Memorandum of Understanding

B&NES Clinical Commissioning Group and Public Health in B&NES Council

1.0 Purpose and scope

1.1 The purpose of this Memorandum of Understanding (MOU) is to establish a framework for working relationships between Bath and North East Somerset (B&NES) Clinical Commissioning Group and Public Health in B&NES Council.

1.2 The framework will set out the scope of the service (i.e. functions) that public health will provide to the CCG, and the reciprocal responsibilities of the CCG in receiving these services. The MOU will be underpinned by an annual work-programme agreed between the CCG and B&NES Council, which will define the particular deliverables and priorities for a 12 month period (see section 4).

1.3 This Memorandum, covers the 3 domains of Public Health and the strategic planning functions that underpin these domains:

- **Population healthcare** -. input to the commissioning of health services, evidence of effectiveness, care pathways.
- **Health improvement** - lifestyle factors and the wider determinants of health.
- **Health protection** - preventing the spread of communicable diseases, the response to major incidents, and screening.

1.4 The functions that public health should provide to the CCG within the domain “population healthcare” are outlined in guidance by the Department of Health; *Healthcare Public Health Advice to Clinical Commissioning Groups (June 2012).* This guidance has been used to inform the core functions that B&NES public health will provide to the CCG.

1.5 This Memorandum will cover the period from October 2012 until March 2014, with the initial six month period being in Shadow form, allowing for review and revision, subject to local needs and national guidance for the period April 2013- March 2014. The Public Health Directorate will transfer from NHS B&NES to B&NES Council on 1st April 2013.

2.0 Context

2.1 Under the Health and Social Care Act, from April 2013 clinical commissioning groups have a duty to access public health advice, information and expertise in relation to the healthcare services that they commission. At the same time, public health teams based in local authorities have a responsibility for providing this advice to clinical commissioning groups (CCGs).

2.2 The (healthcare) public health advice provided by the local authority will be funded from the public health budget allocated to Local Authorities at no cost to the CCG. If in the future, the CCG and public health agree that additional "enhanced" services should be provided by public health, the funding for these would need to be met by the CCG.

2.3 Regulations will prescribe that (population healthcare) advice can only be given by appropriately skilled public health specialists. This includes Faculty of Public Health accredited specialists and qualified multi-disciplinary public health specialists.

3.0 Functions, roles and responsibilities

Population Healthcare

3.1 The Health and Social Care Act 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. Public health will have a key role in providing information and advice to the CCG to support their commissioning decisions.

3.2 In line with DH guidance, PH will provide information that has a largely strategic population focus, synthesising data from a wide range of sources and applying public health skills to analyse the data. It is expected that Central Southern Commissioning Support Unit (CSCSS) will focus more on commissioning processes and clinical systems, including analysis of referrals and activity, procurement and business process. To limit overlap, public health will not provide NHS activity data to the CCG (e.g. number of hospital admissions or outpatient appointments), other than that included within health needs assessments undertaken by the team.

Public Health will:

PH information and analysis to support strategic planning
• Oversee the production and development of the Joint Strategic Needs Assessment, which CCGs can use to inform their commissioning plans. • Produce locality/practice "Health Profiles" to inform commissioning plans. • Provide health needs assessments for particular conditions/disease groups, where they have been identified as a priority area. • Provide ad-hoc advice on methodologies to develop and analyse data and achieve data quality. • Support commissioning practice towards the reduction of local health inequalities and the specific needs of vulnerable and marginalised groups by: - Supporting GPs to collect improved inequalities data, and - by highlighting any inequalities/vulnerable groups within the Health Profiles (as far as possible with the data available). • Advise on the appropriate use of geo-demographic profiling (to identify associations between need and utilisation and outcomes for defined population groups), and use within Health Profiles and the JSNA as appropriate. • Carry out and advise on Health Equity Audits and Health Impact Assessments.
PH information and expertise to support the prioritisation and allocation of resources
• Produce a Programme Budgeting report, making use of appropriate economic analysis (i.e. marginal analysis, return on investment) as appropriate, to support priority setting and decision-making. • Support commissioners to identify areas for disinvestment through use of the Programme Budgeting Report and economic appraisals made available by Avon, Public Health England and organisations such as NICE. • Advise clinical commissioning groups on prioritisation processes, governance and best practice. • Provide support to respond to individual funding requests, including conducting evidence reviews and developing policy guidelines.
PH information and expertise on clinical effectiveness to support commissioning

- Provide public health specialist advice on:
  - The clinical and costs effectiveness of interventions and medicines.
  - Evidence based care pathways, service specifications and quality indicators.
  - Medicines management.

- Identify and assess the population impacts of implementing NICE guidance.

- Design monitoring and evaluation frameworks, and give advice on their use.

- Provide advice on relevant aspects of modelling and capacity planning.

Engagement – public and partners

- Through objective analysis, provide the evidence base for why difficult decisions (that affect members of the public) may have to be made.

- Support the CCG to progress joint commissioning and provision plans with the local authority and other organisations to maximise health gain.

B&NES CCG will:

Support strategic planning

- Consider Public Health data including health inequality data in planning.

- Contribute data and intelligence to the production of the JSNA and other priority needs assessments.

- Work with PH on the development and delivery of the Health and Wellbeing Strategy.

- Incorporate the JSNA and Joint Health and Wellbeing Strategy into NHS commissioning plans.

- Review how well the commissioning plan has contributed to the delivery of the Health and Wellbeing Strategy and to share this review with the Health & Wellbeing Board.

Other areas

- 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.

- Use information on effectiveness, cost effectiveness and acceptability to inform policy decisions on the commissioning of services in order to

maximise health gain and reduce health inequalities.

- Work in partnership with providers and research partners to develop the evidence base for important innovations.

- Share details of arrangements in place with CSCSU and inter-dependencies with public health as they become confirmed (to enable public health to limit overlap in services provided).

Health Improvement

3.3 The Health and Social Care Act gives B&NES Council a statutory duty to improve the health of the population from April 2013. B&NES CCG also has duties to secure continuous improvement and reduce inequalities in the outcomes achieved by health services. This will require action along the entire care pathway from prevention to tertiary care. In addition the local NHS QIPP programme is predicated on successful implementation of preventive measures to reduce the burden of disease including from smoking, alcohol, obesity and falls.

3.4 B&NES Council and CCG therefore have a collective interest in health improvement:

Public Health will:

Health improvement
• Refresh the strategy and action plans for improving health and reducing health inequalities, and seek CCG input into these. Strategies and plans will include those that focus on particular groups and communities (i.e. traveller community), settings, and behaviours and lifestyles (i.e. obesity, smoking, alcohol, injury prevention, sexual health, mental health). • Develop (or advise on the development of) a set of metrics in addition to the Public Health Outcomes to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of the NHS QIPP programme. • Commission a range of health improvement services (i.e. lifestyle services and Health Checks), and engage the CCG in the commissioning cycle. • Support the development of best practice clinical pathways and specifications in collaboration with others (i.e. healthy weight specifications, drug and alcohol intervention specifications, consideration of collaborative tobacco control activity).

- Work with the Council to embed ownership and leadership of health improvement.

- Support the embedding of public health and wellbeing initiatives into frontline services, to improve outcomes and reduce demand on treatment services.

- Facilitate partnership working between the CCG, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention.

B&NES CCG will:

Health improvement
• Contribute to the strategy and action plans for improving health and reducing health inequalities and lifestyle issues. • Encourage primary care practices to maximise their contribution to disease prevention and reducing health inequalities by making 'every contact count' to help address behaviours such as smoking, alcohol misuse, and obesity, and by optimising management of long term conditions. • Ensure that early intervention, primary and secondary prevention is incorporated into commissioning plans and care pathway (re)design. • Utilise contracts with providers to embed reduction of, and the monitoring of, health inequalities and the promotion of health and wellbeing priorities. • Support and contribute to locally driven public health campaigns. • Support the process of joint working on common outcome framework indicators.

Health Protection

3.5 The Health and Social Care Act 2012 will be followed by regulations which are likely to give B&NES Director of Public Health a series of responsibilities in respect of health protection, on behalf of Public Health England. These will include strategic leadership for public health protection including preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of public health incidents and environmental hazards, and assuring NHS resilience.

3.6 The Act designates CCGs as Category 2 responders and bestows on them a duty to co-operate with other responders and to share information both in the planning for and response to major incidents affecting their responsible population. These duties are intended to ensure that CCGs 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 the NHS Commissioning Board.

3.7 Therefore, to ensure robust health protection arrangements:

Public Health will:

Emergency planning and response:
Be responsible for the exercising of Local Authority functions that relate to planning for, and responding to, emergencies that involve a risk to public health[1]. This will include implementing robust integrated emergency management and health protection principles to ensure that: • National and local threats and hazards likely to impact on the health of the local population are understood and captured. This includes working in collaboration with the Local Health Resilience Partnership (LHRP) and Local Resilience Forum (LRF) to develop a risk register (i.e. the Community Risk Register). • Local strategic plans are in place for the protection of the local population's health and wellbeing (from relatively minor outbreaks to full scale emergencies), and for responding to the full range of principle risks identified in the national and local risk registers. Plans will include setting out the core elements to local arrangements, such as local arrangements for a 24/7 on-call rota of qualified personnel (currently delivered through the Director on Call rota system and a fully equipped Incident Room), arrangements for the stockpiling of essential medicines and supplies, and escalation protocols and arrangements for setting up incident/outbreak control teams. • Plans are adequately tested, exercised and subject to peer review. • Debriefing for real incidents is undertaken and learning points are captured and incorporated into future training requirements and plan revisions. • The capacity and skills are in place to co-ordinate the response to major incidents and emergencies, through strategic and tactical command and

[1] See new section 73A(1)(d) of the NHS Act 2006, as inserted by section 30 of the Health and Social Care Act 2012.

control arrangements.

- Staff are appropriately trained or have access to externally provided or accredited training to be able to expedite specific roles and responsibilities during the repose to major incidents and emergencies or communicable disease outbreaks.

Wider health protection:

Public health will:

- Provide advice to the clinical community on health protection and infection control issues (via Public Health England where appropriate).

- Help ensure that the Local Authority and local partners are supporting preventative services that tackle key threats to the health of local people e.g. may involve advising on preparation of cold weather plans, developing local initiatives to raise awareness of risks of infectious diseases based on population needs identified through the local JSNAs etc.

- Provide public health input for developing a Sustainable Development Management Plan against nationally recognised indicators, and for commissioning criteria related to sustainable development.

- Prior to April 2013: Remain responsible for ensuring that adequate public health support is in place for the safe commissioning of screening and immunisation programmes. Post April 2013: Ensure that plans are in place to protect the population, including through screening and immunisation. This will include providing independent scrutiny and challenge of the plans of the NHS Commissioning Board, Public Health England and providers.

- Provide surveillance and public health intelligence relating to childhood and adult immunisation campaigns. This includes feedback and reporting to the CCG, especially where potential risks to public health are identified due to inadequate coverage.

(Discussions are on-going with regards to the roles and responsibilities of public health and the CCG in relation to infection control. The MOU will be updated once these are agreed).

B&NES CCG will:

- Fulfil their duties as a Category 2 responder by co-operating with other local responders and sharing information, both in the planning for and response to major incidents affecting their responsible population.
- Develop and maintain a plan to enable the CCG to implement an appropriate

response to local incidents.

- Participate in single or multi-agency exercises when requested to do so. This may include communication cascade tests, table top exercise participation and triennial live exercise participation.

- Ensure that staff required to respond to a major incident are familiar with Strategic (Gold) and Tactical (Silver) multi-agency command centres and procedures.

- Utilise contracts with providers to ensure they:
  - Have robust business continuity plans in place.
  - Include clauses related to infection prevention and control.

- Encourage constituent practices to have business continuity plans in place to cover action in the event of the most likely business continuity incidents. Plans should include how the general practice will contribute to an emergency response, including the provision of medical support to rest centres and the treatment and triaging of minor injuries.

- Use Public Health information to support immunisation programmes, working together to reach high coverage.

- Contribute to and formalise an organisational Sustainable Development Management Plan.

3.8 The health protection section of this MOU reflects guidance issued by the Department of Health in September 2012[i]. It will be updated to reflect any further guidance from the DH, in light of public health regulations to be made under the 2006 Act as amended by the Health and Social Care Act 2012.

4.0 Annual work programme

4.1 Although the MOU is helpful in outlining the scope of public health services that can be provided to the CCG, as public health capacity is limited, it will be important to focus public health resource on those functions and projects that are priority for both the CCG and public health. An annual work programme will be developed for this purpose.

4.2 The annual work programme will outline the priority projects and functions that public health will provide to the CCG, and the key responsibilities of

the CCG back to public health. The work programme will also set out the key deliverables, outcomes, timescales for delivery, and the named public health lead for each project/function.

4.3 The annual work programme will be agreed by the Public Health and CCG Steering Group, and reviewed at least every 6 months (see section 6).

5.0 Quality of the service

5.1 DH guidance states that public health advice to the CCG should be obtained from an appropriately qualified and skilled public health specialist team. The functions required of CCGs include domains where significant public health science skills are required to perform tasks competently.

5.2 In response to this B&NES Council will ensure that:

- The public health advice is given by a team led by a Faculty of Public Health accredited Director of Public Health, supported by Faculty approved and accredited Consultants in Public Health, and an appropriately qualified and experienced multi-disciplinary public health team.
- The lead public health specialist for the population healthcare ("core offer") aspect of the service will be fully qualified with the Faculty of Public Health (FPH) and subject to all existing NHS clinical governance rules, including those for continued professional development.

6.0 Accountability and governance

6.1 A Public Health and CCG Steering Group will meet every 6 months (every 3 months during the transition period) to oversee the delivery of the MOU and annual work programme. The role of the Steering Group will include providing active direction, periodically reviewing progress against the work programme, acting as a forum for decision making, and identifying actions required to ensure that the service delivers its stated outputs.

6.2 The Steering Group will include representation from (at least) one CCG GP, the CCG Chief Operating Officer, the lead PH Consultant, and the PH Information Analyst.

6.3 The DPH will report to the Health and Wellbeing Board[2] on any key business issues reported by the Steering Group. The Director of Public Health and CCG will also jointly present a brief annual report to the Health & Wellbeing Board, setting out how the service had been provided that year. This will cover the process for engaging with public health expertise, whether the deliverables set out in the work programme have been met, key achievements, and key learning and priorities for the next year.

6.4 The Steering Group will link with (though not report to) other interested committees/forums such as the JSNA Steering Group.

7.0 Legal status

7.1 Whilst this MoU is not legally binding, it reflects current national guidance under which the Local Authority is mandated to provide public health advice and support to the CCG. The CCG as a statutory partner of the Health & Wellbeing Board also requires sound public health advice on which to base its recommendations.

8.0 Reconciliation of disagreement

8.1 Disagreements will normally be resolved amicably at the working level. If this is not possible, any concerns that the CCG have regarding support from the PH service, should be brought to the attention of the DPH. Likewise, if public health staff have concerns relating to CCG work, this should be brought to the attention of the DPH, who will seek to reconcile concerns/disagreements through liaison with the Chief Operating Officer.

8.2 If the issue requires escalation within the Council, this should be to the Strategic Director in the first instance, and then if required, to the Chief Executive of the Council.

8.3 Where disputes cannot be agreed at the local level, the formal mechanism being developed by the Department of Health[3] (and which is due to be set

[2] The purpose of the Health & Wellbeing Board is to provide leadership and direction across agencies that deliver services to improve the health and wellbeing of the residents in B&NES. Both PH and the CCG are statutory members of the Health & Wellbeing Board.

[3] The mechanism will be included in this MOU once it has been published by the Department of Health.

out in regulations[ii]) should be used. Final referral should be to the Local Government Ombudsman.

9.0 Review of Memorandum of Understanding

9.1 This Memorandum will be reviewed initially after six months, and thereafter on an annual basis.

9.2 Proposed review date – February 2013

Memorandum of Understanding Signatories:

Signature:_____	Signature: _____
Date:_____	Date: _____
Paul Scott B&NES Director of Public Health	Dr. Ian Orpen B&NES Clinical Commissioning Group Lead
Signature:_____	Signature:_____
Date:_____	Date:_____
Jo Farrar B&NES County Council Chief Executive	Ed MaCalister-Smith NHS B&NES Chief Executive

[i] Department of Health. 2012 (September). *Health protection and local government.* http://www.dh.gov.uk/health/2012/08/health-protection-guidance/

[ii] Department of Health. 2012 (June). *Healthcare Public Health Advice to CCGs.* Accessed at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_132760