



## **PUBLIC HEALTH TRANSITION**

### Project Initiation Document

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## 1 PURPOSE

The purpose of this project initiation document (PID) is to define the project and to form a firm basis for its management. Information included in the PID will answer the following questions:

- What is the project aiming to achieve?
- Why it is important to achieve it?
- Who will be involved and what are their responsibilities?
- How and when will it happen?

## 2 DOCUMENT CONTROL

| Version             | Date    | Description  | Name & Location   |
|---------------------|---------|--|---|
| Version 1.0 (Draft) | 3/6/11  | Draft presented to Public Health Transition Steering Group on 3/6/11   | 'DRAFT PID & Project Plan 3.6.11.doc'<br>L:\DIR PUBLIC HEALTH\Directorate\General PH\2010 changes\PHTransition Steering Group\2011 June 3       |
| Version 2.0         | 21/7/11 | Amended following comments at PHTSG meeting on 3/6/11 and subsequent discussions. Workstream plans incorporated or referenced. | 'Version 2 PID & Project Plan 21.7.11.doc'<br>L:\DIR PUBLIC HEALTH\Directorate\General PH\2010 changes\PHTransition Steering Group\2011 July 21 |
| Version 2.1         | 29/7/11 | Amendments suggested by PHTSG meeting on 21/7/11 incorporated.   | Version 2.1 PID & Project Plan 29.7.11.doc<br>L:\DIR PUBLIC HEALTH\Directorate\General PH\2010 changes\PHTransition Steering Group              |

## 3 PROJECT BACKGROUND AND CONTEXT

Public Health leadership is planned to move from NHS Sheffield (NHSS) to Sheffield City Council (SCC) as indicated in the Public Health White Paper (2010). The latest date by which this move should take place is April 2013, at which time NHS Sheffield (the Primary Care Trust) will cease to exist (subject to the passage of the Health and Social Care Bill).

Other substantial changes are taking place in the organisation of the NHS at the same time, which will influence the requirements on Public Health in Sheffield. In particular, Clinical Commissioning Groups are being established to undertake the bulk of NHS commissioning; new Health and Wellbeing Boards are being established in top tier local authorities to have oversight of all health and social care commissioning within the area; Public Health England will be established as a new national public health service (incorporating the current roles of the Health Protection Agency and the National Treatment Agency, among other functions); and a new NHS Commissioning Board will be established to commission primary care and specialist services.

### 3.1 Vision for public health in Sheffield

The following vision statement has been developed for approval by SCC Cabinet and NHS Sheffield Board:

*The transfer of public health leadership from the NHS to the City Council is a once in a generation change and opportunity for Public Health. Public Health being led from the City Council will broaden the scope of public health activity, and enable us to have an impact on a much wider range of factors that determine health and ill health for the people of Sheffield. We will build on this change so as to make the biggest possible impact on the health of the citizens of Sheffield.*

*Our aims are both simple and ambitious: to promote good health; to prevent and tackle ill-health; to enable all of us as citizens to make healthier lifestyle choices; and to develop public health capacity and know-how across organisations and communities so as to make a real difference.*

*Although health in Sheffield has improved dramatically in recent years, there are still populations within the City who suffer unacceptably poor health, and wide inequalities in health persist. Health inequalities are among the starkest manifestation of unfairness within our society, and we are committed to reduce them as much as possible.*

*We seek to prevent avoidable ill health wherever it occurs, and to ensure that where ill health does exist, any barriers faced by disadvantaged individuals and communities to necessary treatment and care are removed.*

*We will work with people to ensure they have maximum choice and control in designing their own solutions to things which adversely affect their own, their families' and community's health.*

*To do this we will work with local people and organisations to address the root causes of ill health. We will seek to ensure that the circumstances in which people live and work do not cause them to become unwell. However we are aware that lifestyle 'choices' are heavily influenced by the circumstances in which people live, so that helping people to lead healthier lifestyles means in many cases changing those circumstances.*

*Sheffield City Council will lead Public Health in the City beyond 2011. We will turn the Council into a public health organisation, so that every contact the Council has with the people of Sheffield is designed to have a positive impact on their health. Furthermore, from within the Council we will organise the efforts of the whole of Sheffield society to promote health, prevent disease, and prolong life. Wherever possible, we will prioritise improving the health of those whose health is currently poorest, so as to reduce inequalities.*

*Although Public Health will be led by the Council, Public Health capacity will not be restricted to it. Public Health expertise will also be active and visible in local communities, amongst GPs, in the NHS, in wider public services, in the voluntary, community and faith sector, and in local businesses.*

*Our vision is that by doing all this, we will improve health and wellbeing for all.*

### **3.2 Project approach**

The project will follow the main stages outlined below. Each stage is considered complete on sign-off of its key deliverables.

#### **Stage 1: Project initiation**

- Agreement of vision for public health in Sheffield
- Establishment of Public Health Transition steering group and workstreams with identified leads.
- Public Health Transition Plan agreed, with timescales, performance management and monitoring approach specified
- Mapping of existing NHS Sheffield and Sheffield City Council public health activity and cost

#### **Stage 2: New arrangements agreed**

- A model of a new public health service delivered from the local authority, including a model for input by public health into the Clinical Commissioning Groups
- SCC Cabinet and NHSS Board agreement of the post-transition model of public health provision in SCC

#### **Stage 3: Implementation of new arrangements**

- Human resource processes implemented to enable staff to be transferred safely
- Process for transfer of a ring fenced public health budget established

#### **Stage 4: Project closure with new arrangements in place**

- Staff and budget transferred by April 2013 at latest
- Evaluation and Review Plan

## 4 PROJECT DEFINITION

### 4.1 Project Aim

The overarching aim of the project is to ensure a safe and effective transition of the public health function from NHS Sheffield to Sheffield City Council. The transition should ultimately enable a broadening of the scope of public health activity to have an impact on a much wider range of factors that determine health and ill health for the people of Sheffield.

A paper on the future shape of public health in Sheffield written by the Director of Public Health with input from SCC is attached (Appendix I). Recommendations from this paper are:

- A 'distributed' model of Public Health be adopted as the preferred model
- Negotiations continue with Senior Officers and elected members within SCC to determine the detail and implement the model.
- Discussions continue with Clinical Commissioning Group colleagues about the best way to make Public Health expertise available to them, and the best way to make primary care more public health focussed.

### 4.2 Project Objectives

This section outlines specifically what Sheffield City Council and NHS Sheffield aim to achieve through the public health transition project. The project objectives will be guided by the priorities for public health in Sheffield and will:

- Determine a form for public health within Sheffield City Council that reflects the functions of its public health leadership
- Ensure the model that emerges for public health in SCC is capable of securing maximum public health outcomes for the city from the resources available
- Ensure the arrangements for health protection and the NHS elements of emergency planning and resilience are integrated appropriately within SCC (and with other external bodies as appropriate)
- Establish a model for public health input into the commissioning function to be performed by Clinical Commissioning Groups (CCGs)
- Support staff in NHSS and SCC through the uncertainty of the change process
- Establish robust communication and consultation processes
- Establish the working arrangements and relationships for public health in the council with Public Health England
- Establish the working arrangements and relationships for public health in the council with other existing and future NHS providing and commissioning bodies
- Transfer staff to the SCC within a properly managed HR process
- Transfer the ring fenced public health budget from NHS Sheffield to Sheffield City Council

### 4.3 Project Scope

The project will be directed and overseen by the Public Health Transition Steering Group. Its work will be done through five workstreams, each one jointly led by an officer from NHS Sheffield and one from Sheffield City Council. The workstreams are summarised in Table 1.

*Table 1: Summary of workstreams*

| Name                         | Overarching scope of each workstream  | Joint Leads                                    |
|------------------------------|---|--|
| 'Model'                      | Design and development of a model for public health delivery in Sheffield City Council, including relationships with CCGs & Public Health England | Lee Adams (SCC)<br>Jeremy Wight (NHSS)         |
| 'Human Resources'            | Human Resource elements of public health transition, including internal relations & communications with NHS and SCC staff                         | Sue Palfreyman (SCC)<br>Christine Joy (NHSS)   |
| 'Finance'                    | Finance implications of the transition, including work on the ring-fenced budget  | Liz Orme (SCC)<br>Brian Richards (NHSS)        |
| 'Corporate'                  | Corporate issues including: governance; legal; contracts; procurement; business transfer; estates & facilities; IT                                | Barry Mellor (SCC)<br>Jill Dentith (NHSS)      |
| 'Public Health Intelligence' | Public Health Research, Information and Analysis  | James Henderson (SCC)<br>Louise Brewins (NHSS) |

#### 4.4 Project Assumptions

This PID and the associated project plan are based around a number of key assumptions which are detailed as follows:

| Ref. | Assumption Description  |
|------|---|
| 1    | The national policy direction of transferring the public health function from the NHS to local authorities remains unchanged during the national 'pause' and subsequent legislative amendment |
| 2    | The deadline for the transition to be completed is April 2013 when PCTs are to be abolished   |
| 3    | The vision for public health is agreed by SCC Cabinet and NHSS Board  |
| 4    | A 'distributed' model for public health is acceptable to SCC  |

#### 4.5 Interfaces

The external organisations / third parties this project interfaces with include:

- Project to establish new Health & Wellbeing Board and Health Watch
- Clinical Commissioning Groups
- Public Health England
- South Yorkshire & Bassetlaw PCT Cluster
- National Commissioning Board
- Acute and community trusts and VCF sector in Sheffield

### 5 PROJECT ORGANISATIONAL STRUCTURE

The sponsors of the project are Lee Adams, Deputy Chief Executive of Sheffield City Council, Richard Webb, Executive Director of Communities, Sheffield City Council and Jeremy Wight, Director of Public Health, Sheffield City Council and NHS Sheffield.

#### 5.1 Project Board: The Public Health Transition Steering Group (PHTSG)

The PHTSG will direct and supervise the transition of the public health function from NHS Sheffield to Sheffield City Council and will report to the Shadow Health and Wellbeing Board once this group is established. Until then, it will report to the NHS Transition Team and to the SCC Health Transition Board. The Chair of the Steering Group is Jeremy Wight and the Deputy Chair is Lee Adams. Please see Appendix II for the full terms of reference of the PHTSG. The steering group will oversee the work of the project through its various workstreams. The leads for each workstream are members of the steering group.

##### 5.1.1 Overview of PHTSG responsibilities

- Provide overall direction and management of the public health transition
- Hold accountability for the success of project
- Provide the 'project voice' to the outside world: disseminating information from and conveying external information to the project
- Ensure required resources are available
- Provide direction to workstream leads
- Monitor progress of work streams through their reports to PHTSG meetings
- Approve all major plans and authorise changes
- Provide an escalation point for key unresolved project issues that have not been able to be resolved through the normal process of dialogue and investigation between interested parties

#### 5.2 Work streams

The work of the project will be done through the five workstreams which are summarised in Section 4.3. Workstreams plans are presented in more detail in section 7.

## 6 COMMUNICATION PLAN

There is an integrated communications plan for the overarching health transition project. It is important that all groups are given consistent messages. Table 2 outlines some of the public health specific activities being undertaken, but these should be read within the context of the integrated communications plan. This is currently being co-ordinated within the Sheffield Health Transition Project Team (see Section 9.2.1)

Responsibility for public health transition internal communications (with NHS Sheffield and Sheffield City Council staff) lies within the Human Resources workstream, guided by the integrated communication plan. Responsibility for communications with external bodies lies with the Sheffield Health Transition project generally, and specifically within the model workstream: for example developing relationships and models of working with Clinical Commissioning Groups and Public Health England.

Table 2: Public health communication activities

| Interested party   | Information  | Provider   | Frequency                                 | Method of Communication  |
|--|--|--|---|--|
| All stakeholders   | Consultation and engagement  | Public Health Transition Steering Group            | One off event to be held in November 2011 | Stakeholder event  |
| All stakeholders (NHS; SCC; Clinical Commissioning Groups) | Public Health Prospectus   | Deputy DPH NHS Sheffield Public Health Directorate | One off. Published in June 2011           | Publication available on NHS Sheffield website* and copies distributed to key stakeholders |
| Public Health Staff NHS & SCC                              | Weekly update  | DPH  | Weekly                                    | Email / Public Health team   |
| NHS Sheffield staff  | Update and discussion  | DPH  | Fortnightly                               | 'Darnall Café' lunchtime meeting   |
| Board and Executive Management Teams NHSS and SCC          | Seeking agreement to approach Requests for authorisation to proceed Progress updates | Public Health Transition Steering Group            | To comply with corporate timescales       | Meeting papers   |

\* <http://www.sheffield.nhs.uk/about/publications.php>

## 7 OUTLINE PROJECT PLAN

Section 8 contains a first draft of a table containing key elements of the delivery plan. It is anticipated that this will be populated in more detail by workstream leads, once the approach set out in this section for each workstream has been agreed at the PHTSG meeting on 21/7/11. Once key tasks and actions are identified for each area of work, a GANTT chart should be prepared to show visually the timeline of the project.

### 7.1 Model

The joint leads for this workstream are Jeremy Wight, Director of Public Health for NHS Sheffield and Sheffield City Council and Lee Adams, Deputy Chief Executive of Sheffield City Council. The below represents an earlier version of a plan for this work; this will be refined and updated at the first meeting of the workstream on 22/7/11.

### 7.1.1 Background (Where are we now?)

The Public Health Directorate in NHS Sheffield has 109 posts (93 wte) and 100 staff in post (84 wte). This includes DAAT and Development Nursing team posts. The Directorate budget is approximately £5.8M, the majority of which is spent on staff costs (this does not include the Pooled Treatment Budget for substance misuse treatment, and a number of budgets for commissioned public health activity. Three consultants are jointly appointed (with the Children's and Communities' portfolios in SCC). The Directorate covers the full range of PH functions, including health improvement, health intelligence, support to health services commissioning, and health protection (in conjunction with the Health Protection Agency). It also includes the Drug and Alcohol Action Team (DAAT). Strong relationships already exist with Community Assemblies, and are being established with Clinical Commissioning Groups. Within Sheffield City Council there is a Director of Health Improvement with a small supporting team. Most City Council functions impact on the health of the public, though few City Council staff would identify themselves as working in Public Health.

Most Public Health services are commissioned by NHS Sheffield (PH Directorate and others) and provided by a range of external agencies – both NHS trusts and voluntary sector organisations. In addition GPs deliver PH interventions such as vaccination programmes, chronic disease management programmes, certain screening services, etc., either as part of core contracts or as enhanced services. The Directorate also has a team of PH nurses who work with primary care to improve long term conditions management and deliver QIPP targets. A Healthy Communities team work at a local community level developing, coordinating and commissioning services, and providing training.

A ring fenced budget for public health will be identified from NHS resources and transferred from the NHS to Public Health England (PHE). PHE will allocate funding to local authorities, keeping a proportion of the funding back in order to commission some public health services itself (this may include some screening services, vaccination and immunisation services, etc). This budget will be in 'shadow' form in 2012/13, and implemented in full in 2013/14.

Initial thoughts about how the different programmes which it will be the responsibility of LAs to commission (according to the Funding and Commissioning consultation paper) may be organised are presented in Appendix III. Other local priorities are identified in Appendix IV.

### 7.1.2 Purpose

The recent Government White Papers indicate that Public Health will transfer to Sheffield City Council. We need to ensure that the new arrangements for Public Health in Sheffield are designed so as to ensure maximum effectiveness in delivering population health improvement and reduction in health inequalities.

### 7.1.3 Membership

- Director of Public Health (Jeremy Wight) (Lead)
- Deputy Chief Executive (Lee Adams) (Lead)
- Consultant in Public Health, NHSS / SCC (Fiona Day)
- Consultant in Public Health, NHSS / SCC (Sue Grieg)
- Director of Health Improvement, SCC (Chris Shaw)
- GP (Ted Turner)
- SCC Director, Place (Name to be confirmed)

### 7.1.4 Objectives

- An optimally sized and designed Public Health Department within the City Council to deliver agreed functions. These will include providing strong strategic leadership, maximising the public health influence on other parts of the Council so as, in turn, to maximise the health improvement impact of the whole organisation.
- Effective commissioning of health improvement activities from other agencies.

- Effective commissioning of selected health services, e.g. treatment for substance misusers, certain services for children and young people, sexual health etc.
- Ensure that public health support is integrated (on a day to day basis) into the CCG in its commissioning of health and social care services
- Ensure clear and strong links with primary care as health service providers and as deliverers of health improvement
- An effective health protection function, working in conjunction with Public Health England (which will incorporate the current Health Protection Agency). This will include the Public Health contribution to emergency planning and management of infectious diseases and environmental hazards.
- Ensure these changes are complementary to other organisational changes the NHS is undergoing, including the development of joint commissioning with SCC.

#### 7.1.5 Scope

#### 7.1.6 Deliverables

- Agree the key functions of Public Health in SCC and design the new public health arrangements to enable them to be achieved.
- Review the existing PH Directorate in NHS Sheffield
- A proposed model for public health input into the new CCGs
- Establish new financial arrangements.
- Ensure business continuity and emergency preparedness
- An agreed engagement plan with external stakeholders (eg CCGs, Public Health England)
- Maintain effective delivery of Public Health functions during the process of transition.

#### 7.1.7 Monitoring

- A RAG (red/amber/green) rating will be applied to each of the outputs to monitor progress against agreed milestones and timescales.

#### 7.1.8 Milestones

All of this will need to be achieved by, at the latest, the end of March 2013, at which time PCTs will be abolished. There may be some advantages of making the changes prior to then. However it is understood there will be no announcements on funding allocations before March 2012.

#### 7.1.9 Key dependencies

### 7.2 Human Resources

The joint leads of this workstream are Sue Palfreyman, Head of HR service delivery in Sheffield City Council and Christine Joy, Associate Director of HR for NHS Sheffield.

#### 7.2.1 Purpose

- To strategically lead and manage the HR impacts of the Public Health transition to Sheffield City Council.
- To ensure positive employee relations during the transition phase, and to establish a framework for the on-going management and integration of Public Health into the Council, including the arrangements for induction of NHS staff
- To establish an appropriate framework to meet future organisational and professional development needs
- To consider and address the public health training implications of the new arrangements

#### 7.2.2 Membership

| <u>SCC</u>                               | <u>NHS</u>                                  | <u>Other</u>  |
|--|---|---|
| Head of HR Service Delivery (SP)         | Associate Director of HR (CJ)               | Nominated pension body representatives (as appropriate) |
| HR Business Partner                      | Other nominated HR support manager (Band 8) | Legal advisors  |
| Nominated communications lead            | Nominated communications lead               | Finance (as appropriate)                                |
| Recognised Trade Unions (as appropriate) | Staff side (as appropriate)                 |   |
| HR Connect                               | NHS Payroll services                        |   |

### 7.2.3 Objectives

- To support staff in NHSS and SCC through this period of uncertainty and change, including addressing issues of cultural and organisational differences
- To ensure a smooth and successful transition to SCC, including legal compliance if appropriate, in relation to a TUPE, TUPE-like or secondment transfer arrangement
- To ensure an effective and comprehensive communications plan is in place, and meets the needs of all internal stakeholders

### 7.2.4 Scope

- To establish the nature of the transition, taking account of national guidance on transfer arrangements
- To establish constructive and effective employee relations arrangements during and post transition, ensuring that all recognised Trade Unions and employees have a full and equitable opportunity to contribute to, shape and influence the transition
- To identify the key challenges and dependencies in relation to the transfer, and to determine how these may be addressed
- To identify and agree post-transfer arrangements in relation to employment (depending on the type of transfer), including such issues as pensions, terms and conditions, rates of pay, recruitment processes and future vacancies
- To consider any immediate issues arising out of people management policies and procedures in both organisations
- To determine the most appropriate means of supporting individual professional development, career progression and structural issues
- To develop a communication strategy which meets the needs of all internal stakeholders, including formal aspects of the consultation process

### 7.2.5 Key deliverables / outputs

- The HR aspects of the transition are managed effectively, legally, and in a timely manner
- All parties are well-informed and fully understand the implications of the transition, both individually and organisationally, having had an appropriate opportunity to contribute to decisions made.
- Agreed timescales are met
- A well developed workforce plan is agreed and is ready for implementation

### 7.2.6 Monitoring of the workstream/outputs

- A RAG rating will be applied to each of the outputs to monitor progress against agreed milestones and timescales.

### 7.2.7 Milestone Dates and Timescales

- To be determined by Steering Group and by national guidance.

### 7.2.8 Key Dependencies

- National guidance on transition arrangements including pension and TUPE issues, being received at the appropriate time, and being fit for purpose for local need
- Financial clarity on the impact of the transfer being available for all parties
- Political clarity on the future direction of travel, in particular in relation to proposed changes to the NHS
- Achievable timescales
- Effective engagement with the Trade Unions, staff side, all employees affected and other key stakeholders

### 7.3 Finance

The joint leads of this workstream are Liz Orme (SCC) and Brian Richards (NHSS).

#### 7.3.1 Purpose

- To strategically lead and manage the financial impact of the Public Health transition to Sheffield City Council.

#### 7.3.2 Membership

- Assistant Director of Finance (Communities), SCC (Liz Orme)
- Head of Finance (Performance Management), NHSS (Brian Richards)

Other members, as appropriate:

- Director of Public Health, NHSS
- Director of Communities, SCC / Director of Commissioning, SCC (TBC)
- Assistant Director of Finance, NHSS
- Finance Manager (Communities), SCC
- Contracts Manager, SCC

#### 7.3.3 Objectives

- To ensure there is a shared understanding between NHS Sheffield and Sheffield City Council in relation to the level of funding classified as Public Health in line with national guidance.
- To ensure a smooth and successful transition of funding to Sheffield City Council.

#### 7.3.4 Scope

- To establish the level of budgets within NHS Sheffield in relation to public health, taking account of national guidance on the scope of public health.
- To identify the funding split between Sheffield City Council, Public Health England and NHS Commissioning Board in line with national guidance.
- To agree internal distribution/allocation arrangements of the SCC element
- To identify the third party contracts linked to the public health budgets and lease contracts in relation to properties.
- To ensure communication of financial aspects to the Steering group and its members
- To estimate and include support service costs (eg IT, HR, accommodation etc.) in transfer arrangements

#### 7.3.5 Deliverables

- The baseline level of funding is agreed by all parties.
- All parties are well informed and fully understand the implications of the transfer of funding.
- To comply with any agreed timescales including those requested by the SHA/DoH.
- Produce detailed plans regarding business as usual.
- A well developed finance plan is agreed and is ready for implementation. Taking into account systems to ensure business as usual following the transfer.

#### 7.3.6 Monitoring

- A RAG rating will be applied to each of the outputs to monitor progress against agreed milestones and timescales.

#### 7.3.7 Milestones

- To be determined by the Steering Group and by national guidance.

#### 7.3.8 Key dependencies

- National guidance on transition arrangements and the scope of public health services included.
- Financial clarity on the impact of the transfer being available for all parties
- Political clarity on the future direction of travel, in particular in relation to proposed changes to the NHS
- Achievable timescales
- The level of public health running cost savings.

## 7.4 Corporate

The joint leads of this workstream are Barry Mellor, Commercial Director, SCC and Jill Dentith, Head of Corporate Services, NHS Sheffield. A detailed plan will be produced after a meeting of the corporate workstream leads on 26/7/11 and will be presented to the PHSTG meeting on 2/9/11

### 7.4.1 Purpose

### 7.4.2 Membership

- Commercial Director, SCC (Barry Mellor)
- Head of Corporate Services, NHS (Jill Dentith)
- Head of Procurement, NHSS (Caroline Mabbott)
- Director of Business Strategy, CYPF, SCC (John Doyle)
- Consultant in Public Health, NHS S (Chris Nield)
- Director of Legal Services, SCC (Lynne Bird)

### 7.4.3 Objectives

### 7.4.4 Scope

- Legal services
- Procurement and contracting (NB links with Finance workstream)
- Estates and facilities
- Informatics/IT (NB links with Public Health Intelligence workstream)
- Governance
- Communications (in terms of the service that public health get at the moment rather than communications for the project which is been lead elsewhere).

### 7.4.5 Deliverables

### 7.4.6 Monitoring

### 7.4.7 Milestones

### 7.4.8 Key dependencies

## 7.5 Public Health Intelligence

The joint leads of this workstream are James Henderson, Director of Policy and Research, SCC and Louise Brewins, Head of Public Health Intelligence, NHS Sheffield.

### 7.5.1 Purpose

To develop and implement a plan that, post-transition, ensures the following:

- Health and well being commissioning decision making is evidence based
- Public health intelligence provided is of high quality, impartial and authoritative
- Function is efficient, effective and integral to the commissioning cycle

### 7.5.2 Membership

- Louise Brewins, NHSS (Workstream Lead)
- James Henderson, SCC (Workstream Lead)
- Ann Richardson, NHSS
- Lerleen Willis, NHSS
- SCC Team member TBC

Stakeholders:

- GP Commissioners – Geoff Shrecker and Charles Heatley
- Sheffield City Council portfolios
- NHSS Public Health Directorate (through consultant leads)
- Sheffield Health & Social Care NHS Foundation Trust
- University of Sheffield – Sheffield Centre for Health and Related Research
- Sheffield Hallam University – Faculty of Health and Wellbeing
- South Yorkshire Comprehensive Local Research Network
- NHSS Health Informatics Service

### 7.5.3 Objectives

- To identify our users/customers and ensure their public health intelligence needs are met

- To ensure continued efficient and effective access to relevant data sources and flows
- To maintain existing high levels of quality and rigour and to provide the H&W Board with assurance of this through the Joint Strategic Needs Assessment
- To propose a future delivery model that is fit for purpose

#### 7.5.4 Scope

Encompasses all elements of Sheffield Public Health Intelligence which includes:

- Research – formal academic research undertaken, commissioned or used by the PH Directorate to improve health and tackle inequalities in health.
- Evaluation – programme/project/service evaluation undertaken, commissioned or used by the PH Directorate to improve health and tackle inequalities in health.
- Information – public health data sources including ensuring appropriate use and quality assurance
- Analysis – statistical analysis, interpretation and presentation of epidemiological and related health and well being data.
- Audit – national public health guidance and standards (e.g. NICE PH guidance) and related governance arrangements.
- Knowledge management – public health library service (current awareness bulletins, electronic resources, journals/article request, literature searching, critical appraisal, publications, patient information, specialist collection, 'Evidence Based Practice News', links to other resources/websites).

#### 7.5.5 Deliverables

- Option appraisal and preferred delivery model
- Agreed information sharing/data access arrangements (including quality and governance standards)
- Public Health Intelligence offer/prospectus
- Business model
- Stakeholder relationship plan
- Communication plan (internal and external)
- Budget/resource schedule
- Schedule of specific transition details

#### 7.5.6 Monitoring

An action plan will be produced and this will form the basis for managing/monitoring performance.

#### 7.5.7 Milestones/Timescales

- Overall life span 1<sup>st</sup> July to 30<sup>th</sup> November 2011
- Outline and action plan 21<sup>st</sup> July 2011
- Detailed timescales to be built up from the action plan

### 7.6 Yorkshire and Humber Checklist

NHS and Local Government (Yorkshire & Humber) have produced a checklist for use by local authorities and PCTs to assess their readiness for the upcoming changes to the NHS (Appendix V). This contains guidance and a framework for developing public health transition plans and will be used to inform Sheffield's approach.

## 8 DELIVERY PLAN

| Work stream  | Deliverable   | Lead           | Time scale  | Achieved? (see key) |
|--|---|----------------|-------------|---------------------|
| MODEL  | Agree a vision statement for PH in Sheffield  | JW             | April 2011  |                     |
|  | Option paper for design of new PH function and structures in SCC  | JW, LA, RW     | April 2011  |                     |
|  | Cabinet members briefed   | JW, LA, RW     | On-going    |                     |
|  | Structures identified for discussion with other internal and external stakeholders  | JW             | August 2011 |                     |
|  | Clarify and develop role of Scrutiny relating to Public Health  | LA             | On-going    |                     |
|  | Paper to NHSS Board and EMT / Cabinet   | JW, LA         | Sept. 2011  |                     |
|  | Arrangements for emergency preparedness included in design of new system  | JW             | July 2011   |                     |
|  | Restructure PH Directorate to deliver running cost savings and in preparation for transfer to SCC   | JW             | July 2011   |                     |
|  | Deliver agreed efficiency and cost savings for 2011/12  | JW             | April 2011  |                     |
|  | Review existing directorate to identify functions that will transfer to SCC, those that will go to CCGs/CSU, those that will go to external providers           | JW             | May 2011    |                     |
| Ensure all staff are properly supported to continue to do their jobs properly, and offer appropriate training for future roles | JW  | On-going       |             |                     |
|  |   |                |             |                     |
| HR   | Work through HR implications of design of new PH function within SCC, including grading of posts, line management arrangements, specialist register status etc. | CJ, SP         |             |                     |
|  | Clarify process for transferring staff to new posts, including TUPE, 'slotting in' and ring fenced applications   | CJ, SP         |             |                     |
|  | Clarify impact on relevant existing staff within SCC and extent to which they will be part of above process   | SP, LA, JW, SP |             |                     |
|  | Formal consultation with staff and unions (both within NHSS and SCC)  | JW             |             |                     |
|  | Implement transfers, including formal consultation period on TUPE transfers as required   | JW, CJ, SP     |             |                     |
|  | Induction process for staff moving to SCC   | LA             |             |                     |
|  | Ensure staff are kept informed  | CJ, SP         |             |                     |

|                   |  |            |           |  |
|-------------------|--|------------|-----------|--|
|                   |  |            |           |  |
| FINANCE           | a. Clarify NHSS expenditure on different identified elements of PH as per the funding consultation document                    | BR, LO     | Feb 2011  |  |
| Named Lead<br>TBC | b. Clarify likely amount of ring fenced public health budget to come through Public Health England to SCC                      | BR, JW     | 2012      |  |
|                   | c. Consider possible early transfer of PH funds directly from NHSS to SCC prior to establishment of 'ring fenced' budget above | JW, JN, EW | July 2011 |  |
|                   |  |            |           |  |
| CORPORATE         | To be filled in after workstream meeting on 26/7/11  | BM, JD     |           |  |
|                   |  |            |           |  |
| PH INTELLIGENCE   |  | JH, LB     |           |  |

**Key to names:**

JW Jeremy Wight

LA Lee Adams

RW Richard Webb

CJ Christine Joy

SP Sue Palfreyman

BR Brian Richards

LO Liz Orme

JH James Henderson

LB Louise Brewins

BM Barry Mellor

JD Jill Dentith

JN Julia Newton

EW Eugene Walker

**Key to RAG (Red/Amber/Green) rating:**

Green / Horizontal shading: Achieved within the timescale set

Amber / Diagonal shading: Partly achieved / Progress made - Keep a watchful eye

Red / Vertical shading: Timescale missed / Little or no progress - Pay urgent attention

## 9 APPENDICES

### 9.1 APPENDIX I 'Future Shape of Public Health in Sheffield City Council' Paper

#### Introduction

Public Health is 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organised efforts of society.' The health and wellbeing of the people of Sheffield is critical for the success of the City as a whole. It is therefore highly appropriate that good health and wellbeing should be one of the Council's 'strategic cores'.

Public Health leadership is planned to move from NHS Sheffield to the City Council in the near future, as indicated in the NHS White Paper and more recently in the Public Health White Paper. The exact time at which this is to occur is yet to be determined, though it will be at the very latest by April 2013, at which time NHS Sheffield (the Primary Care Trust) will cease to exist (subject to the passage of the Health and Social Care Bill).

Other substantial changes are taking place in the organisation of the NHS at the same time, which will influence the requirements on Public Health in the City. In particular, Clinical Commissioning Groups (CCGs) are being established to undertake the bulk of NHS commissioning; new Health and Wellbeing Boards are being established in top tier local authorities to have oversight of all health and social care commissioning within the area; Public Health England is being established as a new national public health service (incorporating the current roles of the Health Protection Agency and the National Treatment Agency, among other functions); and a new NHS Commissioning Board is being established to commission primary care and specialist services.

The public health function in the Council also needs to be consistent with the principles of 'Future Shape' (see appendix), the strategic direction the Council is taking in redesigning its services. This consists of seven principles: Focus on outcomes; Choose and use; Devolution and localism; Prevention; An enterprising council; Fair charging and Fairness. Moreover if 'Good Health and Wellbeing' is to be one of the 'Strategic Cores' for the Council, as has been suggested, then Public Health must be shaped accordingly.

Our aim in managing the transfer of Public Health from the NHS to the City Council must be to design a new system that ensures that the objectives of continuing to improve the health of the people of Sheffield, and reduce health inequalities, are most effectively met. This paper describes the form that Public Health needs to have in Sheffield City Council in order to discharge our responsibilities and have the greatest positive impact on health in the City. Although based in the City Council, Public Health will have to be more than simply a City Council function. To have the maximum impact on the health of the people of Sheffield, we will have to work with and for others, including General Practitioners as both commissioners and providers, other health services providers, the voluntary and academic sectors, local businesses etc..

#### Function

In order to have maximum impact on the health of the people of Sheffield, Public Health will need to operate effectively across the three domains of health improvement, health protection, and health services public health.

#### *Health improvement*

Health improvement (which includes health promotion, public health advocacy, healthy public policy, etc.) will be delivered in three ways: firstly, by commissioning health improvement programmes and services from other organisations, including both statutory and non-statutory providers, as at present; secondly, health improvement can be achieved by influencing the wide range of activities of the City Council so that all its activities are shaped to improve the health of the people of Sheffield, wherever possible; thirdly, through some services directly provided by members of the Public Health directorate in the Council.

Sheffield has long been a WHO 'Healthy City', with work led from within the Council. The City Council has an existing Health Improvement team, and each Portfolio has produced a public health statement. The additional resources available for commissioning health improvement activity from within SCC are likely at best to be equivalent to those currently being spent on such activities by NHS Sheffield, and quite possibly less. There will therefore be little scope to achieve a transformational change in health improvement through that route (although the portfolio of such activity being commissioned will need to be reviewed). However there is scope to achieve transformational change in health improvement in the City through the wider influence of the Council. The breadth, scale and reach of the City Council's activities provides opportunity to impact on the 'root causes' of ill health in a way that was harder to do when Public Health was based in the NHS.

There is considerable scope for health improvement work to be undertaken by and from general practices in the City. The geographical spread of practices, and the status of GPs and primary care as a source of health advice, gives them unrivalled potential as a vehicle for public health interventions. This could include for example financial inclusion work including benefits advice, family support work, etc.

#### *Health protection*

Although Directors of Public Health will be responsible for the health of the local population, the arrangements for discharging health protection responsibilities remains worryingly unclear. It is proposed that the DPH will be jointly appointed between the Council and Public Health England (PHE), and will be accountable to the Secretary of State for Health through PHE. The DPH will be responsible for ensuring that there is 24 hour availability of public health expertise to respond to outbreaks of infectious disease and other public health emergencies. However responsibility for emergency planning in the new arrangements is unclear: in particular it is not clear who will be responsible for emergency planning for health services.

The City Council does, of course, have experience, expertise and responsibilities already with regard to emergency planning. Public Health and any health services emergency planning will need to be fully integrated with the Council's existing and continuing other EP responsibilities.

Vaccination programmes will continue to be delivered primarily through primary care, and will be commissioned by the NHS Commissioning Board on behalf of PHE. Screening programmes will be commissioned in the same way.

In addition, the previously existing health protection responsibilities of the Council will continue, such as Environmental Health, Trading Standards, Licensing, etc..

#### *Health services public health*

The provision of high quality health services is one of the determinants of population health and a means to reduce (or, if not optimally distributed and accessible, increase) health inequalities. Public health expertise is essential to ensure that health (and social care) services are commissioned and delivered according to the needs of the population, the evidence base, to reduce inequalities, and to ensure value for money. There is a danger that the transfer of Public Health away from the main locus of health services commissioning (undertaken in future by Clinical Commissioning Groups) will lead to that commissioning proceeding without Public Health input. We must ensure that does not happen.

Health services public health is arguably the most technically exacting facet of public health, and it is certainly often contentious. It combines knowledge of the costs and benefits of healthcare interventions with epidemiological and interpretive skills in order to guide commissioning decisions. As the margins of benefit from new drugs and treatments get smaller, and the recognition and range of adverse effects larger, the need for good epidemiological and health economic analysis (core public health skills) of commissioning decisions becomes ever greater. It is imperative that Public Health expertise is able to

continue to directly influence health services commissioning in the future, for both long term conditions and other services. How we do this in Sheffield needs to be explored further.

Variation of quality in primary care is recognised nationally to impact on the health of the population. In recent years the development of primary care, and in particular the development of primary care teams' management of people with chronic disease, led by the Public Health Development Nurses, has been a vital element of Public Health work in the City. There is good evidence that the improvement in health care that has resulted has led to decreased mortality, increased life expectancy, and reduced health inequalities. This work needs to continue.

Public health expertise will also be important if the new Health and Wellbeing Boards are to function properly in their role of overseers and system managers. The core public health skills of assessing population health needs and evaluating health services must be made available to the Health and Wellbeing Board in order to enable it properly to discharge its responsibilities.

### **Form**

Public Health within Sheffield City Council needs to be designed to influence all parts of the Council's activities and operate optimally across the three domains described above. This can best be achieved by implementing a dispersed model of PH expertise, whilst maintaining a strategic core team.

The core team needs to be large and strong enough to provide health improvement leadership across the Council, discharge health protection responsibilities including in particular staffing an on call rota for health protection and for responding to public health emergencies, and have capacity adequately to support GPCC. In a city the size of Sheffield, this will require a number of fully trained and accredited public health specialists (i.e. equivalent to the current 'consultant' status in the NHS), each of whom would be expected to have an area of specialist interest and responsibility, and be supported by other staff with public health skills and experience (i.e. equivalent to 'public health principals' and 'public health practitioners' in the NHS).

This core team will need to be supported by an expert, adequately resourced, Public Health Intelligence team, administrative support, etc. *[NB Under current rules, PH Information staff working outwith the NHS would not have access to essential NHS datasets. We have to hope that these rules will be changed, but if not, some creative solution will need to be found. Alternatively it may be necessary for the PH information team to be hosted in an NHS organisation, presumably the GP Commissioning Consortium, in order to retain access to those datasets.]*

The core team will work closely with the existing SCC Policy, Research and Performance teams. There will need to be a discrete Public Health business plan (which will include objectives that are to be achieved by working with and through other Portfolios and departments).

As noted above, the main prize to be sought in the new arrangements is turning the whole Council into a public health driven organisation. It is this that will lead to the greatest increase in health improvement activity and hence have the greatest impact on health in the City. In order to achieve this, public health expertise needs to be linked strongly into and influence all Portfolios within SCC, so as to impact on their business plans and activities. This will best be achieved by placing public health consultants (who will also be members of the core team, above) in each Portfolio, with appropriate staffing support. They should be jointly line managed by the relevant Executive Director and the Director of Public Health. This will enable them to participate in the overall shaping of the public health agenda in the City, contribute to the discharge of general public health responsibilities, and receive professional support and provide a channel for professional accountability.

Individual health improvement programmes could be commissioned by public health consultants, and their supporting staff, within each Portfolio. For example, the school nursing

programme would be commissioned from within the Children and Young People's Portfolio, whilst programmes to address public mental health needs would be commissioned from within the Communities Portfolio.

It will be important for public health expertise to be placed in each Portfolio. Within Portfolios, there will be particular service areas where it will be especially important to have a public health focus. These should include (but not necessarily be limited to):

- Adult Social Care (including both mental health and older people)
- Community Assemblies and Libraries
- Housing
- Environmental Health, Licensing and other regulatory functions
- Culture
- Highways and Transport
- Sustainability
- Resources (workplace health).

Most existing and anticipated public health responsibilities can be seen to map into these arrangements, though there may be some functions that do not fit so readily, e.g. dental public health. The options then would be either to have some PH staff not associated with another Portfolio or department, or to find a fit, e.g. placing dental public health within the CYP Portfolio whilst acknowledging the broader responsibilities for adult oral health.

Public Health input to Community Assemblies will be provided by the Healthy Communities team, which has been re-structured around the CAs. Each CA area already has at least one Health Improvement Principal working with it, and this arrangement should continue. The detail of the working arrangements will need to be discussed and will no doubt change and evolve over time, as Community Assemblies themselves develop. The Healthy Communities team has good links with General Practice in some areas of the City. These will need to be developed further if the public health potential of primary care is to be realised.

One way to structure the public health team to provide expertise to GPCC would be to divide responsibilities, and hence ensure the maintenance of expertise, in ways that reflect the likely nature of the support requested. In effect, this means being able to provide advice about health services commissioning according to the likely broad areas into which health services can be divided, such as maternity services, children's health services, acute (emergency) care, chronic disease management, mental health etc. Individual public health specialists could then have a notional sessional commitment for supporting the GPCC. For the most part there is a relatively straightforward 'read across' between these areas and the areas of health improvement responsibility that PH specialists would have within the structure outlined above. What will be essential will be a mechanism (part of the core team function) for ensuring that requests for support and advice from GPCC are responded to appropriately.

An alternative approach would be to have dedicated post(s) with responsibility only for health services Public Health, situated within the PH core team. These would then work very closely with GPCC (and any Commissioning Support Unit that supports the GPCC) as well as supporting the Health and Wellbeing Board and liaising with the NHS Commissioning Board. These options will need to be discussed further with the emerging GPCC.

Appropriate financial arrangements would need to be in place to identify all expenditure against the ring fenced public health budget, and ensure proper accountability. It is essential that existing SCC responsibilities that relate to Public Health (e.g. environmental health services) are not identified as public health spend against the new ring fenced public health budget, as that would in effect open the way to significant disinvestment from Public Health in the City.

### **Outstanding issues**

Some details of the way in which a public health team within SCC will discharge all its responsibilities cannot be determined until there is a lot more clarity about the wider organisational architecture, distribution of responsibilities, accountability routes and funding

available within the new arrangements. For example, the way in which the DPH will have to work with PHE at local level is, as yet, completely undefined. Similarly it is not at all clear what responsibilities the DPH (and hence PH team within the Council) will have for NHS emergency planning. However these can almost certainly be accommodated within a dispersed model of PH as described above.

Other issues that remain for further consideration include:

- How the potential of primary care in public health is to be realised.
- How Public Health in the City Council will work with secondary care providers, the academic sector, etc.
- The relationship between the Public Health function within the City Council and existing SCC service areas with direct public health impact, such as environmental health.
- How public health expertise will be made available to GPCC, and how this will be resourced.
- The further development of the Healthy Communities team, and relations between them and both the Community Assemblies and General Practices.
- Possible collaboration across South Yorkshire, or further afield.

### Recommendations

1. That the distributed model of Public Health, as described above, be adopted as the preferred model, albeit accepting that much detail needs to be determined.
2. That negotiations continue with Senior Officers and elected members within SCC to determine that detail and implement the model.
3. That discussions continue with GPCC colleagues about the best way to make Public Health expertise available to them, and the best way to make primary care more public health focussed.

Jeremy Wight, Director of Public Health  
April 2011

### Appendix – Future Shape – how the seven policies will shape Public Health

#### Focus on outcomes:

Public Health has always been 'outcomes focussed'. The 'dispersed' model is explicitly intended to maximise improvements in Public Health outcomes, rather than providing organisational neatness and ease of management. Health services public health is explicitly aimed at improving health outcomes, and so needs to be preserved and strengthened. Improvement in the Public's health could become a high level shared outcome for the whole Council.

#### Choose and Use:

Where Public Health delivers and commissions services at individual level we will ensure that choice is incorporated wherever possible. We will make sure that our needs assessment work (including the JSNA) is informed by what individual communities (including non-geographically defined communities) say is important to them.

#### Devolution and Localism:

Our Healthy Communities Programme will increasingly be designed around Community Assemblies so that they are closer to local communities. We will also make sure that other public health programmes are similarly built around the needs of individual communities wherever this can be done without undue sacrificing of efficiency.

#### Prevention:

Prevention is integral to Public Health. The discipline of health services public health ensures that this is done in a cost effective manner.

#### An enterprising Council:

The majority of public health activity within the City is already delivered by public, voluntary and private sector agencies working to contracts, often competitively tendered. This will continue. We will in particular continue to value of voluntary sector organisations' knowledge of local communities, and their ability to mobilise volunteers. The scope for using social investment bonds to finance public health activities will be explored.

#### Fair Charging:

The scope for charging for public health services is probably small, but will be explored further. The 'polluter pays' principle is important in terms of environmental health protection.

#### Fairness:

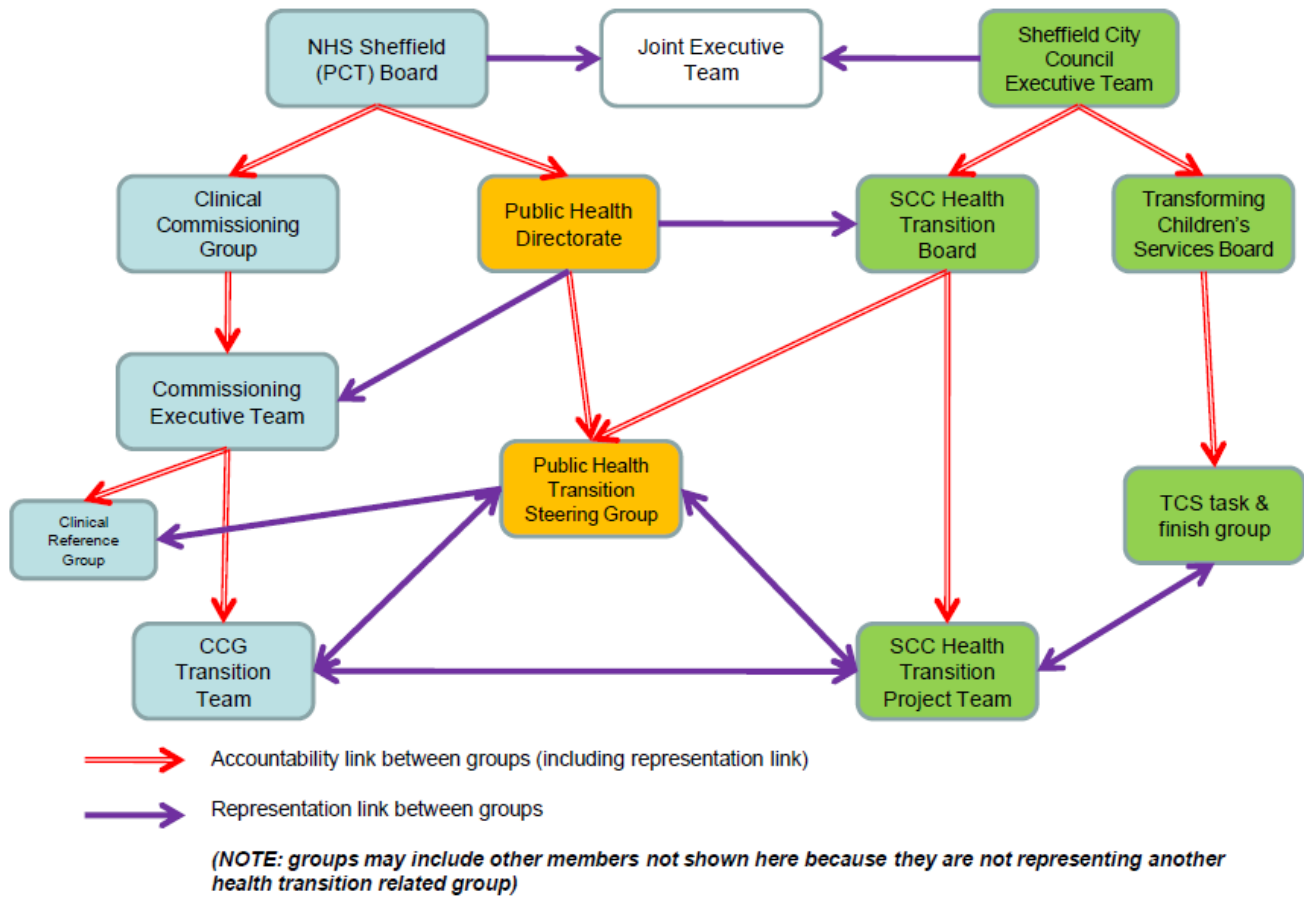
The reduction of health inequalities is a major ambition of Public Health. Disciplined design and delivery of public health programmes has to take equity, and the impact on health inequality, into account through equity impact assessments and rigorous evaluation. Health services public health is concerned, among other things, with ensuring equity in commissioning of health services.

## 9.2 APPENDIX II Terms of Reference: Public Health Transition Steering Group

(To be ratified by meeting on 21/7/11)

|     |  |
|-----|--|
| 1.  | <b>Constitution</b>  |
|     | The Public Health Transition Steering Group is a time limited sub group of the Shadow Health and Wellbeing Board. It is expected to operate from June 2011 to April 2013   |
| 2.  | <b>Purpose</b>   |
|     | To oversee the implementation of the public health transition plan and to authorise, delegate or undertake the tasks in each organisation that are required to ensure a safe transition of the public health function from NHS Sheffield to Sheffield City Council   |
| 3.  | <b>Membership</b>  |
| 3.1 | <p><b>NHS Sheffield:</b><br/>           Director of Public Health – Jeremy Wight (Chair)<br/>           Consultant in Public Health – Sue Greig (Children &amp; Young People)<br/>           Consultant in Public Health – Fiona Day / Sheila Paul (to alternate)</p> <p><b>Sheffield City Council</b><br/>           Deputy Chief Executive – Lee Adams (<i>Deputy Chair</i>)<br/>           Executive Director of Communities – Richard Webb<br/>           Director of Health Improvement – Chris Shaw</p> <p><b>Work stream representative</b><br/>           Model for public health delivery in SCC – Jeremy Wight/Lee Adams<br/>           Human Resources – Christine Joy/Sue Palfreyman (to alternate)<br/>           Finance – Brain Richards / Liz Orme (to alternate)<br/>           Corporate - Barry Mellor/Jill Dentith (to alternate)<br/>           Public Health Intelligence - Louise Brewins/James Henderson (to alternate)</p> <p><b>Other</b><br/>           Public Health Transition Project Manager – Julia Burrows (until end July 2011)<br/>           GP – Karen O'Connor</p> |
| 3.2 | If a member cannot attend, he/she will send an authorised deputy   |
| 3.3 | Administrative support to the meeting will be provided by SCC business support unit  |
| 4.  | <b>Frequency of meetings</b>   |
|     | The Steering Group will meet approximately every 6 weeks. Dates of meetings will be arranged for 6 months in advance.  |
| 5.  | <b>Reporting Arrangements (internal and external)</b>  |
|     | <p>The Public Health Transition Steering group will report to the Shadow Health and Wellbeing Board. Until this is established, the steering group will report to the NHS Transition Team and the SCC Health Transition Board.</p> <p>Each work stream lead will develop a detailed work plan for approval by the steering group and provide progress reports to each meeting</p>  |
| 6.  | <b>Relationships</b>   |
|     | <p>The relationship of the PHTSG to other structures and groups planning the health transition is shown overleaf (9.2.1). Relationships, interface and joint work will be developed with existing and future organisations and structures including:</p> <ul style="list-style-type: none"> <li>• Clinical Commissioning Groups and Commissioning Support Unit</li> <li>• Sheffield Health and Wellbeing Board</li> <li>• Public Health England</li> <li>• South Yorkshire &amp; Bassetlaw PCT Cluster</li> <li>• NHS, independent and VCF provider organisations</li> <li>• NHS Commissioning Board</li> </ul>  |
| 7.  | <b>Review</b>  |
|     | <p>The Terms of Reference and membership of the Steering Group will be reviewed as required; given this is a time limited group.</p> <p>The Steering Group will have regard to the Yorkshire and Humber checklist for use by Local Authorities and PCTS to assess readiness for the upcoming changes to the NHS</p>  |

9.2.1 Sheffield Health Transition Planning Map – July 2011 v 4



### 9.3 APPENDIX III Local Authority Public Health Commissioning Responsibilities:

What might be done where?

| Nationally funded or Mandatory work led by SCC | Is this also a local priority? | To be Strategic in Core PH Team                  | To be Commissioned and where from                                | To be elsewhere in SCC and where   | To be with GPC organisations/or with GPs              |
|--|--------------------------------|--|--|--|---|
| Sexual Health apart from Contraception (PHE)   | Yes                            | Overall strategy                                 | Foundation Trusts  | Communities for prevention and Forge Centre and CHIVSH or as social enterprise or with GPC | Commissioning role from Foundation Trusts             |
| School Programmes Immunisation                 | Yes                            | Oversee Child Health Programme Strategy          | Foundation Trusts  | Commissioning Role CYP?  | Could Commission                                      |
| PH impact of Climate Change                    | Yes                            | Strategy but <u>with</u> Director of SD in place |  | Place  |   |
| Seasonal mortality i.e. Flu                    | Probably                       | Oversee strategy and provide technical advice    | PHE will lead  | Communities to lead in SCC   | Could Commission                                      |
| Accident Prevention                            | Yes                            | Strategy? Or in place                            | Commission from?   | Road Safety/Place  |   |
| Public Mental Health                           | Yes                            |  | Yes, some programmes. MH Trust/VCF/PH Champions                  | Communities  | Some aspects at primary commissioning role care level |
| Support PHE re: Nutrition work                 | Yes                            | Yes  | Yes, some programmes from VCF and Trusts Public Health Champions | Place  | Yes, primary care nutrition work                      |
| Physical activities                            | Yes                            |  | Some VCF   | Place  |   |
| Obesity  | Yes                            | Yes  | VCF, PH Champions Trusts   | Place  | Yes, need some resource and commissioning role        |

|   |  |                |   |  |   |
|---|--|----------------|---|--|---|
| Drug Misuse   | Yes  |                | Some projects, VCF, Trusts                                    | Communities/DAT                        | Yes, requires resources at PC level                                   |
| Alcohol Misuse  | Yes  |                | Some projects, VCF, Trusts                                    | Communities/DAT                        | Yes, requires resources at PC level                                   |
| Tobacco Control                                       | Yes  | Yes - strategy | VCF, PH Champions   | Some aspects with Environmental Health | P Care needs resources  |
| NHS Health Check Programme                            | ?  |                |   |  | Yes at this level   |
| Health at work  | Yes  | Yes - strategy | Commission from City Council, SOHAS, VCF, Chamber of Commerce | Could lead from Environmental Health?  | SOHAS, commissioning GPC  |
| Reducing and preventing birth defects (infant health) | Yes - infant health and wellbeing - a broader definition | Yes - strategy | From Trusts, NCT  | CYP to lead?                           | Requires resources and to commission                                  |
| Prevention of Cancer                                  | Yes  |                |   |  | Lead from P Care?   |
| Dental PH   | Yes  |                |   |  | Lead from P Care?   |
| Emergency preparedness (PHE leads)                    | Yes  |                |   | Emergency Planning Shared Service      |   |
| Children's PH 5 - 19                                  | Yes  |                | VCF/Trusts  | CYP                                    | Will need resources and commissioning role                            |
| Community safety and violence prevention and response | Yes  |                |   | Communities                            | Need to define role. Could commission domestic violence work from NHS |
| Social Exclusion                                      | Yes  |                | VCF. Social Enterprise  | Communities/DCX?                       |   |

#### 9.4 APPENDIX IV Other Local Priorities

- Financial inclusion, anti poverty work, strategic lead DCX's and commissioned work via GPs and CLASSY
- Healthy Housing  
Communities and Place lead
- Healthy Transport  
Place lead
- Food  
Place lead
- Pollution control and prevention  
Place lead
- Health of most vulnerable – BME, disabled, new arrivals, asylum seekers and travellers  
Communities lead, probably needs senior PH post focussing on this.  
Policy lead DCXs
- Built environment and health  
Place lead

## 9.5 APPENDIX V Yorkshire & Humber Regional Transition Checklist



**“Checklist” for use by local authorities and PCTs to assess their readiness for the upcoming changes to the NHS**

### **Introduction**

This checklist has been drawn up in response to the changes that will be made to the National Health Service in 2013 and the impact that these will have on local authorities and local partnerships between the NHS, local government and other stakeholders. It was an agreed action from the joint meeting of local authority and PCT Chief Executives that was held in October 2010. It is linked to the principles of joint working that were shared after the joint meeting (these are attached again for reference). This checklist has been designed for use within local partnerships and local authorities, PCTs and emerging GP consortia are encouraged to review their position against the points in this list to assure themselves of their preparedness and use it to draw up their local transition plans. Both the SHA and LGYH hope that it helps with your preparation ahead of the changes to the NHS in your community and we would welcome feedback on it through existing geographical and professional groups and the new regional transition leadership group.

Attached with this checklist is a timetable that summarises some of the key stages in the transition to the new arrangements in April 2013

### **Joint Commissioning**

Joint commissioning structures are in place including a forum involving local government and NHS commissioners with a risk strategy agreed to enable these to operate through the transition period ahead of the changes in April 2013;

### **Health and Wellbeing Boards**

A timetable and supporting plan has been agreed between the local authority and its counterpart PCTs to enable the Health and Wellbeing Board to be in place in shadow form by 2012/13;

An approach has been developed to promote engagement between elected members and officers of the local authority with the emerging local GP consortia;  
Local NHS, independent and voluntary sector providers have been engaged in the thinking around the development of the HWB;

Local partnerships have been reviewed to identify how they will operate after April 2013 with a plan being developed to enable the new Health and Wellbeing Board to assume its statutory responsibilities with GP Consortia involvement;

Arrangements for producing the JSNA have been reviewed in the light of the upcoming changes to the NHS, including the engagement of emerging GP commissioners;

The implications of developing a Joint Health and Wellbeing Strategy have been identified and factored into local plans to develop Health and Wellbeing Boards and GP consortia;

#### **Place based working and efficiencies**

There is a process in hand for identifying the opportunities and benefits to be gained from a place based approach to investment and service delivery;

There is a joint plan and vision for realising efficiencies for cross-sectoral services, supported by a work programme that is reflected in both the PCT's QIPP plans and the local authority's financial planning;

A view has been taken on the asset and estates position across the sectors and the opportunities for shared use of these to improve service delivery and the potential to achieve efficiencies;

The scope for sharing back office functions has been identified within shared plans to identify and achieve efficiencies;

A joint approach to risk and reward linked to funding decisions and identified efficiency gains has been agreed between local government and NHS partners;

#### **Planning, finance and workforce**

Arrangements for membership of Corporate Management Teams have been reviewed to ensure senior cross-sectoral involvement in local authority and PCT structures;

Taking account of differing national processes and timescales for allocations and planning frameworks, a process has been developed locally to align the budget planning cycles between local government and the NHS;

When proposals for investment or service change are developed in one sector, there is a process to make an assessment of the impact of these changes on services provided by other sectors and include the results of this when proposals go to the relevant decision making bodies;

There is a shared risk management plan and dispute management process in place locally to deal with financial and service issues that are cross-sectoral.

A joint workforce plan has been developed that covers both the transition of NHS staff to local authority employment, where relevant, and the development of new skills and approaches to the workforce where services are provided by both sectors to local residents;

#### **Involvement of service users and carers**

There has been a process developed locally to align the approaches on personalisation within social care and the commissioning of NHS services, including the development of personal health budgets in the areas piloting these, and a plan developed to engage GP commissioners in the personalisation agenda;

An assessment has been made of the opportunities reduce overlapping contacts with service users and carers and to streamline access routes to, services which are provided by different agencies;

Arrangements for citizen involvement and engagement in Health and Wellbeing Boards have been developed including a transition plan from LINKS to HealthWatch.

#### **Emergency preparedness and resilience**

A plan has been developed that clarifies local responsibilities for emergency preparedness under the current statutory arrangements and that identifies the migration path to April 2013 and beyond;

This plan addresses how the resilience of local NHS services will be ensured after 2013 in the event of both a short term major incident but also a longer term incident such as pandemic influenza;

These arrangements have been tested including using a scenario of an incident occurring after the changes in April 2013 have come into force;

#### **Public health services**

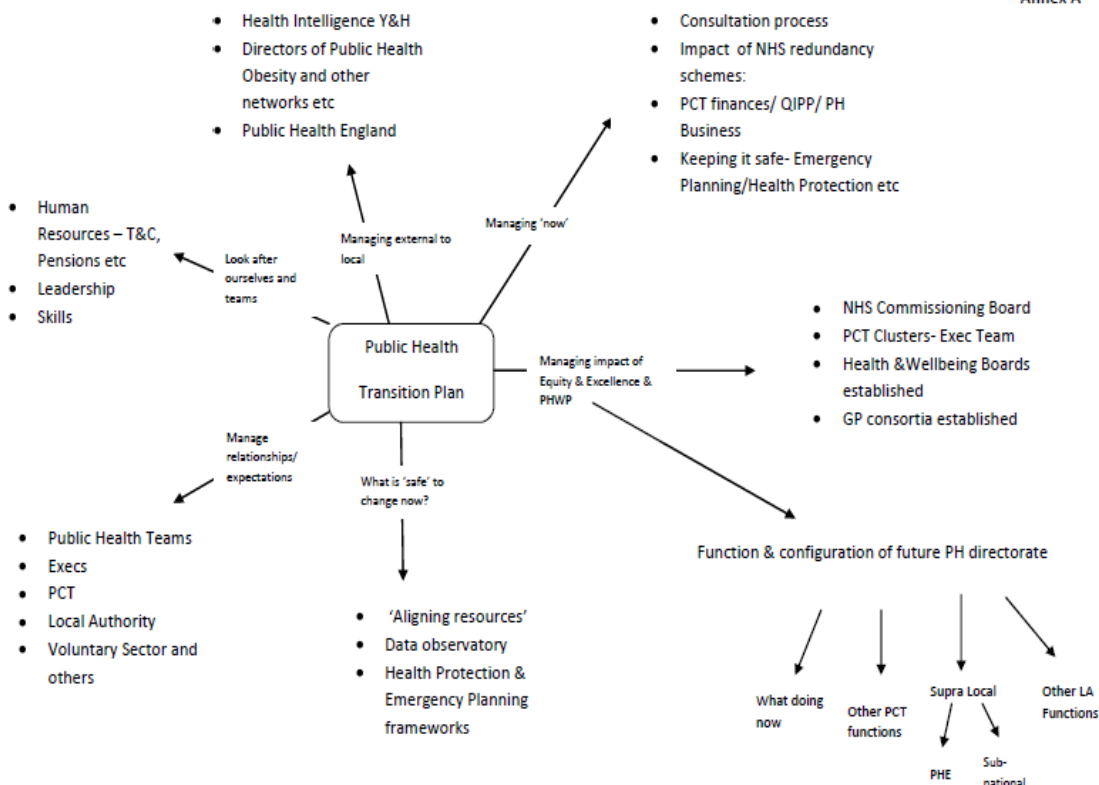
A plan has been agreed locally on the transfer of public health responsibilities and staff from the PCT to the local authority;

The Public Health Transition will be a considerable change management programme within the overall transition to the new arrangements. The attached diagram has been drawn up to inform the development of local transition plans for public health services. It covers:

- HR issues to be resolved to enable the transfer to happen by 2013
- Connecting to the national arrangements, including Public Health England
- Managing the current service and addressing risks to delivery
- Impact of linked changes flowing from "Liberating the NHS" and the Public Health White Paper
- Identifying what changes could be made ahead of 2013
- Managing relationships and expectations

Framework for developing public health transition plans: small 'c' checklist

Annex A



ANNEX B

# Timescale

## By April 2011

- A wide spread of Pathfinders and connections with Early Implementers
- GP Consortia engagement in PCT Operational and Commissioning planning demonstrated

## 20011/12

- Preparation of GP Consortia, ready for authorisation
- PCT Clusters and single executive teams in place by June 2011
- Development of Commissioning Support Units
- Arrangements agreed for Health and Wellbeing Boards by LAs and GPCs
- Agreement of plans for the public health transfer between LAs and PCTs

## 2012/13

- GPCs start to be authorised and take on more delegated responsibilities
- GPCs decide whether to contract with CSUs or not
- Health and Wellbeing Boards operating in shadow form
- HealthWatch arrangements funded by local authorities
- Public Health arrangements in shadow form, HR implications addressed

## April 2013

- PCTs abolished, accountability transfers to GPCs, LAs and NHSCB
- GPCs responsible for NHS Commissioning with some services commissioned nationally
- Commissioning Support Units become social enterprises/joint ventures
- Public Health becomes the responsibility of local authorities
- Local authorities commission NHS complaints advocacy
- Health and Wellbeing Boards go live