Appendix One

North Tyneside Public Health Transition Plan - Transfer of Public Health Functions to the Local Authority

Purpose

This plan outlines arrangements for the transition of public health responsibilities following system changes outlined in the Health and Social Care Bill currently before Parliament. It is a critical step towards achieving the aim of transforming the Council into a public health-driven organisation, so that every contact the Council has with the people of North Tyneside is designed to have a positive impact on their health.

The model for future public health delivery in North Tyneside will incorporate both wider determinants and individual behaviour. It will follow Marmot's life stage model[1] and will also consider links between key wider determinants such as housing, education, transport, regeneration and crime and disorder. The Health and Wellbeing Board will focus on the health and wellbeing priorities for the people of North Tyneside, integrating services and pooling resources more effectively.

This plan relates specifically to the process of transition from North Tyneside Primary Care Trust (PCT) to North Tyneside Council in relation to public health staff and resources and also the commissioning responsibilities and new public health functions of the Council to ensure that it can effectively deliver its new public health responsibilities from 1 April 2013.

Local Context

The seven priorities set out in the North Tyneside Council Strategic Plan 2012 – 2015 Widening Horizons are:

- Delivering sustainable growth
- Delivering excellent education, skills and employment opportunities
- Supporting people to be healthy and independent and protecting the vulnerable
- Creating safe and secure communities
- Protecting and enhancing the environment
- Helping people to make a positive contribution
- Making change happen, improving customer service and facing up to our financial challenges

[1] Fair Society, Healthy Lives, Marmot M, February 2010

Although health in North Tyneside has improved dramatically over recent years, there are still populations which suffer unacceptably poor health and wide inequalities in health persist.

There is a difference in life expectancy of around 11.5 years for men and 9.1 years for women between the most and least deprived areas of the borough. It is estimated that up to half this difference in life expectancy is due to smoking, as this contributes to the two major causes of death in the borough: cardiovascular disease and cancer. We are committed to reducing health inequalities through better targeting of resources and ensuring access to services for those with greatest need; with a vision for promoting health and wellbeing based on the six Marmot principles:

- give every child the best start in life
- enable all children, young people and adults to maximise their capabilities and have control over their lives
- create fair employment and good work for all
- ensure a healthy standard of living for all
- create and develop healthy and sustainable places and communities
- strengthen the role and impact of all health prevention

National context

The Public Health White Paper: Healthy Lives, Healthy People: our strategy for public health in England (Nov. 2010) set out the Government's long-term vision for the future of public health in England, which is designed to be more effective and give clear accountability for the improvement and protection of the public's health. Health Lives, Healthy People: Update and way forward in July 2011 provided further clarity on the role of local authorities and the Director of Public Health (DPH) in health improvement, health protection and population healthcare.

A summary of the reformed public health system was published as a series of factsheets in December 2011 (The New Public Health System, Public Health England (PHE)'s Operating Model, and Public Health in Local Authorities); these define the roles and responsibilities of PHE and local authorities.

Local authorities will take the lead for improving health and co-ordinating local efforts to protect the public's health and wellbeing, and ensure that health services promote population health. The local authority will have responsibilities across all three public health domains:

- leading investment for improving and protecting the health of the population and reduce health inequalities using the ring-fenced grant

- ensuring plans are in place to protect the health of the population and ensuring an appropriate public health response to local incidents, outbreaks and emergencies
- providing public health expertise, advice and analysis to Clinical Commissioning Groups (CCGs), Health and Wellbeing Board and the NHS Commissioning Board (NHS CB) (through a "core public health offer")

The local authority will have a role in:

- supporting, reviewing and challenging NHS commissioned immunisation programmes
- supporting, reviewing and challenging NHS commissioned national screening programmes
- ensuring that plans are in place to protect the health of the population

PHE will deliver services (health protection, health information and intelligence, services for the public through social marketing and behavioural insight activities), lead for public health and support the development of the public health specialist workforce.

Public health leadership in local authorities

Local authorities are well-placed to assume responsibility for improving public health for the following reasons:

- their population focus
- the ability to shape services to meet local needs
- the ability to influence wider social determinants of health
- the ability to tackle health inequalities

Local authorities will take on a new duty to take such steps as it considers appropriate for improving the health of the people in its area. One key way is to commission a range of services from a range of providers from different sectors, work with clinical commissioning groups and NHSCB to create as integrated a set of services as possible. The way in which a local authority fulfils this duty may vary between localities, including operating through planning, leisure policies, partnership and developing a diverse provider market for public health improvement activities. They will want to ensure the health needs of disadvantaged areas and vulnerable groups are addressed, improving the health of the poorest, fastest.

Local political leadership will be critical in ensuring that public health receives the focus it needs. The Cabinet lead for health is a key person, but there needs to be a broader engagement amongst all local political leaders.

Appendix 1 provides further details of the public health functions and responsibilities of local authorities and PHE along with a timeline for transition

Transition Goal
By 2013 to achieve the smooth transfer of PCT public health functions to the local authority, with sufficient resources to create a high quality and locally accountable public health system.

Transition Planning
The Regional Director of Public Health will be responsible for agreeing local and regional transition plans by the end of March 2012. A Public Health HR Concordat between the NHS and local government covers the principles relating to the transfer of public health staff. Local Government Transition Guidance was published in January 2012 to support the reforms, including transfer, selection and appointment activities. North Tyneside Council and NHS North of Tyne are working together on developing the relationships and joint working that will facilitate a robust transition for April 2013.

A North Tyneside Public Health Transition Group, comprising senior officers and managers, is overseeing the transition of public health from North Tyneside PCT to North Tyneside Council. The Transition Group has six work streams and under the agreed Terms of Reference (Appendix 2) operates as a Task Group of the Health Improvement Commissioning Board. The Group will provide leadership and accountability for transition, and will manage risks to the successful delivery of the Public Health Transition Plan (Appendix 3).

The North Tyneside Public Health Transition Plan, with proposed timescales, is being agreed through the appropriate NHS and Council decision making processes including sign off by Cabinet and the North of Tyne Transition Board. The plan has also been shared with the Health and Wellbeing Board and Clinical Commissioning Group Joint Board. Public Health Transition governance has been aligned to the NHS North of Tyne Transition.

Senior Leadership Team – review	17 January 2012
Regional review of draft plans	19-20 January 2012
NHS North of Tyne Transition Board – update	24 January 2012
Health and Wellbeing Board – review	9 February 2012
LINks – review and update	TBC
Health and Adult Social Care Subcommittee	23 February 2012?
PCT Board sign-off	TBC
Cabinet sign-off	12 March 2012
CCG Joint Board - update	TBC

Subject to the passage of the Health and Social Care Bill the local authority will assume statutory responsibilities for commissioning and/or providing public

health services from April 2013 (Appendix 4), following the abolition of the PCT. The publication of 2012/13 PCT financial allocations and shadow allocation will indicate the level of resources available locally to support the transition to the new system in each local authority. Ring fenced public health budgets will be allocated directly to the local authority in April 2013.

This plan details the tasks and risks to be addressed in order to ensure a robust transition, based on the currently published information and guidance. It is a framework that will be reviewed and updated through the Public Health Transition in line with the Department of Health transition plan template, new legislation, national guidance, and publication of key public health updates.

Transition Management
Public Health Transition is a large and complex process with various parallel and dependent activities. Project management arrangements detailed in a project initiation document, with clearly defined objectives, outcomes, scope, action plan with key milestones, and a risk register with mitigation. The Transition Plan will be performance managed and progress communicated across organisations. The Public Health Transition Group will convene the related work streams and delegate tasks to organisational leads.

The transition is not just a project with a specific end point. The Public Health Transition Group will also lead a change management process to embed public health within the local authority.

Mapping Functions
An exercise is underway to map current and potential health improvement functions of the Council (using the definition of health improvement as defined in 'Healthy Lives Healthy People (2010) as including people's lifestyles as well as inequalities in health and the wider social influences of health).

This exercise will conclude with recommendations for maximising the potential of the Council to improve the health and wellbeing of local people through the commissioning and delivery of mainstream services and through work with key partners and in particular the Health and Wellbeing Board.

Transition Principles
The operating principles agreed by the Transition Group are to:

- promote transparency, particularly in relation to public health budgets, contracts and risks
- share staffing and capacity to administer and manage the transition plan
- work collaboratively and with pace to minimise disruption to services and uncertainty for employees affected by changes
- have regard to the Public Health HR Concordat and subsequent guidance, such as the Local Government Transition Guidance

- ensure decisions reflect current governance arrangements within individual organisations
- consult and engage with employees and their representatives and ensure they are fully informed and supported during the change process
- promote equitability and fairness in all transfer, selection and appointment processes

Appendix 1

Public Health Functions and Responsibilities in Local Authorities and Public Health England (PHE)

Public health functions and responsibilities in local authorities

Local authorities will be required to deliver their new public health functions to: tackle the causes of ill-health and reduce health inequalities, promote and protect health, and promote social justice and safer communities. Some of these functions are regarded as mandatory to ensure that some service areas have greater uniformity of provision especially where they are legally required (such as health protection, and the provision of contraception).

The **mandatory services** include:

- Appropriate access to sexual health services (except abortion services, which will be commissioned by CCGs, and Sexual Assault Referral Centres (SARC), which will be commissioned by NHSCB)
- Duty to ensure there are plans in place to protect the health of the population
- Ensure NHS commissioners receive public health advice they need
- Deliver the National Child Measurement Programme
- Offer the NHS Health Check assessment

The elements of the Healthy Child Programme (age 5-19) previously proposed as mandated is subject to further review and will not be mandated during 2013.

Other commissioning responsibilities include:

Prevention and Lifestyle services

- Tobacco control and smoking cessation services
- Alcohol and drug misuse services
- Public health services for children and young people aged 5-19
- Interventions to tackle obesity such as community lifestyle and weight management services
- 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

Health Protection

- 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
- Local authority role in dealing with health protection incidents, outbreaks and emergencies
- Local initiatives that reduce public health impacts of environmental risks

Wider determinants of health

- Public health aspects of promotion of community safety, violence prevention and response
- Public health aspects of local initiatives to tackle social exclusion

These functions are deemed discretionary and the commissioning of the services will be guided by the Public Health Outcomes Framework, the local Joint Strategic Needs Assessment and the joint health and wellbeing strategy.

A specific mandatory function for local authorities is to provide public health advice to NHS commissioners. The general areas of input are on:

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

Local authorities will be required by the Government to collect and return the National Child Measurement Programme (NCMP) data so that the programme can continue to successfully fulfil its public health surveillance function by ensuring good quality and reliable data on the prevalence of child obesity. For the NHS Health Check programme, local authorities will be mandated to offer everyone eligible between the ages of 40-74, to receive an assessment of their risk of heart disease, stroke, diabetes and kidney disease, every five years. Local authorities will need to work closely with clinical commissioning colleagues to ensure that there is a clear pathway for interventions for those identified as high risk.

The role of the Director of Public Health

DPHs will be appointed at an appropriate status within the local authority, in line with the position of the Directors of Children's Services and Adult Social Services. It is proposed that the DPH is added to the list of statutory chief officers in the Local Government and Housing Act 1989. The responsibilities of the DPH will be defined by statutory guidance and DPHs will be trained public health specialists.

While the decision regarding organisation and structures is a matter for local determination, it is clear that the legal responsibilities for the DPH will translate into the DPH acting as 'the lead officer in a local authority for health and championing health across the whole of the authority's business'.

The DPH will be responsible for all the new public health functions of local authorities, including any conferred on local authorities by regulation. They will also be required to produce an annual report on the health of the local population. They will be statutory members of the health and wellbeing board.

The DPH will be the person elected members and other senior officers will consult on a range of public health issues, including emergency preparedness to concerns around access to local health services. They will promote a life-course approach by working closely with Directors of Children's Services and Adult Social Services, and with NHS colleagues. They will also work with the new Police and Crime Commissioner to promote safer communities.
The formal accountability of the public health ring-fenced grant rests with the Chief Executive, but it is expected that day-to-day responsibility for and management of the grant is delegated to the DPH.

For emergency planning, a Lead DPH from a local authority in the LRF will be appointed to coordinate the public health input to planning, testing and responding to emergencies across the local authorities in the LRF area. The Lead Director of Public Health will co-chair a Local Health Resilience Partnership with a lead director appointed by the NHS Commissioning Board. The Lead DPH will have access to a health emergency planning resource.

In relation to screening and immunisation programmes, the DPH will advise on whether screening or immunisation programmes in their area are meeting the needs of the population and whether there is equitable access.

Public Health England

Public Health England (PHE) will be established in April 2013 as an executive agency of the Department of Health and will have three key functions:

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

The services will include information and intelligence to support effective action, to promote and protect health and wellbeing, prevent illness, advance equality, tackle inequalities and improve public health outcomes. PHE will also design and deliver nationwide communications and interventions to support the public to

protect and improve their health, including the use of social marketing and behavioural insight techniques.

Indicative National Transition Timeline - for the transition of PCT public health commissioning activity and functions to the local authority.

By end of December 2011
- Policy documents published on the new system, defining the way in which public health will be delivered nationally and locally

By end of January 2012
- Public Health Outcomes Framework published
- PCT clusters produce first drafts of transition plans covering all transition issues in 2012/13. Council actively involved
- Local Government Transition Guide published

From January 2012 onwards
- Development of vision and strategy for new local public health system
- System preparation including new public health commissioning and contracting development
- Agreement on support functions for public health in new role (HR, IT, estates, finance support)
- Agreement on HR transfers, and financial issues

By end of March 2012
- Local transition plans to be agreed between PCTs, local authorities and regional director of public health
- Sign off by Cabinet
- Assessment of transition plans and feedback by the end of April 2012

From April 2012
- Monthly milestone monitoring of PCT clusters as part of combined SHA/LA assurance process
- Commencement of process of transferring public health duties to Council

October – end December 2012
- Formal assessment of progress with transfer from PCT to local authorities
- Completion of process of transferring public health duties to Council including transfer of staff
- Robust governance in place

From April 2013
- By end of March 2013 PCTs will be abolished and all PCT responsibilities for public health ceased. Formal handover completed

- From April 2013 local authorities will receive direct grant allocation to carry out public health functions
- TUPE of public health staff to the local authority will be complete

Appendix 2

North Tyneside Public Health Transition Group
Terms of Reference

Purpose
The purpose of the Group is to oversee the transition of public health responsibilities from North Tyneside PCT to North Tyneside Council. The Group will also identify and manage risks or barriers that could negatively affect a smooth transition.

Objectives
- Develop and implement the Transition Plan and maintain a Risk Register
- Establish and manage the transition work streams
- Provide progress reports to the Health Improvement and Prevention Partnership Board and the Health and Wellbeing Board
- Implement a Communication Strategy to build understanding and support for the transition process

Accountability
The Public Health Transition Group will be directly accountable to the Health Improvement Commissioning Board.

Membership

Name	Role or representation
Marietta Evans (Chair)	Director of Public Health, North Tyneside PCT / NTC
Jacqui Old (Vice Chair)	Head of Adult Social Care, North Tyneside Council
Ian Atkinson	Public Health Business Manager, NHS North of Tyne
Anne Graney	Health and Wellbeing Partnership Manager, North Tyneside Council
Haley Hudson	Senior Manager Strategic Planning, Partnerships and Transformation, North Tyneside Council
Mark Longstaff	Education Services, North Tyneside Council
Suzanne Duncan	Assistant Business Partner, Human Resources, North Tyneside Council
Sue Graham	Principal Accountant, Finance, North Tyneside Council
Caroline Latta	Communications, NNH North of Tyne
Jeanette Headley	Communications, North Tyneside Council
Viv Geary	Legal Services, North Tyneside Council
TBC	Commissioning & Contracting, North Tyneside Council
Lesley Currer	Human Resources, Once North East
Gary Walsh	Finance, NHS North of Tyne

Meetings
The Group will meet monthly in the first instance. The frequency of meetings will be reviewed regularly. The Group will be quorate with the Chair or Vice Chair, one LA representative and one NHS representative.

Public Health Transition Workstreams

The following list describes the key work streams for the public health transition process. Not all of the work streams will require separate meetings but may be managed within the main Public Health Transition Group meetings, via papers, through email contact or virtual meetings.

Workstream	**Method of communication**	**NTC Lead**
Vision and Model for Public Health - To develop and communicate a vision for public health for North Tyneside Council - To work with lead officers in the Council to secure ownership of the vision	Paper to SLT and Cabinet	Marietta Evans
Capacity and Impact of commissioned Public Health Programmes - Ensure that the new arrangements for Public Health in North Tyneside are designed to ensure maximum effectiveness in delivering population health improvement and reduction in health inequalities.	Paper to SLT and Cabinet	Marietta Evans
Finance and Resources - To strategically lead and manage the financial impact of the Public Health transition to North Tyneside Council.	Meetings/email exchange with NHS North of Tyne Finance	Susan Graham

Human Resources - To strategically lead and manage the HR impacts of the Public Health transition to North Tyneside 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	Meetings/email exchange with Once North East NHS HR	Suzanne Duncan
Information and Intelligence 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 - Intelligence function is efficient, effective and integral to the commissioning cycle	Via Intelligence Executive meetings	Marietta Evans
Governance and Risk	Picked up in NHS North of Tyne DsPH meetings	Marietta Evans
Communication and Engagement - Ensure regular communication on	Regular newsletter and picked up within wider Health and Wellbeing communications	Marietta Evans

transition to key stakeholders	Specific consultations to take place with affected staff	
Workforce Issues	Paper to SLT and Cabinet	Marietta Evans
Emergency Planning and Health Protection - The retention of an effective health protection function for North Tyneside, working in conjunction with Public Health England. This will include the Public Health contribution to emergency planning and management of infectious diseases and environmental hazards.	Picked up in NHS North of Tyne DsPH meetings	Marietta Evans
Joint Intelligence - Develop mechanism for sharing joint intelligence to support Health and wellbeing Board and commissioner decisions	Joint intelligence Group	Marietta Evans

Reporting Arrangements
North Tyneside Public Health Transition Group will report to the Shadow Health and Wellbeing Board and the North of Tyne Transition Board.

Regular updates will also be provided to the Council Senior Management Team and the Public Health Transition Plan will go to Cabinet for sign off in March 2012.

Marietta Evans
Director of Public Health

RAG rating:
GREEN: completed
AMBER: on track & clear actions
RED: actions unclear or not met

Appendix 3

Draft North Tyneside Public Health Transition Plan

WORKSTREAM 1: VISION AND POLICY To develop and communicate a vision for public health for North Tyneside Council and work with lead officers in the Council to secure ownership of the vision NTC Lead: Marietta Evans						
ID	**Tasks**	**Risks**	**Lead**	**Timescale**	**RAG rating**	**Comments**
1.1	Produce a first draft Transition Plan covering all transition issues in 2012/13, including transition plans for public health development with local government. Share with senior Council officers and members	Key issues omitted from the Draft Transition Plan	ME	January 2012		First draft completed
1.2	Develop JSNA Development Plan with key partners including CCGs. Share with Health & Wellbeing Board	Failure to support commissioning decisions with data and intelligence	ME	January 2012		Plan has been developed, to be shared with Health & Wellbeing Board
1.3	Formal transition plan to be agreed between PCT, local authority and regional director of public health	Failure of local system to make adequate preparation for new public health responsibilities	ME	March 2012		Deadline for submission of final plan to RDPH 16/03/12

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
1.4	Develop a draft Health and Wellbeing Strategy based on needs and priorities identifies in the JSNA, for circulation and consultation	Failure to produce the Annual DPH Report 2011/12 to set the scene for a local health strategy	AG	June 2012		
1.5	Complete mapping exercise with regard to Council health and wellbeing functions	Failure to embed health and wellbeing within Council	AG	February 2012		
1.6	Develop a vision and core purpose for the new Public Health Function in the local authority and its ways of working	Inability to generate wider ownership for public health in the local authority	ME	April 2012		Paper to SLT 17/01/12 for agreement of proposals on development of health and wellbeing function of the Council
1.7	Health and Wellbeing Strategy signed off by the Health and Wellbeing Board to inform public health commissioning and the first clinical commissioning group commissioning plans for 2013/14	Failure to develop a robust JSNA and health strategy in advance of agreed commissioning intentions for 2013/14	ME	September 2012		

WORKSTREAM 2: FORM AND FUNCTION NTC lead: Marietta Evans						
ID	**Tasks**	**Risks**	**Lead**	**Timescale**	**RAG rating**	**Comments**
2.1	Map/identify existing and future public health responsibilities for the Council and wider partners	Lack of clear demarcation between national, sub national and locality responsibilities	ME	September 2012		
2.2	Publish local authority public health structures and produce policies to cover the relevant new organisational arrangements post transfer	LA ring fenced budgets for public health insufficient to cover the cost of public health structures and functions.	ME	September 2012		
2.3	Design an operating model for the delivery of public health functions	Failure to unlock the synergies with the wider role of the local authority in tackling the determinants of health inequalities. Less effective delivery and more complexity in health protection	ME	June 2012		Draft for consultation will be informed by mapping exercise above

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
		responses after the separation of public health functions across LA/PHE/NHS CB				
2.4	Clarify where public health is positioned within the Local Authority and its alignment to the Council's structure	Instability of Council structures with possible budget cuts and reorganisation disrupts alignment	ME	September 2012		
2.5	Outline proposals for public health functions across a bigger (supra local) area	Lack of political will to share functions at the most appropriate level	ME	December 2012		
2.6	Develop relationships to internal bodies e.g. Health and Wellbeing Board and Health Scrutiny, and external bodies e.g. Clinical Commissioning Groups, sub-national structures and Public Health England	Lack of integration between commissioning of public health and commissioning of health care	ME	Ongoing		
2.7	Negotiate Core Public Health Offer for NHS Commissioners/CCGs in line with DH guidance	Failure to provide appropriate public health skills/ support NHS Commissioners	ME	July 2012		

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
2.8	Maintain key public health services in transition: • Health Protection • Emergency Planning • Screening • Public Health Commissioning Health Improvement • Health Intelligence • Performance Monitoring • STAC Rota	Lack of grip on corporate public health responsibilities as capacity is aligned to localities Potential SUI or incident	ME	Ongoing		
2.9	Establish local arrangements and local authority responsibilities for health protection and emergency planning from April 2013	Failure to respond resulting in risk to the public	ME	December 2012		Planning session taking place with key LA leads April 2012. Council plans to be developed in line with new emergency planning responsibilities

WORKSTREAM 3: FINANCE AND RESOURCES To strategically lead and manage the financial impact of the public health transition to North Tyneside Council NTC lead: Susan Graham						
ID	**Tasks**	**Risks**	**Lead**	**Timescale**	**RAG rating**	**Comments**
3.1	Complete DH Return 'PCT spend on future local authority public health responsibility'	Expenditure in 2010/11 does not reflect the budget allocation, and the 'pace-of -change' policy perpetuates a relatively low spend.	SG	September 2011		
3.2	Identify current PCT and LA budgets that fall within the proposed public health responsibilities of the LA	LA investment lost ahead of the allocation of ring fenced budgets as Council comes under financial pressure.	SGr	June 2012		Work underway to build picture of total spend
3.3	Risk assess the 2012/13 shadow allocations to see if the grant covers the services, programmes and functions associated with the transfer of public health responsibilities	Failure of ring fenced budgets to move towards allocations weighted for health inequalities in the short to medium term.	IA	February 2012		
3.4	Agree transfer of any public health funds via section 75 prior to April 2013	Failure to secure funding within Council to procure services	ME	March 2012		e.g. drugs pooled treatment budget

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
3.5	Establish arrangements and protocols for access to IT, data, and health intelligence for Council public health staff and staff transferring to LA employment	Failure of staff to be able to fulfil duties due to unresolved short term information governance issues and organisational barriers Unable to access NHS data thereby compromising public health delivery	KB/BL	September 2012		North of Tyne group established led by KB. BL is North Tyneside PCT representative
3.6	Agree processes for accountability and sign off for use of public health budget		ME	March 2013		
3.7	Establish a transparent accounting process for public health expenditure under the conditions of the ring fenced public health grant	Ring fenced grant not used for areas of greatest public health need	FR	March 2013		
3.8	Identify any relevant assets and establish arrangements for their transfer to the local authority	Assets not available to staff	ME	September 2012		

WORKSTREAM 4: WORKFORCE AND HUMAN RESOURCES To strategically lead and manage the HR impacts of the public health transition; ensure positive employee relations during the transition with a framework for the ongoing management and integration of public health into the Council and to establish an appropriate framework to meet future organisational and professional development needs NTC lead: Suzanne Duncan						
ID	**Tasks**	**Risks**	**Lead**	**Timescale**	**RAG rating**	**Comments**
4.1	Regular sessions with individual staff to talk about the developing situation and each person's options	Delays in the development and circulation of destination options	SG	Ongoing		
4.2	Provide a map of organisational changes, which are likely to impact on employees during transition and into potential new organisations e.g. PHE	Delays in the development and circulation of destination options	ME	June 2012		
4.3	Map staff and functions in the PCT Public Health Directorate that may transfer to the local authority, having regard to the Public Health HR Concordat and the Local Government Transition Guidance	Council is not constrained by Concordat or local government guidance	ME	April 2012		
4.4	Align staff to the future operating model for public health and align management, budgets and contracts in the local authority	Imbalances in the distribution of public health expertise across the localities	ME	July 2012		

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
4.5	Develop interim arrangements for staff aligned to the LA, having regard to the Local Government Transition Guidance, and produce a governance agreement for the ongoing delivery of core NHS duties	Lack of specificity of roles and responsibilities during alignment	ME	April 2012		Consider developing MoU
4.6	Circulate locally agreed HR arrangements to all staff affected by the transition	Delays in the development of locally agreed HR arrangements	JL	April 2012		Lesley Currer is the NoT contact for Once North East -
4.7	Embed transition programme objectives into personal development plans, identifying areas of need and opportunities e.g. pre-transfer shadowing arrangements to help staff become familiar with the new organisation	Loss of focus on personal and professional development	ME	June 2012		
4.8	Ensure business continuity for key public health functions and secure the retention of public health expertise	Public health workforce may be lost during transition due to uncertainty and lack of clarity on	ME	Ongoing		

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
		future roles e.g. Public Health Consultant capacity				
4.9	Advise on the location and integration of public health intelligence support, and the necessary capability and capacity to deliver the 'core offer'	Lack of specialist intelligence capacity	ME	April 2012		Discussions ongoing across North of Tyne
4.10	Scope the transfer of functions and employees followed by confirmation that the functions are substantively the same and within the scope of TUPE	Delays lead to low morale of staff during transition	JL	September 2012		
4.11	Make specific proposals for the terms and conditions of the public health workforce	Employment contract transfer proposals are seen as a barrier by PH specialists who seek to move to avoid loss of terms and conditions	JL/AL	September 2012		
4.12	Delineate public health roles and responsibilities, job descriptions and person specifications, and transfer and/or recruit Public Health staff	Failure to attract specialist public health capacity	ME	January 2013		

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
4.13	Agree job description, location and accountability of the DPH	Location of DsPH within the local authority may not be at sufficiently high level and limit the scope for influencing the wider determinants of health, such as transport and education, and the ring fenced public health budget.	Chief Exec NTC	Early 2013		
4.14	Appropriate induction to local authority and establish an organisational development programme for all staff	Loss of focus on personal and professional development	ME	Early 2013		
4.15	Review personal development plans for staff transferring to local authority	Loss of focus on personal and professional development	ME	Early 2013		
4.16	Clarify arrangements and funding for Medical Examiner	Council fails to fulfil duty	ME	June 2012		Clarity required from DH
4.17	Clarify arrangements for PH Specialist Trainees	Failure to provide training opportunities for trainees	ME	June 2012		Link to regional workforce transition workstream

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
4.18	Develop training and education opportunities to support a wider public health workforce	Failure to plan for medium to long term workforce needs	ME	Early 2013		
WORKSTREAM 5: COMMISSIONING AND PERFORMANCE To ensure that the new arrangements are designed to provide maximum effectiveness in delivering population health improvement and reduction in health inequalities NTC lead: Marietta Evans						
5.1	Review all health improvement contracts and service specifications for 2012/13 e.g. full review of the service specification for the School Nursing Service	Failure to engage key Council managers	ME	From April 2012		
5.2	Identify and record risks associated with each contract	Council unaware of risks leading to potential failures or poor performance in service provision	ME/IA	March 2012		
5.3	Agree a process for the novation or termination of existing NHS service agreements in advance of re-specification, tendering and contracting running up to April 2013	Review of existing services leads to destabilisation and under-performance	ME	March 2012		Meeting arranged on 24 Feb with Louise Robson re regional plan for this process
5.4	Where appropriate give notice to providers with regard to novation or termination of contracts	Giving notice leads to destabilisation and under-performance	ME	April 2012		Should be informed by meeting above

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
5.5	Propose which, if any, health improvement services will be transferred to the local authority	Failure to assess alternative business models for health improvement	ME	March 2012		
5.6	Agree the public health services/programmes to be run at a supra-local level	Lack of supra-local public health leadership	ME	September 2012		Discussions required North of Tyne and at a regional level via Local Transition Planning workstream
5.7	Scope the implications of transferring commissioning responsibilities to the local authority, ensuring NHS commissioners receive public health advice	Council does not have the expertise and capacity to commission public health services effectively	ME	September 2012		To follow contract review – schedule developed
5.8	Establish arrangements for contracting Local Enhanced Services with GPs	Services fail leading to poor outcomes for patients	ME	June 2012		Clarity required on where ownership of this will sit in future
5.9	Explore opportunities for shared services and/or different service delivery models	Inability to provide value for money and/or provide effective services	ME	June 2012		

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
5.10	Realign the performance information and reporting tool (PIRT) to the new public health outcomes framework	Disruption to performance management during transition to a health outcomes approach	IA	April 2012		
5.11	Develop local indicators to monitor performance in relation to the Public Health Outcomes Framework		ME	December 2012		Initial discussions with Council performance lead – needs to be embedded in Council reporting system
5.12	Public Health performance and risk reporting to be integrated into the Council's monitoring systems	Lack of focus on public health outcomes	IA	September 2012		
5.13	Agree IT, contracting and procurement support to be aligned to Public Health	Inefficiencies caused by ad hoc alignment	ME	September 2012		
5.14	Provide clarity on the public health function in the Council, including the core offer to provide expertise, advice and analysis to the clinical senates, CCGs and the Health and Wellbeing Board	Loss of focus on prevention, integrated pathway development and health inequalities in health care commissioning	ME	January 2013		

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
5.15	Maintain and improve standards of public health performance with robust performance monitoring arrangements	Failure to maintain performance whilst managing transition towards new arrangements	ME	Ongoing		
5.16	PCT legacy document produced, which includes Public Health Directorate	Document does not include all information required for ongoing delivery	SG	Early draft by October 2012		
5.17	Public Health file mapping exercise to include the auditing an cataloguing of files within the PH Directorate	Cataloguing does not include all files required for ongoing delivery	SG	End 2012		This will contribute to preparation for data migration
WORKSTREAM 6: GOVERNANCE AND RISK NTC lead: Marietta Evans						
6.1	Develop scheme of delegation or memorandum of agreement between the Council and the PCT with regard to governance arrangements and accountabilities during the transition year	Lack of clarity with regard to accountability	ME	March 2012		Under discussion with Council colleagues

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
6.2	Identify clinical and non-clinical risk and indemnity issues in relation to all contracts transferring to the local authority	Council unaware of risks leading to potential failure of service provision or litigation	ME	September 2012		
6.3	Identify and agree future arrangements for the reporting of SUI's/Incidents and Patient Group Directions	Failure to learn from SUIs/incidents and potential risk to clients/patient safety	ME	September 2012		Agreement required at supra-local level
6.4	Agree a risk sharing approach with the Council during the transition year	Lack of clarity with regard to accountable body with regard to risk	ME	March 2012		Consider as part of MoU
WORKSTREAM 7: COMMUNICATION AND ENGAGEMENT Ensure regular communication on transition to key stakeholders and engagement with staff through the transition process NTC lead: Marietta Evans						
7.1	Liaise with major providers on changes to public health commissioning	Destabilisation following changes to commissioning leadership	ME	Ongoing		Being undertaken via contract meetings
7.2	Consultation events to engage with elected members and services managers to ensure that public health reforms are embedded across the local authority	Lack of engagement following failure to dedicate sufficient time and resource to communication	ME	Ongoing		Taking place with Select Committee/SLT/ HWB

ID	Tasks	Risks	Lead	Timescale	RAG rating	Comments
7.3	Co-ordinate reports to the executive teams of the Council and PCT to provide assurance and accountability for transition	PH transition is not prioritised within the wider whole system reform process of the NHS	ME	Ongoing		
7.4	Consultation with the public health workforce on transition planning and proposed changes to employment and working arrangements	Failure to dedicate sufficient time and resource to engagement and communication with staff lowers morale	ME	Ongoing		Specific consultations to take place with affected staff
7.5	Communication and engagement with staff side on proposals to align/transfer public health staff to local authority (statutory requirement where TUPE applies)	Failure to dedicate sufficient time and resource to engagement and communication causes unnecessary delays to the transfer of staff	ME	Ongoing		
7.6	Circulate a monthly briefing for PCT and LA staff detailing the developing situation	Failure to dedicate sufficient time and resource to communication causes	ME	Ongoing		

		unnecessary confusion and lack of engagement				

Transition Plan Leads

ME Marietta Evans, DPH (These tasks will be delegated to appropriate Officers)
AG Anne Graney, Health & Wellbeing Co-ordinator, NTC
AL Alison Lazazzera, Strategic Manager, Human Resources, NTC
BG Brian Lonsdale, North Tyneside PCT
IA Ian Atkinson, Business Manager, NHS North of Tyne
FR Fiona Rooney, Strategic Director, Finance and Resources, NTC
KB Kath Bailey, PH Specialist NHS North of Tyne
JL Janine Lutz, Head of HR, Once North East Human Resources
SG Sue Gordon, Executive DPH, North of Tyne
SGr Sue Graham, Principal Accountant, Finance, NTC

Appendix 4

North Tyneside Public Health Transition Timeline

ID	Tasks	Timescale
3.1	Complete DH Return 'PCT spend on future local authority public health responsibility'	Completed
1.1	Produce a first draft Transition Plan covering all transition issues in 2012/13, including transition plans for public health development with local government	Completed
1.2	Develop draft JSNA Development Plan	Completed
Prep for 4.4	Begin consultation with PCT public health staff with regard to alignment to localities	Completed
3.3	Risk assess the 2012/13 shadow allocations to see if the grant covers the services, programmes and functions associated with the transfer of public health responsibilities	February 2012
5.3	Agree a process for the novation or termination of existing NHS service agreements in advance of re-specification, tendering and contracting running up to April 2013	March 2012
5.5	Propose which, if any, health improvement services will be transferred to the local authority	March 2012
1.3	Formal transition plan to be agreed between PCT, local authority and regional director of public health	March 2012
	Sign off Public Health Transition Plan and submit to DH	March 2012
1.6	Develop a vision and core purpose for the new Public Health Function in the local authority and its ways of working	April 2012

	Formal assessment of transition plan and feedback	April 2012
4.3	Map staff and functions in Public Health that may transfer to the local authority, having regard to the Public Health HR Concordat and the Local Government Transition Guidance	April 2012
	Develop 'handover' plan from NHS NOT to locality lead arrangements	April 2012
4.5	Develop interim arrangements for staff aligned to the LA, having regard to the Local Government Transition Guidance, and produce a governance agreement for the ongoing delivery of core NHS duties	April 2012
4.6	Circulate locally agreed HR arrangements to all staff affected by the transition	April 2012
4.9	Advise on the location and integration of public health intelligence support, and the necessary capability and capacity to deliver the 'core offer'	April 2012
5.10	Realign the performance information and reporting tool (PIRT) to the new public health outcomes framework	April 2012
5.1	Commence detailed contract reviews and service specification reviews for all commissioned health improvement services	
1.4	Develop a draft Health and Wellbeing Strategy based on needs and priorities identifies in the JSNA, for circulation and consultation	June 2012
2.3	Design an operating model for the delivery of public health functions	June 2012
3.2	Identify current PCT and LA budgets that fall within the proposed public health responsibilities of the LA	June 2012
4.2	Provide a map of organisational changes, which are likely to impact on employees during transition and into potential new organisations	June 2012
4.7	Embed transition programme objectives into personal development plans, identifying areas of need and	June 2012

	opportunities e.g. pre-transfer shadowing arrangements to help staff become familiar with the new organisation	
4.4	Align staff to the future operating model for public health - staff begin new locality roles	July 2012
1.7	Health and Wellbeing Strategy signed off by the Health and Wellbeing Board to inform public health commissioning and the first clinical commissioning group commissioning plans for 2013/14	September 2012
2.2	Publish local authority public health structures and produce policies to cover the relevant new organisational arrangements post transfer	September 2012
2.4	Clarify where public health is positioned within the Local Authority and its alignment to the Council's structure	September 2012
3.5	Establish arrangements and protocols for access to IT, data, and health intelligence for Council public health staff and staff transferring to LA employment	September 2012
4.10	Scope the transfer of functions and employees followed by confirmation that the functions are substantively the same and within the scope of TUPE	September 2012
4.11	Make specific proposals for the terms and conditions of the public health workforce	September 2012
5.6	Agree the public health services/programmes to be run at a supra-local level	September 2012
5.7	Scope the issues and implications of transferring commissioning responsibilities to the local authority: ensuring NHS commissioners receive public health advice	September 2012
5.12	Public Health performance and risk reporting to be integrated into the Council's monitoring systems	September 2012
5.13	Agree IT, contracting and procurement support to be aligned to Public Health	September

		2012
5.16	PCT legacy document produced, which includes Public Health Directorate	early draft October 2012
	Formal assessment of progress with transfer from PCT to local authorities	October 2012
2.5	Outline proposals for shared public health functions across a bigger (supra local) area	December 2012
5.17	Public Health file mapping exercise to include the auditing and cataloguing of files within the PH Directorate	End 2012
4.13	Agree job description, location and accountability of the DPH	Early 2013
4.14	Appropriate induction to local authority and establish an organisational development programme for all staff	Early 2013
4.15	Review personal development plans for staff transferring to local authority	Early 2013
4.18	Develop training and education opportunities to support a wider public health workforce	Early 2013
4.12	Delineate public health roles and responsibilities, job descriptions and person specifications, and transfer and/or recruit Public Health staff	January 2013
5.14	Provide clarity on the public health function in the Council, including the core offer to provide expertise, advice and analysis to the clinical senates, CCGs and the Health and Wellbeing Board	January 2013
3.6	Agree processes for accountability and sign off for use of the public health budget	March 2013
3.7	Establish a transparent accounting process for public health expenditure under the conditions of the ring fenced public health grant	March 2013

	PCTs abolished and all PCT responsibilities for public health ceased	March 2013
	Local authorities receive direct grant allocation to carry out public health functions	April 2013
2.6	Develop relationships with internal bodies e.g. Health and Wellbeing Board and Health Scrutiny, and external bodies e.g. Clinical Commissioning Groups, sub-national structures and Public Health England	Ongoing
2.8	Maintain key public health services in transition: • Health Protection • Emergency Planning • Public Health Commissioning • Health Improvement • Health Intelligence • Performance Monitoring • STAC Rota	Ongoing
4.1	Regular sessions with individual staff to talk about the developing situation and each person's options	Ongoing
4.8	Ensure business continuity for key public health functions and secure the retention of public health expertise	Ongoing
5.15	Maintain and improve standards of public health performance with robust performance monitoring arrangements	Ongoing
7.1	Liaise with major providers on proposed changes to public health commissioning	Ongoing
7.2	Consultation events to engage with elected members and services managers to ensure that public health reforms are embedded across the local authority	Ongoing
7.3	Co-ordinate reports to the executive teams of the Council and PCT to provide assurance and	Ongoing

	accountability for transition	
7.4	Consultation with the public health workforce on transition planning and proposed changes to employment and working arrangements	Ongoing
7.5	Communication and engagement with staff side on proposals to align/transfer public health staff to local authority (statutory requirement where TUPE applies)	Ongoing
7.6	Circulate a monthly briefing for PCT and LA staff detailing the developing situation	Ongoing

Appendix 5

North East Public Health Transition

Regional Position Statements

January 2012

Below are a series of summary position statements as at end of January 2012 for:

- *Emergency preparedness, resilience and response*
- *Human Resources*
- *Immunisation*
- *Screening, and*
- *Communication and engagement.*

These statements will be updated on a regular basis as details of proposed changes become clearer and policy papers produced.

Emergency Preparedness, Resilience and Response

HPA Lead: Tricia Cresswell

The statutory duties of NHS bodies and their boards in relation to emergency preparedness, resilience and response remain in place until 31 March 2013.

Unless review is required for immediate operational reasons, all NHS plans and response arrangements at local level will remain in place. Plans will only be revised once final structures are understood;

Unless review is required for immediate operational reasons, all HPA plans at local level will remain in place. Plans will only be revised once final structures are understood;
The regional STAC plan is currently being revised following the STAC training in 2011 and prior to the STAC exercise in February 2012. This revision is for operational reasons and will continue to reflect current structures;

Exercising of current plans will continue in relation to Olympic assurance;
From 3 October 2011, the three NHS Strategic Health Authorities (NHS North East, NHS North West and NHS Yorkshire and Humber) have operated under a single management framework, NHS North of England. However the role of the SHA in command and control structures in relation to major incidents extending beyond one PCT cluster area remains unchanged.

Human Resources

Once North East HR Lead: Janine Lutz

There is a HR Regional transition plan based on requirements of organisations as set out in the PH Human Resources Concordat. The plan will be reviewed and developed further as/when new information emerges. Partnership working with Local Authorities has commenced and there is a view to work regionally across all 4 PCT clusters on HR issues to ensure consistency across the North East with sender and receiver organisations. The Transition plan sets out the legislative requirements under TUPE and incorporates the requirements as set out in the Concordat.

Immunisations

PHNE Lead: Fergus Neilson

The Director of Public Health is responsible to oversee and ensure delivery of nationally recommended immunisation programmes to the PCT population. They are also responsible for implementing local, targeted programmes in accordance with the needs of their population and within the context of national guidance.

The future arrangements for Immunisations in the new public health system are for the policy to be set by Public Health England, and for this policy to be implemented through the NHS Commissioning Board. The Director of Public Health in local authorities will have a role in overseeing and commenting upon the delivery of immunisation programmes for their population. The details of how this will be configured within the new public health system are still being developed.

Each PCT should have a suitable qualified and experienced PCT Immunisations Coordinator to lead and coordinate the programmes. This person reports to the Director of Public Health and the Director of Public Health provides regular updates to the PCT Board on immunisation programme performance and issues.

The PCT will continue to oversee and support the providers to deliver immunisation services, in accordance with national guidance in the "Immunisations Green Book".

Screening

PHNE Lead: Fergus Neilson

The Regional Director for Public Health has overall responsibility of overseeing screening programmes. The Director of Public Health is responsible for overseeing and ensuring the highest standard of national screening programmes for the PCT population.

Client/patient pathways for each screening programme need to be coordinated across several departments and organisations. Throughout the transition, the PCT is committed to ensuring that there will be an identified public health lead (PCT Screening Lead) for each screening programme to maintain minimum standards. The PCT Screening Lead must also have access to colleagues in other functions, e.g. contracting, commissioning, communication and clinical governance. Due to the relative complexity of screening programme it is important that there are clear accountabilities and governance structures. It is also important that each component of a screening pathway is supported by an explicit service agreement.

The PCT will continue to review the performance of its screening programmes and where minimum standard or targets are not being met, will put in place a plan of action to ensure they are.

The PCT will contribute to forming plans for screening programmes in the new public health system, and actively make changes to ensure appropriate staff are available as the plan emerges. This may include sharing staff and resources between local PCTs.

Communications and Engagement

Leads: Rachel Chapman/Simon Mills

The Communication and Engagement plan focuses on the transfer of the health improvement function to local authorities, including the responsibility for public health campaigns, although there will be links with other workstreams. However, the plan also includes the functions that will transfer to Public Health England:

Public Health North East
Health Protection Agency
National Treatment Agency
North East Public Health Observatory
Quality Assurance and Reference Centre
Northern and Yorkshire Cancer Registration and Information Service

Such wide ranging changes will require a comprehensive communications and engagement plan to manage the information flow with internal and external stakeholders, ensure views are taken into consideration wherever possible around the transition and help mitigate any risks from such major change. In relation to the transfer of the health improvement function to the local authorities, it will also be important to work closely with communications and engagement colleagues in local authorities, and again provide whatever support may be necessary, as they begin to assume responsibility for public

health campaigns.

A key task during the transition will be to ensure that communications and engagement is consistent across all partners.

This plan identifies the key communications and engagement activities that will be necessary during the transitional period. It will be refined following the publication of the expected national policy papers.