THE REPORT

Item 5

By:	Meradin Peachey – Director of Public Health
To:	Health Overview and Scrutiny Committee – 9th March 2012
Subject:	Briefing on recent developments relating to NHS reform and public health transition
Classification:	Unrestricted

Recommendations

1. This briefing is for the KCC Health Overview and Scrutiny Committee and comments or observations are welcome.

Introduction

2. Since December a large number of documents have been issued by the Department of Health and LGA regarding reforms to the NHS and the transition of Public Health to local authorities.

3. This briefing summarises some of the most pertinent:

The Factsheets issued on:

1. Public Health in Local Government
2. Public Health England's Operating Model

The other documents are:

- Public Health Workforce Issues – Local Government Transition Guidance
- Public health transition planning support for primary care trusts and local authorities
- Towards establishment: Creating responsive and accountable clinical commissioning groups
- The NHS Outcomes Framework 2012/13
- LGA/DH Healthwatch Implementation Programme: Offer of support to Local Authorities
- The Public Health Outcomes Framework – Improving outcomes and supporting transparency
- Baseline spending estimates for the new NHS and Public Health Commissioning Architecture
- The draft guidance to support the provision of healthcare public health advice to CCG's has been issued for consultation

4. We still await important documents that will give final detail of the public health budget allocations and the main workforce transition guidance.

Key Issues for Kent

5. The Outline Transition Plan for Public Health has been submitted to the DH. The draft summary plan is attached for HO&SC to consider.

6 The baseline spending estimates for local authorities that are calculated from the reported spend of the relevant PCTs in the last financial year give Kent a budget equivalent to £24 per head p.a. This compares very unfavourably with other local authorities where the highest per capita figure is £117 (Tower Hamlets). Of the 152 authorities concerned only 15 have lower levels of funding.

7. The budget identification process that has been undertaken nationally revealed that the average figure for staffing costs was 10% of overall budgets. In Kent this figure was less than 4% because of the relatively fewer numbers of Public Health Consultants

8. The CCGs should be operating in shadow form by April 2012. KCC needs to consider whether or how it engages with the Commissioning Support Organisations that are being established.

9. CCG budgets will be delegated from April and this holds potential implications for any integrated commissioning and the discussion at the last Shadow Health and Wellbeing Board refers.

10. Issues remain concerning CCGs operation at locality level and how they will relate to district councils and Locality Boards.

11. KCC needs to develop and agree a vision for the public health function for which it will be responsible.

12 The transfer of public health service contracts requires careful consideration under Due Diligence to ensure they are fit for purpose in the new arrangements.

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Appendix 1 - CCG Establishment

Towards establishment:
Creating responsive and accountable clinical commissioning groups - Draft Dec 12

This guidance essentially outlines good practice in establishing public sector organisations including the principles of "Good Governance Standards for Public Services" and the Nolan Principles. Following the report of the Future Forum some changes have been made around membership of the governing body (most likely to be a Board). The document also addresses issues such as the sharing of functions across CCGs and sub-CCG level locality arrangements

Earlier guidance (Towards Authorisation) set out the configuration issues and authorisation process. Authorisation remains with the NHS Commissioning Board. All GP practices must belong to a CCG.

Although officially in draft there will be no further guidance issued on establishment or governance beyond any necessary amendments to this document subject to the passage of the Health and Social Care Bill.

Towards establishment deals with the CCG establishment process and governance arrangements sets out the expectations of how CCGs will be set up and poses a list of questions for CCGS to answer as they progress.

This includes:

- setting out the CCGs responsibilities
- developing a constitution
- establishing good governance arrangements
- identifying leadership roles
- demonstrating public accountability and probity
- identifying key leadership roles

CCGs are designed to bring far greater clinical leadership to commissioning of services and improve public influence and CCG clinical leaders will be expected to have a visible role in their communities.

CCGs will draw on existing NHS expertise to help establish themselves and their role.

Constitution

Minimum requirements for the constitution and partner organisations to be involved, including local authorities and other members of the shadow Health and Wellbeing Board, are set out. The constitution will include:

- the defined geographic area for which the CCG is responsible including unregistered patients in the area
- a vision for commissioning local health care services
- governance arrangements for any subcommittees
- arrangements to involve partners including the public, local authorities and health care professionals in commissioning decisions

The requirements for good governance are laid out to include:

- Corporate governance
- Clinical governance
- Financial governance
- Information governance and
- Research governance

Accountability and probity

The accountabilities to the Health and Wellbeing Board to deliver the Joint Health and Wellbeing Strategy based on the Joint Strategic Needs Assessment and to Local Authority's overview and scrutiny function are stressed.

Key meetings are to be held in public

A written communications strategy for public and partners is recommended.

Arrangements and safeguards to manage conflicts of interest need to be in place including guidance concerning community based services provided by GPs.

Governance

The CCG will require a governing body to oversee the good governance and legal probity of the organisation and to determine re-numeration issues for its officers. Regulations will be issued to clarify who may, or may not, be a member of the governing body.

The membership will include:

- at least one registered nurse
- one secondary care specialist doctor
- at least two lay people = one to champion patient and public empowerment and one to oversee audit, re-numeration and managing conflicts of interest
- GP member practices will decide how they are to be represented.

An Accountable Officer and a Senior Finance Officer must be appointed and an Audit and Re-numeration Committee established. A Quality Committee should be considered.

Other committees or sub-committees can be established according to the CCGs constitution.

Localities

CCGs may choose to operate at a lower population, or locality, level. This will require clear governance and accountability arrangements including schemes of delegation where necessary. Issues that will need to be considered include relationships with the CCG Governing Body, risk sharing, sharing and devolution of resources, consistency and compatibility with local arrangements of partner organisations.

Leadership roles

CCGs need to identify their leaders to ensure clinical leadership and discharge their functions to best effect. Leadership roles will include:

An Accountable Officer - to ensure the organisation functions effectively, efficiently and economically; fulfils all its obligations and requirements and the necessary managerial and leadership arrangements are in place. The role is explicitly differentiated from that of a Chief Executive and the se of the title Chief Executive is discouraged

The AO will be a GP who is a member of the CCG, and employee or any member of, the CCG, or where there is a joint appointment, an employee or member of any of hose groups. Further guidance on appointment of AO's will be issued including their expected skills and competencies.

Where the AO is not the Clinical Leader, the Chair of the governing Body should be, to ensure clinical leadership of the organisation is clearly demonstrated. The AO and the Chair of the governing body should not be the same person and the AO could fulfil the role on behalf of more than one CCG.

Chair of Governing Body – should be the Clinical Leader where this is not the AO. The role of the Chair was set out in the government's response to the Future Forum and further guidance will be issued in due course. If the chair is a GP, the Deputy Chair should be a lay member.

Chief Financial Officer – should hold a recognised professional accounting qualification and could exercise the role on behalf of more than one CCG.

The two lay members have separate roles as outlined above and one will be the deputy chair of the governing body.

Further consideration is being given to the issue of the two other clinician members not being employed in local provider organisations

Governance for collaborative arrangements across CCGs

A series of benefits from collaboration and sharing of functions between CCGs are suggested including clinical improvements, efficiency, resilience and risk management. Increased leverage with provider organisations is explicitly referred to. It is clearly stated that strong collaborative arrangements will lead to tangible benefits for patients.

Robust collaborative arrangements across and between CCGs will be required especially regarding joint commissioning arrangements with local authorities.

The Governance and accountability issues are described but the general tenor is that collaboration across CCG functions could being significant benefits.

Appendix 2 - NHS Outcome Framework

NHS Outcomes Framework

The NHS Outcomes Framework for 2012/13 was issued in December 2011 and identifies the indicators that will be used to assess the performance of the NHS against the priorities contained in the previously issued Operating Framework for the NHS.

The framework is structured across 5 Domains

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment; and protecting them fro avoidable harm

The NHS Outcomes Frameworks one part of a trinity that also includes the Public Health Outcomes Framework and the Adult Social Care Outcomes Framework.

All three should be aligned and complimentary with shared indicators such as Under 75 mortality rate from cancer which is intended to be shred with the Public Health outcomes framework (still awaited).

There are therefore important overlaps with local authority responsibilities for social care and public health and the integration of the frameworks is welcome.

The NHS Outcomes Framework will be used to hold the NHS Commissioning Board to account with the setting of expected improvements or level of ambition against indicators being set. Work to integrate health inequalities into the indicators is continuing.

The identification of international comparators is also progressing.

A summary table of the domains and indicators is attached.

1 Preventing people from dying prematurely

Overarching indicators

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare
1b Life expectancy at 75 i males ii females

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
Cancer
1.4 i One-and ii five-year survival from colorectal cancer
iii One-and iv five-year survival from breast cancer
v One-and vi five-year survival from lung cancer
vii under 75 mortality rate from cancer*

Reducing premature death in people with serious mental illness
1.5 *Excess under 75 mortality rate in adults with serious mental illness**

Reducing deaths in babies and young children
1.6.i Infant mortality* ii Neonatal mortality and stillbirths

Reducing premature death in people with learning disabilities
1.7 *An indicator needs to be developed*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions**

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition**

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions*

Reducing time spent in hospital by people with long-term conditions
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers**

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness **

Enhancing quality of life for people with dementia
2.6 *An indicator needs to be developed*

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 **Patient Reported Outcomes Measures** (PROMs) for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia
iv Varicose veins

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed*

Improving recovery from stroke
3.4 *An indicator to be derived based on the proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility / walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were i still at home 91 days after discharge into rehabilitation*** ii offered rehabilitation following discharge from acute or community hospital ***

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services ii GP Out of Hours services iii NHS Dental Services
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 *An indicator to be derived from the survey of bereaved carers*

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children and young people's experience of healthcare
4.8 *An indicator to be derived from a Children's Patient Experience Questionnaire*

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a Patient safety incidents reported
5b safety incidents involving severe harm or death

Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection (HCAI) i MRSA ii C. difficile
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

One framework
defining how the NHS will be accountable for outcomes
Five domains
articulating the responsibilities of the NHS
Twelve overarching indicators
covering the broad aims of each domain
Twenty-seven improvement areas
looking in more detail at key areas within each domain
Sixty indicators in total
measuring overarching and improvement area outcomes

The NHS Outcomes Framework 2012/13
at a glance

**Shared responsibility with the public health system and Public Health England and local authorities - subject to final publication of the Public Health Outcomes Framework.*

*** A complementary indicator is included in the Adult Social Care Outcomes Framework*

****Indicator replicated in the Adult Social Care Outcomes Framework*

Indicators in italics are placeholders, pending development or identification of a suitable indicator.

Appendix 3 – Updates to Public Health System

Public Health System Factsheets

A series of factsheets setting out the roles and responsibilities of local authorities including specific local authority public health functions, the role of the Director of Public Health and commissioning responsibilities have been issued by the Department of Health.

The factsheets give more information on the roles of local government and Public Health England and further details of which responsibilities will be mandatory for local government. Expectations of the accountability of Directors of Public Health are included.

Local government leading for public health

The factsheets emphasise the role of local authorities as a shaper of place and their expertise in building strong relationships with local populations and service users and in tackling health inequalities. Directors of Public Health (DPH) will be well placed to bring health inequalities into the mainstream of local authority's business as well as more widely, for example through relationships with the police for issues such as crime reduction, violence prevention and reducing reoffending, which also affect health inequalities.

To be effective local authorities should:

- Include health in all policies
- Invest the new ring-fenced grant in high-quality public health services
- Encourage health promoting environments
- Support local communities
- Tailor services to individual need
- Make effective and sustainable use of all resources, using evidence to direct to areas and groups of greatest need.

The importance of involving district councils in two-tier areas is emphasised.

Commissioning

The local authority commissioning responsibilities are set out. The Government expects that local authorities will commission, rather than directly provide, the majority of services to engage local communities and the third sector in the provision of public health. The desirability of a range of providers and of commissioning from staff-led enterprises is emphasised. Local authorities should decide which services to prioritise for choice on a diverse provider model based on local needs and priorities and informed by the joint strategic needs assessment. Local authorities are in an excellent position to test out new and joint approaches to payment by outcomes, such as reducing drug dependency.

The role of the Director of Public Health

The Health and Social Care Bill makes clear that each authority must, acting jointly with the Secretary of State for Health, appoint a Director of Public Health. The DPH can be shared with another local authority, where that makes sense. DPHs may come from "a wide range of disciplines including, but not limited to, medicine".

Directors of Public Health will be added to the list of statutory chief officers. Statutory guidance on the responsibilities of the Directors of Public Health will be issued. Further guidance has been issued to relating to the appointment of a DPH through a letter from the Chief Medical Officer and the Chief Executive of the LGA.

The Government expects direct accountability between the DPH and the local authority Chief Executive for the exercise of the local authority's public health responsibilities but it is unclear how this will operate in authorities that do not have a Chief Executive post.

Responsibilities of the DPH

- the public health functions of local authorities
- the DPH annual report on the health of the local population
- statutory membership of health and wellbeing boards
- promoting opportunities for action across the "life course" working with the Directors of Children's Services and Adult Social Services
- working with local criminal justice partners and the proposed new Police and Crime Commissioners.
- Day-to-day responsibility for the ring-fenced grant.

A Public Health Workforce Strategy is to be published, accompanied by formal public consultation.

Public Health responsibilities of Local Authorities

It is intended that local authorities have key responsibilities across the three domains of public health.

Some responsibilities are mandatory:

- Appropriate access to sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- Steps to be taken to protect the health of the population, in particular giving the local authority 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
- NHS Health Check assessments
- The National Child Measurement Programme

Further consideration is being given to responsibility for the Healthy Child Programme (Ages 5-19).

Other responsibilities include:

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (and in the - longer term all public health services for children and young people)
- interventions to tackle obesity
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- 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
- local initiatives to reduce excess deaths as a result of seasonal mortality the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks
- Local authorities may also choose to commission additional services under their health improvement duty.

The Government has revised its previous view that abortion services would rest with local authorities. They will remain provisionally with the NHS and be commissioned by clinical commissioning groups, subject to further consultation. Sexual assault services will rest with the NHS Commissioning Board and responsibility for early diagnosis of cancer etc will be shared between Public Health England and the NHS Commissioning Board.

In relation to commissioning services for children under 5, the Government aims to bring responsibility for these services within local government by 2015.

Public health advice to NHS commissioners

This factsheet gives considerable detail on the type of advice that local authorities will be expected to give NHS commissioners. This includes population data of the kind that local authorities are familiar with, but also more medical advice, such as advice on medicines management and prescribing policies.

Professional appraisal and support, and capacity building

Public health specialists working in local authorities will continue to be expected to undergo the revalidation process. The Department of Health will also expect non-medical public health specialists to undergo a professional appraisal. Options are currently being considered on how this will work.

Much of the information given in these factsheets is not new. What is new is the amount of detail on matters such as the advice service that DsPH and their teams will be required to provide to the NHS and to Clinical Commissioning Groups in particular.

Appendix 4 – Public Health England Operating Model

Public Health England Operating Model

The operating model for Public Health England (PHE) has been issued detailing how Public Health England (PHE) will be expected to work with local government and their respective roles. Detail is also given of the proposed national, regional and local structures for PHE, including local units spanning a number of local authority areas and based on the existing Health Protection Units. PHE will be expected to take a major role in emergency planning and further detail will be issued on its role and the respective roles of Directors of Public Health.

Subject to the passing of the Health and Social Care Bill, in April 2013 Public Health England will be established as an executive agency of the Department of Health, and its Chief Executive will be accountable, to the Permanent Secretary and the Secretary of State for Health, for performance and strategic development. It will have an advisory Board with at least three non-executive members.

Local authorities will lead local public health and PHE will not duplicate the work they do. PHE will be expected to develop "a culture of subsidiarity", focused on support for local accountability and action. PHE will be "the expert body with the specialist skills to support the system as a whole". It will support local authorities by providing services, expertise, information and advice "in a way that is responsive to local needs" and is based on evidence of what works.

PHE will work with the NHS Commissioning Board to provide public health and population healthcare advice "to ensure the prevention of ill health and promotion of good physical and mental health and wellbeing are addressed systematically across services and care pathways". PHE will work with the devolved administrations to tackle nationwide threats to health from infectious disease, radiation, chemicals and other health hazards and to respond to UK-wide emergencies.

The three main functions of PHE are:

1. **Delivering services to national and local government, the NHS and the public**

    - specialist public health services as described above
    - information and intelligence to support effective action locally and nationally
    - support for NHS and local authority health and care services and public health programmes

2. **Leading for public health**

    - publish information on local and national health and wellbeing outcomes and supporting improvement action
    - support public health policy development

- support effective and integrated public health delivery across the system
- work with partners to build the evidence base

3. Supporting the development of the specialist and wider public health workforce.

Organisational structure

PHE will have three structural components:

- a national office with four hubs that oversee its "locally facing services" – these will be co-terminous 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 these locally facing services and act in support of local authorities, organisations and the public in their area will be developed from the 25 current health protection units of the Health Protection Agency to provide co-ordination across several local authorities in managing incidents and outbreaks. Consultation about how Public Health England can best provide its responsiveness and expert contribution to localities will occur with local authorities, health and wellbeing board early implementers and local partners in early 2012

- a distributed network for some functions including information and intelligence, and quality assurance, located alongside the NHS and academic partners.

Timetable

The Chief Executive will be appointed in April 2012.

Approximately 5,000 existing staff will transfer to PHE from the Health Protection Agency, the National Treatment Agency for Substance Misuse, the NHS, the public health observatories and the Department of Health from April 2013. Full details of this transfer will be published in June 2012.

While the operating model gives more definition to the proposed functions of Public Health England, further clarification about the roles of PHE and local DPH's in providing expert advice to the NHS, particularly in the area of emergency planning and resilience will be needed.

Appendix 5 – Local Healthwatch

Local HealthWatch

The government has announced some significant changes to the timescales for establishing Local HealthWatch and further details around funding:

- Local HealthWatch will now start in April 2013, rather than October 2012. Synchronising the start date with other NHS reforms will help us ensure that we set up Local HealthWatch to support the new health landscape in Kent.

- £5k funding for each of the Local HealthWatch pathfinders has now been agreed (KCC, the Kent Link and Kent and Medway Networks put in a joint bid and have been accepted onto the pathfinder programme)

- The exact sum that Local Authorities will receive to fund Local HealthWatch has not yet been announced although we have been informed that it will be based on the Relative Needs Formula rather than working age population

- In recognition of the critical leadership role Local Authorities have in setting up Local HealthWatch, The Local Government Association has established a new HealthWatch Implementation programme sponsored by the Department of Health. Lorraine Denoris who led Kent's LHW Readiness Programme, is to be the Strategic Co-ordinator for this programme.

NHS
Kent and Medway

Kent Public Health OutlineTransition Plan

v.1.1

January 2012 to March 2013

Thursday, 01 March 2012

Version Control

Version	Date	Amendments
v.1	18 January 2012	Creation of original and draft outline plan following publication of DoH guidance and the requirement to submit this plan to SHAs by the end of January 2012
v.1.1	20 January 2012	Updated document, added lead names where identified and cross checked with Medway's PH Outline Transition plan.

Introduction

This Kent Public Health Transition Plan supports NHS Kent and Medway and Kent County Council in the transformation of the local public health system including the transfer of accountability from the NHS to local government through the transition year.

The plan is build upon Department of Health and Local Government Association guidance published in January 2012:

1. Public health transition planning support for primary care trusts and local authorities[1]
2. Public Health workforce issues. Local government Transition guidance[2]

Whilst this plan pertains to NHS Kent and Medway and Kent County Council, there will also be an analogous plan for NHS Kent and Medway and Medway Council and where the plans relate to NHS Kent and Medway, the plans will be aligned to ensure a consistent and collective approach.

The plan builds upon further guidance published previously in December by the Department of Health including:

- The New Public Health System: Summary
- Public Health in Local Government:
    - Local government leading for public health
    - Local government's new public health functions
    - The role of the Director of Public Health
    - Commissioning responsibilities
    - Public health advice to NHS Commissioners
- Professional appraisal and support, and capacity building
- Public Health England's Operating Model

[1] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132178

[2] http://www.dh.gov.uk/health/files/2012/01/public-health-workforce-issues.pdf

1. **Ensuring a robust transfer of systems, services and staff**

Define Elements of Transfer	Current status	Actions	Identified Lead
Understood and agreed set of arrangement as to how the local public health will operate during 2012/2013 system	○ Memorandum of Understanding between the NHS Kent and Medway PCT Cluster and Kent County Council	○ MOU require updating to reflect the County abolishing the post of Chief Executive ○ MOU needs updating to reflect how the public health system will operate during 2012/13 ○ Agree working arrangements for joint working between Kent County Council and Medway Council ○	
Plan that sets out the main elements of transfer including functions staff TUPE and commissioning Contracts for 2012/12 and beyond	○ Mapping exercise completed for current establishment – 1/4ly returns submitted to DH; ○ Establishment matched against ESR/public health budgets ○ Employment T&C and PCT HR policies – eg Office locations – estates review in hand	○ Cluster PCT organisational change policy yet to be agreed ○ Liaise with new Cluster HR lead ○ Impact on staff of potential proposed relocation of base	Susan Nwanze….PCT HR lead for PH Transition Amanda Beer KCC Karen Hudson KCC

Agreed transition milestones	○ Part of wider PCT Cluster programme ○ Undertaking work to ensure there is an agreed set of milestones for transition ○ Meeting 8th February to gain agreement on key HR milestones	○ Need to agree PH transition milestones as part of overall transition	○
Plan to develop the Joint Strategic Needs Assessment	Kent Health and Wellbeing Board in shadow status as one of the national pathfinders Public Health currently producing and consulting upon a new JSNA for Kent.	JSNA summary to Performance Overview and Scrutiny Committee; mid Jan 2012 JSNA to H&WB Board 18th Jan 2012 JSNA to All Party member briefing 31st Jan 2012 JSNA to Be consulted upon and completed by March 18th 2012	Meradin Peachey Abraham George Natasha Roberts
Plan for ensuring the smooth transfer of and commissioning arrangements to Kent County Council	○ Contract Mapping exercise completed as part of Cluster review (lead by Daryl Robertson) ○ Novation lead identified ○ Performance management process in place 2012/13 ○ providers and CCGs to receive letter of intent re services to be contracted until 31.3.13 ○	○ Governance pathways and accountabilities to be defined ○ Need to engage with LA process ○ Performance of PH programmes currently reported to POSC and PAT (both in KCC governance system) ○ Need to further check we	Matt Capper (PCT) Tricia Bailey

		have complete set of contracts covered ○ Ensure we have agreements with KCC on: ○ Transition risk registers agreements ○ Assurance Framework	
Plan for ensuring the smooth transfer of public health functions and commissioning arrangements migrating to the NHS Commissioning Board and Public Health England	○ Totality of movement yet to be determined: ○ Screening ○ Imms and Vacc ○ PH support to Specialist Commissioning ○ Ensure PH Consultant input into the Kent HP On-call rota is maintained	○ Need to develop and test ongoing understanding of how PH functions will move to Public Health England and NHS Commissioning Board ○ Ongoing communication with Kent HPU as transition proceeds	○
Plan on delivering the core offer of Kent County Council public health support (advice) to Clinical Commissioning groups	○ specification written; discussions being held with CCGs on PH leads for each CCG in Kent ○ PH leads for each CCG currently identified and are working with each CCG	Revisit as and when CCGs combine/merge/change	Declan O'Neill

2. Meeting Public Health Delivery Plan and Target during Transition year

Define Elements of Transfer	Current status	Actions	Identified Lead
Delivery of mandated services during and after transition • Appropriate access to sexual health services • Plans to protect the health of the population • Public health advise to commissioners • National Child Measurement Programme NHS Health check measurement	○ Delegated leads identified– review in light of staff changes ○ JSNA and Needs Assessments ○ Health checks ○ Emergency planning in place ○ MOU with local Kent HPU ○ PH advice to commissioners ○ PH advice to Clinical Networks eg Cardiovascular etc	○ Retirement of WK DoHI; authorised signatory/budget lead ○ Identify gaps ○ Ensure business continuity (2012 to 2013 ○ Olympic year – impact of external events) ○	○
Clarity around the delivery of critical PH services/programmes locally: • Screening programmes • Immunisation programmes • Drugs and alcohol services • Infection control and prevention	○ Current programmes in place and are robust. ○ Screening Programmes currently co-ordinated for Kent and Medway via Kent PH department with specialist team ○ Imms and Vacc co-ordinated by Kent PH department ○ Drugs & Alcohol services commissioned via Kent DAAT hosted by KCC ○ Infection Prevention and Control currently provided by the Director of Nursing	○ There is a need to undertake further work locally as to how these are delivered through transition and beyond and testing of those arrangements carried out	

3. Workforce

Define Elements of Transfer	Current status	Actions	Identified Lead
Have the workforce elements of the plan been developed in accordance with the principles encapsulated within the Public Health Human Resources Concordat	○ Mapping staff destinations ○ 1-2-1 meetings for all staff ○ 1/4ly returns completed ○ Letters to all staff 31st January ○ Future Structure ○ Appointment of DPH guidance issued ○ Skill mix ○ Identify future functions to inform appropriate skill mix ○ Identify job descriptions/persons spec ○ Intelligence support to CCGs ○ Mandatory training/revalidation ○ All staff to continue to use existing appraisal process; ○ PDPs identified; ○ training identified ○	○ HR have informed letter to be issued in January to all staff ○ HR to identify timetable for TUPE requirements etc ○ Specialist HR advice required (e.g. for contracts for medics) ○ Awaiting timetable ○ Ensure correct interview process is adhered to prevent legal challenge ○ Consultation timetable ○ Communications ○ Full and working alignment to KCC directorates ○ Workforce co-ordinator to advise? ○ Create portfolio of appropriate JDs – align with KCC HR processes? ○ Identify “back office/admin” support both within public health, and elsewhere (eg finance, comms, HR, commissioning) ○ needs to align to KCC processes	○

4. Governance

Define Elements of Transfer	Current status	Actions	Identified Lead
Does the PCT with local Authority have in place robust internal and performance monitoring arrangements to cover the whole transition year, including schemes of delegation	○ Cluster PCT Board ○ Cabinet/POSC and PAT ○ Health & Wellbeing Board ○ Strategic Oversight Board	Schemes of delegation in place; these will require agreement and transition to KCC Transition plan to go to POSC in March for member scrutiny	
Are there robust arrangements in place for key public health functions during transition and have they been tested eg new emergency planning response to include: Accountability and governance Details of how the Director of Public Health, on behalf of the local authority, assures themselves about the arrangements in place Lead Director of Public Health arrangements for emergency planning, preparedness and response, and how it works across the Local Resilience Forum area.	○ NHS Emergency planning team streamlined across Kent and Medway ○ Team fully integrated with the Kent LRF with the DPH continuing to attend key LRF meetings through transition ○ Plans outline one emergency response across Kent and Medway ○ MOU with HPA and Consultants continuing to provide on call rota support for PH emergencies	Ensure NHS emergency planning team transitions to appropriate place in the new system	Meradin Peachey Matthew Drinkwater
Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of serious untoward incidents/incident	○ Currently via PCT arrangements through	○ Need to work through these governance arrangements for future SUIs , PGDs etc	

reporting and Patient Group Directions			
Has the PCT with the local authority agreed a risk sharing based approach to transition	○ Discussions commenced on risk sharing		
Is there an agreed approach to sector-led improvement	○ Links to CCGs commissioning plans; CCGs have PH named lead ○ Cluster Operating Framework ○ Health Improvement programmes commissioned with LAs and KCHT ○ Links with JSNA and Needs assessments ○ PH links to Clinical Network and emerging Clinical ○ Formal arrangements through joint KCC/PCT Strategic Oversight Board	○ Continuity and succession planning continue to be key to the successful transition	
Is the local authority engaged with the planning and supportive of the PCT approach to public health transition	○ KCC and NHS Kent and Medway fully engaged at a senior level	○ Further work to engage leads to ensure all elements of the plan are covered	

5. Enabling Infrastructure

Define Elements of Transfer	Current status	Actions	Identified Lead
Has the PCT with the local authority identified sufficient Capacity and capability to deliver plan	○ Leads identified	Further leads require identification	
Has the PCT with the local authority identified and resolved significant financial issues	○ Mapping of current spend to shadow budget when published ○ Agreement on overheads ○ Estates	○ hidden costs to be fully identified (resources utilised by public health but not within ph budget e.g. commissioning support, finance support, Comms and engagement , HR support,	Finance leads to be identified from both PCT and KCC
Has the PCT with the local authority agreed novation/other arrangements for the handover of all agreed public health contracts	○ PH contracts and SLAs – Process in place to ensure contracts list is comprehensive and includes PH contracts and SLAs	○ Further work to check list is comprehensive and covers everything	Matt Capper
Clinical and non clinical risk and indemnity issues identified for contracts	○ Currently within standard NHS contracts and within the corporate PCT costs	Discussions in process with KCC	Matt Capper
Are there plans in place to ensure access to IT systems, sharing data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer	○ Currently sits under PCT ○ Access to PCT held info post-transition process established within PCT (eg FOI requests/ access to old docs) ○	Info Sharing agreements to be reviewed future access to NHS data through audit of GP/hospital/KCHT data if public health staff are no longer NHS	Jamie Sheldrake Mark Gray Mark Ashby Terry Hall

		employees ? national view on this ○ Work required on access to current NHS data, information system, library systems, NHS.net for confidential information	
Have all issues in relation to facilities, estates, and assest registers been resolved.	○ Currently sits under PCT ○ Asset register to be interrogated to identify what needs to transfer	○ Estates review in hand ○ Asset review also required to understand what assets PH use and how these will be handled in the trasnfer	Terry hall, IT leads East and West Kent
Plan in place for the development of a legacy handover document during 2012/13	○ PH contributes to cluster document	Need to delineate the PH legacy to be handed over to KCC	Judy Clabby

6. Comms and Engagement

Define Elements of Transfer	Current status	Actions	Identified Lead
Is there a robust Communication plans and does it consider relationships with: • The Health and Wellbeing Board • Clinical Commissioning Groups • NHS Commissioning Board • HealthWatch • Local professional networks	○ Need one	○ ? how links to KCC comms/engagement plan	○
Is there a robust engagement plan involving stakeholders, patients, the public, providers or public health services, contractors and PH England.	○	○	○

Appendix 7 - The Public Health Outcomes Framework – Improving Outcomes and supporting transparency

The Public Health Outcomes Framework – Improving Outcomes and supporting transparency -has been published very recently. It is designed to complement the outcomes frameworks for the NHS and Adult Social Care. It contains the indicators that will be used to gauge how well each authority is addressing public health issues and in particular how they are impacting on health inequalities in their area. Performance against these indicators will inform the distribution of the Health Premium funding although we still await details of how this will be calculated.

The Public Health Outcomes Framework consists of over 60 indicators that are divided between 4 key domains:

Improving the wider determinants of health

Health Improvement

Health Protection

Healthcare public health and preventing premature mortality

The domains and indicators are designed to address public health issues across the Marmot Life Course.

The domains and indicators are attached.

Fuller briefing on the public health outcomes framework and budget can be a brought to future meeting.

Appendix A: Overview of outcomes and indicators

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

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

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- 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 (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- 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 (Placeholder)*
- 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

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- 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 (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from 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 (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Appendix 8 - Briefing on the development of Clinical Commissioning groups in Kent and Medway

In anticipation of the Health and Social Care Bill's passage through Parliament, GPs in Kent and Medway are being asked to form 'Clinical commissioning groups' (CCGs). Subject to the passage of the Bill these groups will be authorised as statutory NHS organisations and take on the responsibility for commissioning health care for their constituent populations.

The CCGs will take over the health commissioning responsibilities from the PCTs. In total, 80% of the PCTs commissioning budgets are anticipated to transfer to CCGs. Unlike PCTs the CCGs will be membership organisations with each constituent GP practice being a constitutionally recognised member of the CCG.

In preparation for the establishment of CCGs, the PCTs will be delegating commissioning responsibilities to the emergent CCGs through establishing them first as sub committees of the PCT Board for 2012/13.

In Kent and Medway it is anticipated that there will be 7 CCGs.

CCG	**Population size (based on GP list size)**	**Estimated potential budget '000**	**Clinical leaders**
Maidstone and Malling with West Kent and the Weald (A single CCG will be confirmed by the current CCG Boards during February.)	463,741	£525, 372	Dr Bob Bowes and Dr Garry Singh
Dartford, Gravesham and Swanley	248,364	£302,063	Dr David Woodhead
Medway	281,923	£340,040	Dr Peter Green
Thanet*	140,157	£213,412	Dr Tony Martin
Ashford*	121,533	£146,582	Dr Navin Kumta
Canterbury* (C4G)	210,107	£262,933	Dr Mark Jones
South Kent Coast*	199,192	£287,028	Dr Chee Mah, Dr Chaudhuri and Dr Bruce Cawdron

* denotes CCGs within the East Kent Federation of CCGs

There is no current resolution for the GP practices in Swale.
In addition to CCGs, the new health commissioning architecture will include the following bodies: Upper tier local government, Public Health England, NHS Commissioning Board, Commissioning support services.