsibilities will be clarified by March 2012 and tested by October 2012.

across the LRF area?			
4.3 Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of SUIs/incident reporting and Patient Group Directions?	DPH and PCT Cluster Nursing Director	Pamela Akerman, Mary Monnington	To be agreed as part of overall transition plan by March 2012.
4.4 Has the PCT cluster with the LA agreed a risk sharing based approach to transition?	CEOs of Council and Cluster, with DPH	Ashley Ayre, Pamela Akerman	To be agreed as part of overall transition plan by March 2012.
4.5 Is there an agreed approach to sector led improvement?	DPH, SD People and Communities	Ashley Ayre, Pamela Akerman	To be agreed as part of overall transition plan by March 2012.
4.6 Is the local authority engaged with the planning and supportive of the PCT cluster approach to PH transition?	B&NES Joint Public Health Transition Group	Paul Scott	B&NES has a formal public health transition group which meets every 6 weeks, chaired by a Strategic Director of the council, with representation at senior level from the CCG, public health, the PCT cluster and the council. The group has an action plan and a risk register which are monitored at each meeting and reports monthly to the Council's Change Programme Board and every other month to the Health and Wellbeing Partnership Board.
5 Enabling infrastructure			
5.1 Has the PCT cluster with LA identified sufficient capability and capacity to ensure	DPH and SD People and Communities	Paul Scott	An assessment is underway and additional project management capacity will be discussed with the Council's Change Programme Board in February

delivery of their plan?			2012.
5.2 Has the PCT cluster with LA identified and resolved significant financial issues?	Finance Directors of Council and PCT Cluster	Denice Burton, Sarah James, Richard Morgan, Giles Oliver	Plan to be agreed by March 2012 A finance return to the Department of Health was made by PCTs in September 2011. It is important to remember that this return was based on actual spend in 2009/10 and differs from commissioning budgets in 2011/12 in the following respects: It reflects underspends in 2009/10 that were used to balance the overall Trust budget. It excludes investments in 2011/12, principally for Health Visiting and Health Checks. In the letter to Local Government Chief Executives on 25th November a potential cut in 'administration' staff was mentioned. This would include all staff not working directly with the public face to face. It would include the DPH, Public Health consultants, intelligence staff and those directly involved in the design of service delivery. A 30% cut in these staff, would severely reduce the ability of Local Authorities to deliver their new Public Health functions, including support to NHS Commissioners.

5.3 Has the PCT cluster with LA agreed novation/other arrangements for the handover of all agreed PH contracts?	Finance Directors of Council and PCT Cluster, with DPH	Denice Burton, Sarah James, Richard Morgan, Giles Oliver	A stock take of existing PH contracts is underway. Plan to be agreed by March 2012
5.4 Are all clinical and non-clinical risk and indemnity issues identified for contracts?	Finance Directors of Council and PCT Cluster, DD Legal & Democratic Services, with DPH	Denice Burton, Vernon Hitchman	Clinical and non-clinical risks are being identified as part of the PH Contracts Stock take. Plan to be agreed by March 2012
5.5 Are there plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer?	DPH, IT Programme Director of Council and PCT	Angela Parratt, Cathryn Poole, Helen Tapson	Discussions have begun with key people in the PCT and the council and the regionally developed Knowledge Management Transition Plan has been used to inform enquiries and will support future planning. A plan will be agreed by March 2012. Arrangements agreed by October 2012
5.6 Have all issues in relation to facilities, estates, asset registers been resolved?	DPH, PCT Finance Director, DD Property, PCT Head of Estates	David Brain, Denice Burton, Tom McBain	Plan to be agreed by March 2012, Arrangements agreed by October 2012
5.7 Is there a plan in place for the development of a legacy handover document during 2012/13?	DPH	Denice Burton, Paul Scott	Plan to be agreed by March 2012 Legacy document to be produced by January 2013
6 Communication and engagement			
6.1 Is there a robust communications plan? Does it consider relationships with the	PCT AD Communications and Corporate Affairs Council Communications &	Jonathan Mercer and Derek Thorne	Public health transition has been discussed at public engagement events, at public board meetings and at our Local Involvement Network

Health and Wellbeing Board; clinical commissioning groups and NHSCB; Health Watch; local professional networks?	Marketing Manager		(LINk). We have met with the Cabinet of the council and the Strategic and Divisional Directors Groups. A dedicated communications strategy will be developed, in parallel with communications strategies for other Council and NHS commissioning changes by March 2012 to cover the transition year 2012/13 and for April 2013 onwards. The communications strategy will include engagement events.
6.2 Is there a robust engagement plan involving stakeholders, patients, public, providers of PH services, contractors and PHE?	PCT AD Communications and Corporate Affairs Council Communications & Marketing Manager	Jonathan Mercer and Derek Thorne	

Appendix 4 B&NES Public Health Transition - RISK REGISTER

Workstream	Risk Description	Risk Likelihood 1-5	Risk Impact 1-5	Risk RAG	Risk Owner	Risk Mitigation & Intended Impact	Risk Actionee	Action Completed by
Business Continuity	Ongoing provision of support services beyond secondment regarding HR, Communication, Finance and IT	2	4	**Amber**	Ashley Ayre	PA to secure arrangements with key leads as part of overall discussions between PCT Cluster, Council, CCG, SE, etc. SJ can provide fairshare planning calculations.	Pamela Akerman	Ongoing - to be monitored.
Business Continuity	Loss of regional programme support networks (including *Healthy Weight, Healthy Lives, Healthy Schools Plus, Social Care, Alcohol and You're Welcome*)	3	3	**Amber**	Pamela Akerman	Planning for public health programmes and support is happening at a regional, sub-regional and local level. Local public health leads are participating in these discussions.	Denice Burton	Apr-12
Finance	PH budget transferred to LA is insufficient to deliver the range and quality of service accountabilities transferred	2	4	**Amber**	Ashley Ayre	Detailed analysis of Indicative budgets between PCT and LA Reconciliation of figures between PCT/LA and DH prior to acceptance/sign off between PCT and LA Prioritisation of PH activities to financial envelop informed by JSNA refresh and resultant Health and Wellbeing Strategy	Denice Burton/J Oakley/Richard Morgan	2012/13 budget to be agreed by end of April 2012.
Workforce	Failure to secure/appoint Joint DPH during 2012-13	3	4	**Amber**	Ashley Ayre & Ed Macalister Smith	Recruitment Pack revised (Nov 11) Partnership agreement that LA to provide capacity to facilitate DPH appointment (recognising that PCT retains final authority) CT/LA agreement to refresh interim DPH arrangements for 2012013	Paul Scott	Subject to new regulation.

Workforce	Implications of secondment and transfer arrangements for individual public health team members, including practical aspects and affect on morale	3	3	**Amber**	Pamela Akerman	Ensure clear HR advice and support available to public health team. Await national Framework. Maintain regular team meetings and communication.	Denice Burton	Ongoing - to be monitored.
Communications	Risk of poor communication around transition to staff, executive and partners undermines confidence in and the effectiveness of the change process.	1	3	**Green**	Pamela Akerman	Monthly briefings provided to Change Programme Board, and bi-monthly to the Partnership commissioning staff (*In Touch*). PCT Board have received draft Governance Plan at May Board meeting.	Paul Scott	Ongoing - to be monitored.
Public Health England arrangements	Lack of clarity about roles and responsibilities of local public health and national Public Health England, and implications for local programmes and required capacity/capability.	3	3	**Amber**	Pamela Akerman	DH have produced detailed guidance on the Public Health England Operating Model and the role of Public Health and the DPH in local government, and this now needs to be worked through during 2012/13 to create new local arrangements.	Paul Scott	October 2012
Health Protection arrangements	Lack of clarity about roles and responsibilities of local public health and national Public Health England, and implications for local programmes and required capacity/capability.	3	3	**Amber**	Pamela Akerman	DH have produced detailed guidance on the Public Health England Operating Model and the role of Public Health and the DPH in local government, and this now needs to be worked through during 2012/13 to create new local arrangements.	Pamela Akerman	October 2012

Emergency Preparedness arrangements	Lack of clarity about roles and responsibilities of local public health and national Public Health England, and implications for local programmes and required capacity/capability.	3	3	**Amber**	Pamela Akerman	DH have produced detailed guidance on the Public Health England Operating Model and the role of Public Health and the DPH in local government, and this now needs to be worked through during 2012/13 to create new local arrangements.	Pamela Akerman	October 2012
NHS Commissioning	Lack of clarity about local public health role in NHS Commissioning.	3	3	**Amber**	Pamela Akerman	DH have clarified the mandatory expectation of public health advice from the council to the CCG. Public health will work with the CCG to develop a MOU around this issue during 2012/13.	Paul Scott	June 2012
Information & Intelligence	A range of intelligence risks, including lack of access to data by moving from the NHS N3 secure 'spine', and Information Governance issues if staff are moved to non-NHS contracts but still need to work with patient identifiable data	2	4	**Amber**	Pamela Akerman	AM to work with SJ and JP to develop an assurance plan using the regional Knowledge Management Transition Plan template. AM to work with Lynda Bird and Angela Parrett at B&NES Council and Cathryn Poole at NHS B&NES AM to work with West of England Public Health Intelligence Transition Group.	Helen Tapson	Assurance plan for knowledge management in place by September 2012

Appendix 5 Terms of Reference - JSNA Steering Group

1. Aim

To inform the Health and Wellbeing Board (HWB) in their development of the Bath and North East Somerset Health and Wellbeing Strategy by publishing an assessment of health and social needs in the population and how local services are meeting those needs.

To support development of a vehicle to present more detailed health and wellbeing data via the internet.

2. Approach

The assessment will be based on the normal resident population of Bath and North East Somerset, unless otherwise stated in specific analysis.

Headline chapters

The following is proposed as an outline structure, based on proposals by the Health and Wellbeing Board from September 2011.

Inequalities (as a cross-cutting issue)

- Wellbeing and other broader social determinants
  - Community Capacity (social capital) and other social assets
  - Cultural activities
  - Employment and Benefits (including Local Economic Assessment)
  - Education and Skills
  - Climate Change and Severe weather
  - Crime and Disorder (Community safety strategic assessment)
  - Housing
  - Benefits
  - The broader environment (e.g. Core Strategy Evidence base)

- Health determinants
  - Early years, breastfeeding, immunisations
  - Public health & lifestyle determinants
  - Smoking, obesity, physical activity
  - Drugs & alcohol

- Broad conditions and trends
  - Morbidity, mortality and life expectancy
  - Planned and Unplanned Care
  - Safeguarding

Managing Long term conditions

- Primary Care
- Planned and urgent health and social care system (including mental Health)
- Medicines Management
- Learning difficulties, physical and sensory impairment

Demographic Trends and Future Forecasting

- Population and demography
    - Explicit focus on equalities dimensions/groups as well
- To draw from all of above as relevant where trends/changes can be identified

Analytical approach:
Analysis of each subject will be developed with HWB members and other stakeholders as relevant and will based on the following questions. For more detail about each section, please refer to Appendix 1.

- What does the data say?
- What does the community say? (public engagement summary)
- Are we meeting the needs?
- What can we realistically do/change? (context)

3. Outputs

A distinct JSNA document, no more than 15 pages long to be published by the board and used as a key document to influence the on-going development of the Health and Wellbeing strategy.

A web-portal holding in-depth analysis referenced in the JSNA document (and other research published by or on the authority).

Milestones

October:
- Engage with Health and Wellbeing Board members
- Finalise ToR,
- Steering Group meeting,
- Engage with key officers/partners as relevant to collect information
- Collate analytical work and commission existing

November
- Health and Wellbeing Board sign off ToR
- Health and Wellbeing Board assess data gaps and prioritise analysis
- analysis & other engagement with key officers/partners as appropriate

December
- Draft JSNA produced
- HWB comment
- Further analysis/engagement as relevant

January – Final document

Ongoing – Online JSNA library

4. Governance

The Health and Wellbeing Board will act as project sponsor for this work. Jon Poole and Paul Scott (see below) will act as project managers.

5. Membership

Name	Role or representation
Pamela Akerman	Director of Public Health, B&NES H&WB Partnership
Mike Bowden	Divisional Director, People and Communities
CCG Board representative as available	B&NES Clinical Commissioning Group
Tracey Cox	Programme Director, B&NES H&WB Partnership
'Helen Edelstyn'	Strategy and Plan Manager, Policy and Partnerships
Jon Poole	Research and intelligence Manager, Policy and Partnerships
Paul Scott	Assistant Director of Public Health, B&NES H&WB Partnership
Derek Thorne	Assistant Director, Communications and Corporate Affairs, B&NES H&WB Partnership
David Trethewey	Divisional Director, Policy and Partnerships

6. Meeting frequency

To be discussed at first meeting.

7. Interdependencies

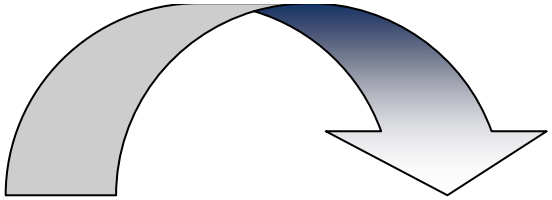
A variety of other individual research projects, including for example '*Understanding our most Vulnerable'*.

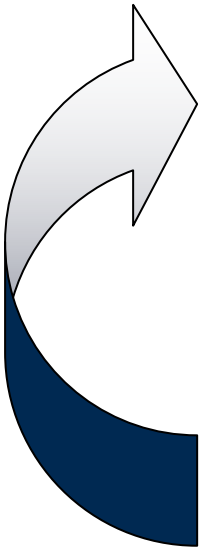
Research Library ("Drupal" Project**) -** developing an online system to store and disseminate research documents. This system is necessary to deliver output 3.2 above.

Analytical Framework

Understanding differences between and within communities

Listening to our communities

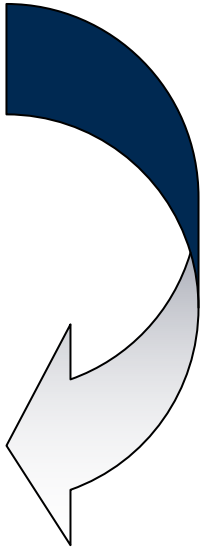




What does the data say?	**What does the community say?**

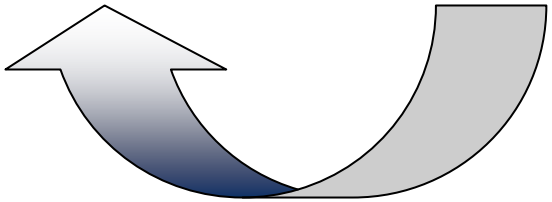
• *Who is our target community?*
• Population & Demography
• Social/Economic Context & determinants
• What are the specific gaps/needs/risks/assets?
• Small area data – geographical variations/equalities groups/"virtual communities"
• Trends and patterns (inc. benchmarking)
	• Strategic Context (inc. community leadership & Elected Member steer)
	• Engagement & Consultation
	  ○ Formal (e.g. surveys, user feedback etc.)
	  ○ Informal (comments to service providers etc.)
	  ○ How do we consult providers? (avoid undue influence)

What can we practically do/ change? *BE REALISTIC* • £££ savings required? • Do we need to deliver more with less? • Political direction • Deliver statutory Requirements • Relationship with other areas (services/geographies etc. What is within our gift to influence? How can we enable the community to deliver more for itself?	**Are we currently meeting the needs?** • Are we doing what we said we'd do (performance) • Service use • Take-up/demand/waits • Gaps (Who are we missing?) • Evidence of effectiveness: ○ Internal or external evaluations • Other quality measures (e.g. value for Money, SROI) • What is the community already delivering?



Quality (Transparency)

Enabling communities



Produced by Research & Intelligence Team, Bath and North East Somerset Council
research@bathnes.gov.uk
05/09/11

Developed from;
LGID (2011) Joint Strategic Needs Assessment: Springboard for Action (LGID)
Shaw,B (2010) How to evaluate impact of environmental research Policy Studies Institute
B&NES Elected member feedback from Cabinet away day – Jun 2011

Appendix 6 NHS Bath and North East Somerset Public Health IP&C Transition Plan

IP&C Function	B&NES Current Delivery	Actions to Ensure Maintenance 2012-13
Assurance of compliance with Health and Social Care Bill, CQC requirements and NHSLA risk management standards	All are elements within providers' contracts. IP&C Team (IPCT) have almost completed baseline audit of Nursing Home standards; plan to audit GP practices Q1 12-13. Non-compliance highlighted and improvement actions suggested.	Maintain contractual mandates. Repeat audits of Nursing Homes and GP practices.
Access to IP&C services by health and social care service providers	Phone & email access; monthly meetings with providers' IP&C Leads. Social care liaise with HPA.	Develop links with social care.
Arrangements for community IP&C	Liaise with HPA.	Confirm expectations.
Cluster IP&C arrangements: • IP&C specialists • Lab services • Service interface	B&NES IPCT comprises: • 0.4 Band 7 qualified IPC nurse specialist + 1.0 Band 6 trainee with minimal analyst and admin support. Infection Control Doctor SLA under discussion • B&NES uses accredited HPA lab in Bristol • Monthly collaborative meeting provides interface opportunity with providers	Cluster IPCT to be confirmed.. Review capacity and expertise in current team with consideration for appointment of qualified specialist.
Gaps in capacity and service provision	Loss of 0.6 Band 7 specialist	Review capacity and expertise in current team
Build IP&C into contracts	Automatic inclusion of IP&C specification in providers' schedules; ad hoc additional input by Senior IPCN. Annual review of contracts.	Develop IPCT's involvement in contracting process.
Assure compliance with national and local KPIs: • Reduction HCAIs	Monthly reporting by providers; scrutiny of results at monthly collaboration meeting and PCT quality board. IPC specialist reviews RCAs of all HCAI-related deaths. Quarterly IPC	Maintain current monitoring. Develop reporting mechanisms to CCG.

• Compliance with national standards, policies and NICE guidance • Reporting HCAI deaths	walkabout with providers monitoring clinical and environmental hygiene. Use of surveillance software to corroborate reporting.	
Monitoring providers' performance against national and local objectives and trajectories	Monthly reporting by providers; scrutiny of results at monthly collaboration meeting and PCT quality board. IPC specialist reviews RCAs of all HCAI-related deaths. Quarterly IPC walkabout with providers monitoring clinical and environmental hygiene. Use of surveillance software to corroborate reporting.	Maintain current monitoring. Develop reporting mechanisms to CCG.
Maintenance of collaboration with HPA/PHE; • Mandatory surveillance of HCAIs & reporting SUIs • Support for health protection incidents & outbreaks	HPA attends monthly collaborative meetings. Support available, within resources, for incidents and outbreaks.	Maintain current collaboration; define responsibilities between health protection and infection prevention services.
Preparedness for predictable health protection incidents	Outbreak management advice available to providers with liaison with HPU as necessary.	Maintain current collaboration; define responsibilities between health protection and infection prevention services.

Lauren Tew
Senior Infection Prevention and Control Nurse
NHS Bath and North East Somerset, Service Improvement and Performance Team
6/3/12

Appendix 7 Human Resources - Draft Outline Transition Plan for B&NES

Time Frame	Date	Action	By	Comments
Pre-Royal Assent	May 2012	Establish PH functions in scope for TUPE transfer	PA/SG	
Pre- Royal Assent	May 2012	Determine if any support functions are in scope, liaising with support functions management as appropriate	PA/SG	
Pre-Royal Assent	June 2012	Produce a list of staff that NHS B&NES deem are in scope for the proposed transfer. Identify any current PH staff not transferring and indicate alternative destinations. Determine employment status and rights of any fixed term, temporary or agency staff	PA/SG	This is a vitally important first step: to establish who is "assigned" to the organised group of services / functions that it is proposed will transfer
Pre Royal Assent	June 2012	Determine who in NHS B&NES and the Council will approve final staff transfer list	PA/SG	
Pre- Royal Assent	July 2012	Approve final staff transfer list	see above	
Pre Royal Assent	July 2012	Determine if a TUPE transfer contract is required and who within BANES NHS and the Council will draw this up. Determine if there is a need to engage solicitors. Determine who will sign the contract	PA/SG	Normally "sender" and "receiver" organisations would engage solicitors at this stage to protect respective interests in respect of indemnities etc post transfer.
Pre-Royal Assent	August 2012	Draft TUPE Consultation Document, particularly establishing and including in the consultation document any "measures" proposed by the Council post transfer. Conduct EIA	PA/SG	
Post Royal Assent	ASAP following Royal Assent	Determine which organisation will pay the Government Actuary's Department (GAD) fees in relation to obtaining a "broad comparability"	PA/SG	If not agreed in the contract or elsewhere

		certificate, and include in TUPE transfer contract		
Post Royal Assent	ASAP following Royal Assent	Instruct GAD to act, complete and send Data Collection Template to GAD	SG/JR	
Post Royal Assent	ASAP following Royal Assent	Consultation Document and Paper to Workforce Committee	SG	
Post Royal Assent	ASAP following Royal Assent	Arrange Board Approval of Consultation document	EG	
Post Royal Assent	October 2012	Sign off Consultation Document	PA	
Post Royal Assent	31.10.12 or earlier	Provide advance copy of Consultation Document to Unions and Staff Forum / Representatives	SG	
Post Royal Assent	01.11.12 or earlier	Staff meeting to commence formal Consultation (Staff Representatives and Unions invited). Issue Consultation Document	PA/SG	
Post Royal Assent	01.11.12 or earlier	Ensure communication and engagements with Council staff	Council?	
Post Consultation Start Date	09.11.12 or earlier	Provide due diligence information to Council, including anonymised list of staff	SG	
Post Royal Assent	03. 12. 12.	Receive GAD calculations	SG	
During Consultation Period		Further joint staff meetings to include Council management representation as appropriate. Individual 1 to 1 meetings offered to staff and undertaken as appropriate, keep Council	SG/ Council?	

		employees informed		
During Consultation Period		Set up FAQs on intranet with responses, keep Council employees informed	SG/Council ?	
	31.01.13	End of Consultation		
Post end of Consultation	06.02.13 or earlier	Feedback outcomes of Consultation to Board, staff, Unions and Staff Forum, and publish details NHS B&NES and Council intranets	SG/Council ?	
Post end of consultation	06.02.13 or earlier	Employee liability information to Council (disciplinary, grievance and pending tribunal or other court proceedings)	SG	
Post end of Consultation	11.02.13 or earlier	Draft TUPE transfer letters for PA's approval and EM-S's signature	SG	
Post end of Consultation	01.03.13 or earlier	Issue TUPE transfer letters. Issue termination forms, liaise with Payroll to ensure smooth transfer	SG	
Post end of consultation	08.03 12 or earlier	Final induction arrangements	PA/SG/Council?	
Post end of Consultation	01.04.13	TUPE transfer date		

Key

PA – Pamela Akerman
SG – Steve Graham
JR – Judith Rawlings

Appendix 8 Work plan for the transition of public health IT and intelligence functions

B&NES Public Health Information, Intelligence & Research Transition – Draft Outline Plan.

Version 2, March 2012. Author: **Helen Tapson**. Accountable Director: **Pamela Akerman**

Intelligence, Information & Research

Rationale: To ensure the public health intelligence, information & research functions are successfully embedded in B&NES Council – ensuring that the Joint Strategic needs Assessment (JSNA) remains on track and supports the development of an effective Health and Wellbeing Strategy for B&NES. In addition, this group will have the remit to consider the transfer of Information Technology (IT) infrastructure / functions in line with the emerging ICT strategy from the Council which is moving towards a vision that enables staff and Councillors access to what they need, where and how they need it.

Outcome: Robust public health intelligence, information & research functions that are successfully embedded in B&NES Council. The JSNA is kept on track and adequate support is provided to the new CCG and to develop the Joint Health and Wellbeing Strategy. Information/intelligence is transferred and stored within information governance guidelines. IT infrastructure is successfully transferred. Staff are enabled to continue with business as usual with minimal disruption to working practice.

Progress: A working group has been established to manage and advise on the information and intelligence transition with representation in both the current public health team, in the PCT ICT team and within the council. A draft project plan has been prepared and an initial meeting arranged to discuss and to allocate timescales to the project.

Key Milestones:
Project team to work towards resolving issues and readiness for total system transfer by 1st September 2012

Transition Issue	Accountable Director	Operational Lead	Commentary on current position
1 Data cleanup and assets transferring			
5.1 Is there a clear plan for the transfer of data from public health and personal drives to council drives?	Pamela Akerman	Helen Tapson, Denice Burton, Shelley Oak Individual project leads	Top level folders mapped and discussions regarding restructure and archiving policy in progress. Once folder structure is implemented, individual team members will reorganise subject folders in line with new structure and new archiving rules, making the contents of these sub folders ready for transition and new smaller storage limits in Council. In addition, access and navigation by multiple new users in the council should be considered in relation to clear labelling and storage of folders.
a. Are preparations in place for interim transfer to Wiltshire PCT?		Simone Lucas (Wiltshire)	14th March – migration from B&NES PCT IT to Wiltshire IT. All files deleted from c./ drive before this date.
5.2 Have risks to current data and intelligence sources during transfer been considered?		Avon transition group led by Susan Hamilton. Helen Tapson to check links with B&NES. Helen Tapson, Cathryn Poole	Avon transition group have produced list of public health data sources used by local analysts. This will be presented to team for consultation and addition at next PH team meeting. Risks to these sources will be considered. Secure copies of data and databases considered 'at risk' (including N3 website access and remote link to Avon server) should be made as a precaution prior to transfer. Wiltshire ICT should be consulted on the best methods for this.
5.3 Have individual team members archived their emails in order to reduce the size of their email folders considerably?		PH Team	Size of email folders limited to 50mb in council other than by exceptions agreed by Head of Transformation. Individuals to personally reduce and organise own folders for transition. Note: Will not be able to keep or transfer emails but some could be archived. Archived e-mails in council sit on an individuals G (personal) drive which is limited to 500mb. Any working documents

			would be held on S drive (folders not currently limited though this will come soon)
2 Identifying information Governance Risks			
2.1 Are there plans in place to ensure that confidential data (both electronic and paper based) is protected during the transition and once in the council in line with Information Governance procedures?	Pamela Akerman	Ian Gale (Council)& Pete Drummond – electronic storage Jeff Wring – paper storage Helen Tapson & Individual project leads	It will be necessary that a folder is created on council system with limited access rights for the storage of person identifiable data. In addition, some physical secure storage will be necessary for Public Health team. Pre transition, data that is confidential should be gathered together in the folder p:/public health (new)/directorate/intelligence/Protected Raw Data in preparation for transition. No person identifiable data will be stored in any other folders.
2.2 Has consideration been given regarding council/CCG access to public health data sources? Will any new data protection agreements need to be drafted as a result?		Jon Poole and Helen Tapson to discuss. Glyn Young and Pete Drummond/Amy Ogborne info security and info governance respectively in Council. (both report to J Wring)	Note – we have a secure link between BANES PCT and the Council. It should be possible to move data between the two networks but IG will need to check this. Access permissions will need to be set up so that data and info from PH and Council is available to appropriate staff. Ascertain what data will need to be shared, set up protocol for ensuring that correct permissions are signed and data sharing agreements drawn up in advance between PH, council and CCG's.
2.3 Have individual PH team members ensured that no confidential data is being sent to general email accounts (only NHS.net)		PH Team	Team members need to liaise with data suppliers to remove personal info before sending where possible. If the personal info is necessary then it should be sent securely and stored in folder mentioned in 2.1.

3 Transfer of IT infrastructure			
3.1 Are council teams prepared for extra phone and computer support and provision that comes with arrival of public health team?		Angela Parratt	Laptop and phone provision needs to be organised by council but this will partially depend on where in council team will sit and on how many people will transfer so need to provide provisional structure. PH need to advise what their requirements are for electronic equipment. People and Communities need to confirm they will meet the costs and provide a cost code. Council will then arrange delivery and related annual recharges. To include laptops/PCs, desk phones, mobiles/smartphones.
3.2 Is there any software that will need IT support not already provided by the council IT team		Helen Tapson to scope software needs. Susan Hamilton doing this for Avon. Discuss with IG	List software needs in team and check against software used in local authority. If there are any not supported, then question necessity and consider alternatives?

Appendix 9 Public Health Communication and engagement strategy

COMMUNICATIONS & ENGAGEMENT STRATEGY

PUBLIC HEALTH TRANSITION

NHS BATH AND NORTH EAST SOMERSET & BATH AND NORTH EAST SOMERSET COUNCIL

Version:	Final
Ratified by:	Paul Scott, William Harding, Jonathan Mercer & Craig MacFarlane
Date Ratified:	9 March 2012
Name of Originator/Author:	Craig MacFarlane & Jonathan Mercer
Name of Responsible Committee/Individual:	Public health transition group
Date issued:	9 March 2012
Review date:	15th June, 2012
Target audience:	Employees of NHS B&NES/B&NES Council & stakeholders

NHS B&NES & B&NES COUNCIL

COMMUNICATIONS STRATEGY

CONTENTS

NHS B&NES & B&NES Council

Communications & engagement strategy for public health transition

VERSION CONTROL

Document Status:	To be approved by Public Health Transition Group & B&NES Council's Marketing Manager
Version:	Final

DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**

Sponsoring Director: **Author(s):**	Paul Scott Craig MacFarlane & Jonathan Mercer
Document Reference:	Communications & engagement strategy – public health trasition

NHS B&NES & B&NES Council

PUBLIC HEALTH TRANSITION

COMMUNICATIONS & ENGAGEMENT STRATEGY

1. EXECUTIVE SUMMARY

1.1 This strategy sets out how the PCT and council will effectively communicate and engage with its staff and stakeholders on the reorganisation of public health into its new organisational home in the local authority and Public Health England. Details of the work programme are given in the public health transition plan, which sets out the purpose, estimated costs and timescales of full transition and outlines the project approach detailing the basis for the management of the project including risks and mitigation. Background details of the public health transition programme are outlined in the Health and Social Care Bill currently being considered by parliament and to be implemented by April 2013.

1.2 The Public Health Transition Group, comprising key strategic directors from both the PCT and Council, is managing the process of transferring public health from the PCT to the local authority.

1.3 Under this reorganisation the overall objectives of public health will be to increase healthy life expectancy and reduce health inequalities. Local authorities will have a new duty to promote the health of their population as part of the reforms. Through the Health and Wellbeing Board they will lead the development of joint strategic needs assessments and joint health and wellbeing strategies, which will provide the means of integrating local commissioning strategies and ensuring a community-wide approach to promoting and protecting the public's health and wellbeing. Public Health England will be created as a new integrated public health service. It will bring together the national health protection service and nationwide expertise across all three domains of public health.

1.5 As part of the transition programme it is important to build confidence and understanding in the new organisational arrangements. It is also essential to develop an understanding among staff of the planned changes ahead.

This communications and engagement plan is aimed at developing these important aspects.

1.6 The following is a summary of activities:

- Health & Wellbeing Board (briefing): On-going
- Council cabinet (briefing): On-going
- Clinical commissioning group (briefing): On-going
- Staff updates: On-going
- Executive briefs
- Engagement with key stakeholders: On-going
- Stakeholder events & briefings: On-going

2. OBJECTIVES

The key objectives of this communication and engagement plan are:

- To raise awareness of the public health reforms, what they mean and how they will be implemented
- To build and develop confidence and understanding in the new organisational arrangements
- To engage effectively with stakeholders throughout the transition programme
- To manage and protect the reputation of the organisation during a period of intense organisational change.

3. TARGET AUDIENCE

Key stakeholders are:

Clinical
- Clinical commissioners
- GPs

Executive & governance
- Health and Wellbeing Board
- PCT cluster Board (operational April 1 2012)
- Cluster EMT
- Council's strategic and divisional directors
- Council cabinet
- Wellbeing Policy Development and Scrutiny Panel
- Councillors

Staff
- PCT staff
- Council staff

Key providers
- Sirona Care & Health (executive)
- The Healthy Lifestyles Hub

- RUH executive
- AWP executive

Third sector & interested groups
- Local Involvement Network (LINk)
- The Care Forum
- The public – Healthy Network

4. KEY MESSAGES (public facing)

The key messages will be developed and targeted to audiences as the work programme matures and becomes clearer.

- The goal is to continue to improve the health of all people, but to improve the health of the poorest, fastest
- Councils are well placed to adopt a wider wellbeing role having already taken on the key role in promoting economic, social and environmental wellbeing at the local level
- Public health has an important role to play within the local authority
- A new body, Public Health England, will develop and deliver a national approach to public health and be responsible for national programmes such as early diagnosis for cancer etc.

5. METHODS

Briefing reports updating the executive on progress are regularly presented. Stakeholder engagement has been ongoing while staff communications are largely supported by team meetings within public health. In addition staff have the opportunity to raise questions directly with the CEO at his monthly meetings while traditional staff communication channels will be used to support awareness raising. Key mechanisms for briefings, engagement and staff comms are highlighted below and outlined in the action plan (appendix 2).

Engagement:
- Clinical Commissioning Committee (briefing reports)
- GP forum-plus (monthly meetings)
- Health and Wellbeing Board (briefing reports & presentation)
- Cluster Board (briefing reports)
- NHS B&NES & NHS Wiltshire cluster Board (briefing reports)
- Cluster EMT (briefing reports)
- Council's strategic and divisional directors (HOW)
- Council cabinet (HOW)
- Wellbeing Policy Development and Scrutiny Panel (HOW)
- Councillors (HOW)
- Public health commissioners (team meetings)

- PCT staff (newsletter, intranet)
- Council staff (HOW)
- Sirona Care and Health executive (reports)
- The Healthy Lifestyles Hub (team meetings)
- RUH executive
- AWP executive
- LINk/HealthWatch (briefing reports & presentation)
- Health and Wellbeing Network (presentation, breakout discussion & feedback)

Communications (internal):

- Staff briefings (public health team meetings)
- Monthly meetings with the CEO
- Develop intranet x PCT & Council
- Incorporate regular updates in newsletter x PCT & intranet

External comms/reputation management:

- Reactive holding lines
- Q&A
- Press release (promoting H&WB Network)
- Dedicated section on website

6. MILESTONES

Jan 2012: Transition Planning Guidance published by DH

Jan 2012: Local Government HR Transition Guidance published

Mar 2012: Local transition plans completed by PCTs

From Apr 2012: Local areas agree arrangements for any in year delegation of functions and secondments/assignment of transferring staff in line with guidance

By Oct 2012: Local areas test arrangements for delivery of specific public health services in particular screening and immunisation, and Emergency Response

Oct 2012: Local areas agree arrangements on public health information requirements and information governance

Jan 2012: Local areas ensure final legacy and handover documents produced

Apr 2013: Local authorities formally take on new responsibilities.

7. PUBLIC AWARENESS

The NHS reforms are immensely complicated and extensive coverage across both the national press and media has resulted in increased awareness in the public realm. Anecdotally given the level of debate and the nature of this debate we can summarise that the reforms are controversial. It's within this context that we will be communicating messaging to our stakeholders, public and staff. This communications and engagement plan is aimed at increasing awareness and understanding and building confidence in the public health reforms.

8. MEDIA HANDLING

Given the high profile nature of the NHS reforms materials will be prepared in the event that the press/media pick up on the transition programme. These materials will include reactive lines and Q&As. A spokesperson will be identified for consideration if we decide to field broadcast interviews and a press release promoting the H&WB Network, which will incorporate the public health transition programme, will be circulated to press outlets.

8.1. A list of newspapers and publications is shown in Appendix 1.

9. QUALITY CONTROL AND EVALUATION

9.1 No major communications materials should be distributed unless jointly signed off by the project lead (Paul Scott) in partnership with comms colleagues at both the PCT and council.

9.2 During the course of the project judgements will be made on the effectiveness or otherwise of the communications and engagement plan and if necessary appropriate action taken. Any such actions will be a jointly agreed process between the project lead and the communications and engagement team.

APPENDIX 1

List of Press Agencies

Newspapers:

Bath Chronicle
Somerset Guardian
The Week In (Keynsham)
MSN Journal
Chew Valley Gazette

Broadcast:

BBC Radio Bristol
BBC Radio Somerset
Breeze
Heart FM
BBC Points West
ITV West

Online:
All of above

NHS Communication Standards

All communications for the Connecting for Health Technology will adhere to the NHS Communications Standards, which are:

- **Open** - the reasons for decisions are available, decision makers are accessible and ready to engage in dialogue. When information cannot be communicated the reasons for non-disclosure are articulated. Questions are anticipated and answered.
- **Corporate** - communication style and messages reflect a consistent view. Messages articulated should be consistent with the values of the organisation they come from and of the NHS as a whole.
- **Two-way** - systems exist to support communication up and down as well as across organisation boundaries.
- **Timely** - information arrives at a time when it is needed, relevant and able to be interpreted in the correct context.
- **Clear** - messages are communicated in plain English, they are easy to understand and are not open to misinterpretation. Written messages are concise, using short sentences and avoiding jargon.
- **Targeted** - the right messages reach the right audiences, in the right manner, at the right time.
- **Credible** - messages have real meaning, recipients can trust their content and expect to be advised of any change in circumstances that may cause the initial message to be invalidated.
- **Planned** - communication is planned: a communication plan exists and is regularly contributed to and reviewed by senior management. Communication activity is appropriate and contingencies for dealing with likely situations specified in advance. Agreed lines to take on a particular issue are articulated and adhered to.
- **Consistent** - messages are delivered in a co-ordinated fashion so that there are no contradictions during the time period in which the message is relevant.
- **Efficient** - the communication and the way it is delivered is “fit for purpose”, cost–effective, to budget and delivered on time.
- **Integrated** - internal and external communication is consistent and mutually supportive.
- **Straightforward** - communications must not be seen to be “gimmicky” or inappropriate for a public sector healthcare organisation.

Public Health Transition Engagement Plan

	Previous engagement	On-going progress report	Bill being enacted (Possibly April/May)	Start of formal consultation with staff	Ending of formal consultation	Some shadow arrangements in place (partially) and tested as part of national planning: October 12	Local areas ensure final legacy and handover documents produced: Jan 12	Staff transfer to Council and wider public health arrangements go live: April 2013
Priority 1								
Engagement with staff affected	Monthly team meetings	Staff meet monthly to discuss transition agenda	Note to staff explaining this and setting out a broad timetable	Consultation document and approach prepared by HR	Advise staff of the outcome of the consultation and the next steps	Briefing note to staff to explain implications	Not required	Welcome to the Council
Health and Wellbeing Board	Progress updates to Health and wellbeing board (Nov 11, Feb 12)	On-going bi monthly report to Health and wellbeing board	Brief note including timetable	Notify Board of intentions/process	Advise board of outcome at the end of the consultation as part of progress update	Progress report - Briefing note to staff to explain implications	Briefing from PS	Briefing to the Board
Cluster Board (EMT)	Progress updates to cluster board	On-going updates as necessary	Briefing from PS	Notify Board of intentions/process	Brief verbal update from PS	Progress report	Notify Board of intentions/process	No longer in existence
Council cabinet	Updated briefing (Sept 11)	Not required	Progress report to Cabinet setting out timescale for transition	Not required	Brief verbal update Form PS	Progress report	Not required	Briefing by PS
Well Being Policy and development Panel	N/A	Not required	Not required	Not required	Progress report to the panel	Needs to be considered	Not required	Note to members of the Panel
Council SDG/directors	Progress updates to directors	As required	Briefing	Not required	Brief verbal update Form PS	Progress report	Briefing from PS	As required
Clinical commissioning group			Progress report and timetable	Not required	Briefing from PS	Progress report	Briefing from PS	Briefing from PS

Priority 2								
Information to other PCT staff	Monthly team meetings	Not required	Brief note on PCT intranet/newsletter	General information on intranet- no proactive comms otherwise	General update to staff	Not required	Not required	Communication with staff
Engagement with key clinical partners, GP's, Sirona, RUH, AWP, Healthy network, LINk, Care Forum	Transition plan presented at GP forum (Sep 11), Health & Wellbeing Network (March 11) & LINk (April 11). In-depth article featured in Care Forum newsletter	Not required	Letter to key partner organisations	Not required	Not required	Not required	Letter to partners explaining situation	Letter to explain that staff have transferred to Council and other information
Council Divisional Directors	Progress updates to directors	As required	Briefing from PS	Not required	Briefing from PS	Not required	Briefing from PS	Briefing from PS
Council staff working directly under new arrangements	N/A	N/A	Email communication	N/A	N/A	N/A	Programme briefing on personal impact on the changes	Briefing Intranet Newsletter

Priority 3								
Public	Bespoke engagement with public via Healthy network (March 11)	Not required NOTE- PREPARE REACTIVE COMMS	Not required	Respond reactively if required			Website and phone line for public	Communications campaign to the public. Information updated on Council website
General information to Council staff	N/A	Not required	Intranet/newsletter	Not required	Not required	Not required	Not required	Intranet/newsletter
Information to other partners			Insert in regular Newsletter	Not required	Not required	Not required	Article in their newsletters	Confirmation to all partners
Information to Councillors	Priority one members updated (Sep 11)	Not required	Communication with Councillors	Not required	Not required	Not required	Not required	Letter to all councillors – successful transfer