Bury COUNCIL

APP NHS Bury

**Bury Public Health Transition**

**Action Plan 2012/13**

## 1. Introduction

1.1 This action plan describes the current state of readiness; action required and identified risks associated with the transition of the Bury public health function, programmes and services to the Local Authority, Bury Clinical Commissioning Group (CCG), National Commissioning Board (NCB) and Public Health England (PHE). Work programmes and actions described in the plan will be undertaken in line with national policy as it currently stands and as it emerges. As such this is a dynamic document that will be reviewed and amended on a regular basis.

1.2 Building on transition work already undertaken locally, this plan will serve the purpose of providing assurance to NHS Greater Manchester (NHS GM), CCG/Locality Board, NHS North, Local Authority (LA) and the local shadow Health and Wellbeing Board and relevant Greater Manchester elements of public health transition going forward.

1.3 The programme of work and associated action plan (embedded at section 17 of this document) is overseen by a formal Public Health Transition Board (PHTB), chaired by the LA Executive Director, Adult Care Services. The Board is responsible for decision making on all key locally determined aspects of public health transition.

1.4 A project initiation document has been defined and agreed, and underpins the work of the PHTB:

**Supporting document: 1.4 a : Project Initiation document 2011-12 refers**
**Supporting document : 1.4b : Project Initiation document 2012-13 refers**

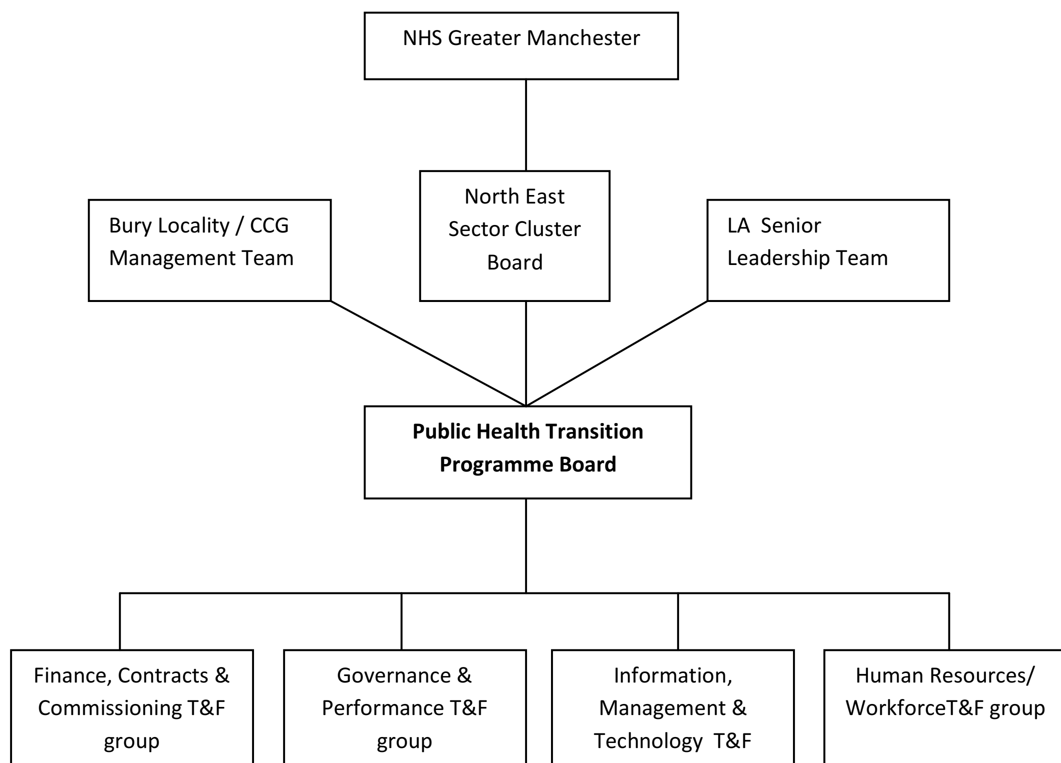
## 2. Governance and accountability

2.1 The Executive Director of Adult Care Services is the chair of the PHTB and executive lead for the transition process and is accountable for this to the LA Chief Executive. The Director of Public Health (DPH) is a member on the PHTB and is accountable to the GM Cluster CEO for the transition process. Detailed governance and accountability arrangements will be develop through 2012 with the transition of agreed duties by October 2012, and formal handover completed by 31 March 2013.

2.2 The PHTB reports to the Council Executive and CCG Board. Assurance for the transition is being monitored with regular updates being shared with the Council Senior Leadership Team, Locality Management Team and shadow Health and Wellbeing Board (sHWB).

2.3 Task and finish groups have been established to mobilise the work programme of the PHTB. Outline responsibilities of each group are covered in section 4 of this plan.

2.4 Governance and accountability arrangements underpinning the transition programme are:




## 3. Local Progress in Transition

3.1 During 2011/12 an initial vision for the integration of the public health functions and team was developed. This vision was supported and agreed by the Council Executive and Bury Locality Group, and was formally signed off by the LA Chief Executive, Managing Director of Bury Locality Board and the Clinical Lead of Bury CCG. The vision is set against a background of transformational change within the Council in both service provision and organizational structures and will be subject to review.

**Supporting document 3.1 : Public Health Transition Vision refers**

3.2 Good progress in implementing the vision has been achieved. In November 2011, following staff consultation, managerial responsibility for the public health team was transferred to the LA under the terms of a memorandum of understanding. This coincided with the physical relocation of the public health team to LA accommodation.

**Supporting document 3.2 : Memorandum of Understanding refers**

3.3 The work programme summarized in this plan describes the key actions required to ensure the safe transfer of functions and responsibilities to the Local Authority (LA), Clinical Commissioning Group (CCG), National Commissioning Board (NCB) and Public Health England (PHE).

3.4 The plan has been agreed by the PHTB, and is supported by the LA Chief Executive and Operating Officer of the CCG. The plan will be submitted for formal sign off by the CCG Board on 25 April, 2012, and by the Council Executive on 13 June, 2012.

## 4. GM Public Health Transition

4.1 Greater Manchester is well prepared for the transfer of public health functions to local authorities. There is a track record of strong collaborative working that recognises the economic, social, organisational and clinical interdependence in Greater Manchester. The 10 Greater Manchester Authorities are committed to improving wellbeing as a fundamental part of Public Sector Reform and specifically through opportunities created in the Community Budgets programme. Leadership is provided by both leaders and chief executives.

4.2 In Greater Manchester we will seize the opportunity of the return of public health to its local authority home to enhance and support our public sector reform programme which addresses our long standing commitments to improving life chances, connecting people to opportunities and addressing poverty.

4.3 The directors of public health as part of the GM Network will build on their strong history of collaboration and shared management of public health activity to work together to develop robust GM level work programmes which can contribute to new delivery models that support the integration of services and provide a robust evidence base that allows us to understand the impact of our investment in terms of improved life chances.

4.4 The vision is to deliver a high quality high value public health system for Greater Manchester that supports the delivery of the new duties and responsibilities for local authorities. It will offer a GM population perspective and evidence base to clinical commissioning groups, and maximise the gain to, and protection of population health through robust leadership, resilient arrangements and deployment of expertise via local authorities and local health and well being boards, as well as on behalf of Public Health England.

4.5 The key challenge for this work is to retain local sensitivity and support to the local leadership of public health whilst acknowledging that in some cases better value and outcomes can be achieved through aggregation of what will be a scarcity of public health skills and expertise. The Greater Manchester Directors of Public Health Group is currently undertaking a review of stakeholders to understand the appetite for shared services at a GM level. The focus of this work includes:

- Health protection commissioning advice and support service for infection control and immunisations and vaccinations linked to emergency planning
- Public health intelligence and research capacity
- Public health commissioning advice, support and co-ordination for screening programmes
- Promotion of behaviour change, through focused social marketing activity and in particular bringing investment into GM
- Support to local authorities for the commissioning of health improvement services specified in their commissioning responsibilities (examples include healthy weight, alcohol and sexual health) and potentially public health support to Clinical Commissioning Groups.

## 5. Ensuring a robust transfer of systems and services locally

5.1 Bury's transition work programme is organised around 4 interrelated workstreams:

### 5.2 Finance, Commissioning and Contracts

a. Responsible for structuring the 2012/13 budget so it can continue to support delivery of high quality and value for money services and achieve management cost savings; establishing clear processes for allocation of the ring fenced budget from 2013/14 onwards; and migrating budgets from the NHS to LA.

b. Building on joint work already undertaken, this workstream will identify all contracted activity and services transferring to the LA, CCG, NCB and PHE. It will establish and agree arrangements for transferring each contract and service as appropriate, ensuring that specialist responsibilities of public health (notably infection control, safeguarding and emergency planning) are addressed within the new system in a way that is legal and sufficient to ensure adequate health protection and safeguarding arrangements are in place across the borough. Commissioners will work during 2012/13 to novate contracts to the LA, formally taking effect from April 2013.

c. Responsibility will include identifying the commissioning arrangements for provider services, establishing the systems (including appropriate commissioning and procurement support) to ensure a strong public health commissioning function in the future; setting future strategy for commissioning provider services; overseeing implementation of this, including developing service specifications and running any new procurement processes that may be required; and alignment of the 2013/14 indicative budget to existing commitments and strategic priorities. For each contract an appropriate source of contracting support will be identified.

d. Issues and considerations relating to facilities, estates and assets will also be reviewed and addressed.

**5.3 Governance and performance management**

a. This workstream focuses on ensuring that robust governance arrangements, schedules of delegation and accountability, and risk sharing agreements are in place between the LA and NHS to ensure the legal transfer of responsibilities and maintain resilience in the public health work programme throughout transition and beyond.

b. Development and agreement of a business transfer agreement (legacy document) will be a priority within this work programme.

c. Work will also focus on aligning performance information and intelligence to ensure resilience in performance management of key indicators through the transition year. This will lead to wider strategic work to develop a shared approach for performance review and sector led support and improvement.

d. Work is also planned to develop a peer review framework aligned with other LAs.

**5.4 Information, management and technology (IM&T)**

a. This workstream involves the identification of IT and information governance requirements to ensure resilience in IM&T functions and responsibilities. The detailed work programme has a focus on:

- IT systems supporting public health
- Datasets (access and security)
- Health intelligence

### 5.5 Human Resources

a. Responsibility for ensuring the continuing transition of the public health staff resource, in accordance with the Public Health HR Concordat. To date this has included work to implement the organisational structure for the new public health system in Bury and managing processes to move people into this new structure. HR provided leadership to consultation and engagement processes implemented to facilitate the smooth transfer of staff. A memorandum of understanding (see section 3.2) secured the early managerial transfer of public health staff into the LA.

b. Clarifying interdependencies between public health and wider PCT functions; identifying associated capacity requirements and workforce plans for the new public health system locally; and, putting in place processes to ensure that these support needs are met, is integral to the forward facing work programme.

c. In addition to securing the formal transfer of staff by 2013 and wider workforce planning, work during the transition year will focus on establishing an appropriate system for ensuring that regulated public health professionals can maintain their registration, and to ensure that Bury continues to provide a high quality public health training role.

## 6 Health and Wellbeing Board

6.1 During 2011/12 considerable progress has been achieved in the development of arrangements for a shadow Health and Wellbeing Board (sHWB). Early in 2011, the sHWB Board met for a number of development sessions and has now begun to move onto a business footing. It will be formally established in shadow form in 2012/13. The shadow Board has a defined business plan which has a focus on delivering a number of core work programmes throughout the transition period including:

- Continuing development of Joint Strategic Needs Assessment (JSNA) to inform and influence priority setting and commissioning intentions.
- Development of a joint health and wellbeing strategy.
- Development and implementation of a communication and involvement framework.
- Development of a relationship framework.
- Development of a community asset mapping framework and approach.
- Development of a robust governance framework.

## 7 Joint Strategic Needs Assessment

7.1 Continuing development of the JSNA is a key priority of the sHWB. Locally the JSNA was last reviewed and published in Nov 2010. Since this time efforts have focused towards establishing a continuing needs assessment approach that is web based and accessible and responsive to a wide range of stakeholders. Work has concentrated on drawing together information into a single intelligence system/hub, ensuring robust governance and data sharing agreements are in

place. A JSNA toolkit and guidance has been developed for local use. Involvement and engagement in continuing needs assessment by a range of stakeholders is critical to the process. This will be enabled through the implementation of the sHWB communication and engagement framework.

7.2 The JSNA is recognized as the backbone to the work of the sHWB. A business case is currently in development to clarify the specialist skills and resource required to secure high quality intelligence through a firm commitment to the long term development and sustainability of the emergent web based approach.

7.3 A project initiation document underpins the JSNA work programme. This has been agreed and signed off by senior executive leaders. Leadership and implementation of the PID is facilitated through the established JSNA Project Group, which is directly accountable to the sHWB.

**Supporting document : 7.3 JSNA Project Initiation document refers**

7.4 Work to define the needs and product requirements of JSNA users is in progress. At the same time, Bury is working in collaboration with the NHS Transition Alliance to review the JSNA approach locally and how this can be maximised to support the requirements and expectations of the sHWB, influencing and shaping the development of the emergent joint health and wellbeing strategy.

7.5 The sHWB has recently endorsed its communication and engagement framework (see section 8) this will underpin the continuing needs assessment process. In addition, the sHWB has confirmed its commitment to develop a robust approach to community asset mapping and has agreed to explore potential models with a view to these being firmly embedded into the rolling programme of needs assessment work locally.

**Supporting document : 7.5 a & 8.1b Shadow Health & Well-Being Board Minutes 29.2.12 refers**
**Supporting document : 7.5 b : Shadow Health & Well-Being Board Community Asset Approaches refers**

## 8 Communication and Engagement Framework

8.1 A communication and engagement framework has been developed and agreed as part of the work programme of the sHWB. Public health transition is one of the three core objectives of this framework.

**Supporting document : 8.1a : Shadow Health & Well-Being Board Communication & Engagement Framework 2012-13 through to Transition refers**

**Supporting document : 7.5 & 8.1b Shadow Health & Well-Being Board Minutes 29.2.12 refers**

8.2 All key stakeholders have been identified in the plan, together with an assessment of what communication is required with them and the best way of doing this. HealthWatch, the NCB and PHE are identified as key stakeholders, with a commitment to establish early links with these bodies when they are formally established.

8.3 Following the publication of the Public Health White paper there has been a continuing commitment to share progress on the emerging transition arrangements and the vision for the new public health system both locally and nationally. In addition to informal discussions with key stakeholders, this has included regular updates and presentations to:

- NHS Bury Locality Board and Clinical Commissioning Group
- NHS Bury Senior Management Team
- LA Senior Leadership Team
- LA Council Executive
- LA Overview and Scrutiny Committee
- Public health team meetings
- Children's Trust Board
- LA Environmental and Developmental Services Directorate
- sHWB

8.4 The transfer of the public health team to the LA was covered in the Manchester Evening News on 30 November, 2011.

**Supporting document : 8.4 : Press Release refers**

## 9 Joint Health and Wellbeing Strategy

9.1 Development of a joint health and wellbeing strategy is in progress. Working in collaboration with the National Leadership Council, the sHWB are actively working towards producing a draft strategy by July (to support CCG authorization), with the final version signed off by September 2012 in readiness to inform commissioning intentions for 2013 onwards. Translating intelligence from the JSNA is integral to this process; the two work programmes are inextricably linked.

9.2 Development of the joint strategy includes work to define a local approach to priority setting that will inform and influence the commissioning intentions of the sHWB. In addition, this

process will help to identify a discrete number of priorities for continuing needs assessment or specific programme areas where more detailed needs assessment work is required.

9.3 The sHWB communication and involvement framework (section 8) will underpin the joint strategy development, review and evaluation process.

**10 Transfer of Mandated Service**

10.1 Throughout the 2012/13 transition year the public health team will continue to maintain resilience in the continuing development, delivery and performance of all public health programmes and mandated services.

a. **Sexual Health Services**

The public health sexual health lead will ensure resilience of the sexual health work programme through transition.

A Bury specific and a GM wide multi-agency/multi-disciplinary sexual health network has been in place for a number of years. Both the local and GM Network have robust commissioning and delivery plans in place and the vast majority of sexual health services are already collaboratively or jointly commissioned across GM.

The split of the future commissioning responsibilities is now known. However, the detail of how sexual health commissioning between the various organisations will work in future and concerns about fragmentation will need to be addressed. The Greater Manchester Directors of Public Health (GM DsPH), supported by the Greater Manchester Sexual Health Network, lead on sexual health commissioning will provide the necessary leadership and be accountable for ensuring a safe transition of responsibilities.

Standard service specifications for young people's sexual health services, and for all age outpatient sexual health services, are being prepared for use across Greater Manchester (GM). As most HIV provision is integrated into mainstream genito-urinary medicine services, the specification for HIV services is being included within these service specifications. This will give the NCB, who will have the lead role for this a useful steer on the commissioning requirements for these services. There is in addition some sharing of the specification for termination services across GM, which will also be shared with CCGs. CCGs will take on this lead role. It is recognised that detailed discussions will be required regarding the safe transfer of responsibility for both HIV and abortion services with these emerging organisations.

Each LA/Primary Care Trust has its own Sexual Health Strategy, outlining the specific issues and priorities for the area. These have action plans attached and will be progressed locally using the existing resources that will transfer across to LAs under the public health ring-fenced budget in 2013.

The Greater Manchester Sexual Health Network has demonstrated itself to be an efficient and effective mechanism for improving sexual health services across GM, and has achieved many notable successes over the past decade. It is the intention of the GM DsPH that the Network should continue, but the exact organisational home for this team has not yet been identified. However, the current host organisation, NHS Manchester, has ensured that the network (staffing, finance and estates) is part of the local transition plan for Public Health Manchester so that the functions of the network can continue to be delivered in 2012/13. The work plan for the network in this transitional year includes the commissioning framework and suite of specifications referred to above. The network will also, in conjunction with the Lead DPH, Consultant in Public Health (NHS Manchester) and locality commissioning leads, conduct an option appraisal and develop clear proposals for future commissioning arrangements. These proposals will be flexible and able to adapt to further clarity on the national context.

b. **Health Protection**

The GM Health Protection Unit has been established over 10 years and works well with health and LA colleagues in all GM localities. To improve resilience and capacity of local health protection functions across Greater Manchester, GM Directors of Public Health have been working with partners to scope the potential for the formation of a pooled budget and flexible workforce for a health protection service across GM. This will recognize the importance of local delivery and relationships, minimize risks and ensure resilience through the transition period and beyond. It will include immunisation and vaccination and infection control with a cross thematic approach of bringing a range of health protection resources together with shared goals and accountability, but retaining a strong local presence.

There are existing plans in place within each health economy that reflect multi-agency working to protect the population in respect of major emergencies and outbreaks of disease, up to and including pandemics. The transition will not detrimentally affect those plans given the close working relationships in existence between NHS and LA colleagues. All plans are under review to ensure they remain reflective of new guidance and structures.

**Supporting document : 10.1b Major Incident Plan refers**

In addition, a GM model for a shared health protection service is in development, fully supported by the LA and NHS resilience. This further strengthens planning, capacity and capability to respond in particular, for infection prevention and control, immunisation and vaccination and outbreak. This is further supported by the continuing development of robust arrangements for STAC within GM. A training package is being produced by the GM HPU and GM NHS Resilience Team that will ensure PH colleagues are fully supported in their roles.

In preparation for post 2013 and structures proposed for EPRR, the Lead DPH and Associate Director Resilience are reviewing the arrangements for the proposed local Health Resilience Partnership Group to work through the detail, in particular what this looks like for GM in relation to membership and terms of reference, building on the robust structures already established. Once this is clarified further discussion will take place with the GMRF Chair to ensure this is aligned to multi-agency structures and processes.

In relation to EPRR the GM NHS Resilience Team will have sole accountability for performance monitoring of the NHS, they also have clear lines of sight to NHS North and the office in Manchester. In addition there are plans to co-locate some resilience functionality with AGMA Civil Contingencies Resilience Unit (CCRU). Taken as a whole the new resilience structures will be more effective and aligned across organisational boundaries.

GM NHS Resilience Team is accountable to the CEO of NHS GM and operates to a pre-identified Offer of Service which includes DsPH, As part of this the team will deliver regular reports to the NHS GM Executive Team and an annual report which will contain performance management reports on the NHS across GM.

The GM NHS already operates as a shared service for resilience, maximising resource and effectiveness; this is replicated in AGMA by their CCRU. The GM NHS Resilience Team and the AGMA CCRU already work closely together and share a common vision for co-location and working practices that will minimise the potential conflict and confusion created by the relocation of public health into LAs. In addition the GM HPU has a central role within GM Resilience Planning and as such there is extremely good working practice historically between these three partners who will ensure DsPH continue to receive the support and assurance required. The development of the GM Shared Service for Health Protection, fully supported by the LA and the NHS provides further assurance of joined up partnership working to ensure a robust service through transition.

A Lead DPH for resilience has been discussed and it is likely that one will be confirmed in the near future, in the interim senior Public Health colleagues are closely involved in the EPRR work stream and are able to comment on specific issues routinely. In addition the Associate Director Resilience attends DsPH meetings when requested and provides updates on GM perspectives and particular work-streams.

The resilience aspects of incident reporting are already covered by the existing structures of a GM Strategic Commander on-call 24/7 supported by a 24/7 Tactical Support Officer with resilience expertise. The transition period will not affect the effectiveness of those arrangements. In addition further work is underway to strengthen the on-call structures across the conurbation with a review of the current PCT Director on-call processes to make these more robust as staff are lost. This is expected to be completed by the 16th April 2012.

In addition to the on call arrangements outlined above, development of a dedicated GM PH on call system will support the GM arrangements and strengthen the response arrangements.

c. **Public health support to health service commissioning**

Work to develop the core offer for public health advice to the CCG is in progress. A working draft has been developed based on the content of the national MoU core offer.

At a GM level, work is underway to build on existing collaborative arrangements to make the best use of relatively scarce specialist expertise. Particular focus is being given to; generation of new EUR policies, needs assessment, health impact assessment, talking to GM wide service reconfiguration issues – safe and sustainable, prioritization and development of standard assessment methodologies, evaluation of innovation, pulling together the outcome of clinical audits – recognition that clinical audit is one of our most under-recognised tools.

The GM Public Health Practice Unit is well positioned to support commissioning particularly on issues of evaluation and review of innovation and a development plan for this unit is underway.

In terms of the NCB, development of a GM wide approach to facilitate the effective provision of public health advice relating to screening, offender/prison health, health visitors, 0-5's child health, veteran health, immunization and vaccination and HIV is planned.

d. **National Childhood Measurement System**

The public health lead for the NCMP will maintain this leadership role throughout transition.

The surveillance programme is well established and has seen rising coverage rates for the last 5 years. The programme is commissioned through Pennine Care and delivered through the school nurses as part of a block contract. To date the coverage rates for Year 6 age children are 98.2% (10/11) compared to 94.3% (09/10) and Reception age 98.8% (10/11) compared to 86.8% (09/10). As a result of this increase in coverage it provides an opportunity to work with schools and target areas who are at risk of developing or increasing rates of overweight and obesity.

e. **NHS Health Checks**

The public health lead for developing the NHS Health Checks will facilitate the continuing development of the programme through transition.

Progress in implementing the NHS Health Checks programme in Bury has been slow. The programme is commissioned by NHS Bury from GP practices through a locally enhanced service agreement. As at March 2011, eight GP practices have been providing NHS health checks, with a further three agreed / expressed interest in providing the service.

Financial recovery prioritization by the PCT has meant that to date, limited financial resources have been committed to enable the implementation of the NHS Health Checks

programme, with only £48K allocated for 2011/12. It is estimated that full implementation will cost £234K per year for provision of the NHS Health Check (the element for with the LA will be mandated), with a further £950K in intervention costs for 2012/13.

A business plan to assure the continuing development of the programme is in development for consideration by the LA and CCG.

## 11 Screening Programmes

11.1 The public health screening lead will ensure resilience of screening programmes throughout transition.

11.2 Public Health Bury completed a local screening self-assessment in October 2011, as part of the GM cluster exercise. Details of local governance arrangements, commissioning and finance arrangements, capacity and cross cover plans and integration with the CCG were collected and submitted for all local cancer and non-cancer screening programmes, in order to inform GM planning and risk assurance.

**Supporting document : 11.2a : GM Screening Risk Register refers**
**Supporting document : 11.2b : GM Screening Commissioning Paper**

11.3 Locally, robust arrangements are in place for performance monitoring and quality assurance. These are reflected in contracts that require appropriate governance arrangements to be in place and adherence to agreed protocols (e.g. reporting of SUI).

11.4 At present, GM oversight is undertaken by the GM Screening Programme Team who will also deliver the GM transition work programme for screening. The GM Cluster executive team are aware a named lead with responsibility for commissioning and performance management of screening programmes is required and this is currently under consideration.

11.5 Work is already underway across the Cluster mapping contracts for all services. However it is unlikely that this will provide the level of detail required for screening as some programmes may be commissioned as part of larger contracts e.g. antenatal screening. In preparation for further in depth mapping (guidance awaited from DH) likely to be required, the following are in place:

- NW transition screening group agreement in principle to fund project management support to map screening contracts has been obtained
- PID in development
- Cluster support for this work via Julie Higgins and Mel Sirotkin

- Agreement in principle that at GM level we will be able to identify some contract elements, e.g., call & recall; laboratory; but that some items may not be possible/appropriate to unpick at GM level e.g., maternity tariff.

11.6 GM commissioning and public health advice to commissioning are unchanged for the transition year 2012/13. Individual PCT, sector and GM Lead PCT collaborative arrangements for screening remain in place.

11.7 A GM screening risk register has been created and will be monitored and maintained by the GM screening programme team. Escalation will be via the Lead GM Screening Transition DPH to Cluster Board if required.

11.8 Arrangements for the management of screening incidents are unchanged for the transition year 2012/13. Serious incident management with PCT DPH leadership as per national guidance remains in place.

## 12 Immunisation Programmes

12.1 Vaccination and immunisation performance has suffered from a lack of sustained investment in Bury. This has resulted in the availability of limited capacity to drive forward and oversee the implementation and performance of immunisation programmes. Funding is being sought to assure resilience in this priority public health programme area throughout transition and to secure buy-in to emergent pooled budget arrangements for a GM shared service model, in the same way Bury has done for infection control.

12.2 During 2011/12 the GM DsPH, under the auspices of the NHS GM Cluster, agreed to the development of an interim GM wide health protection service covering immunisations and vaccinations and infection control. This work has been taken forward in partnership with and supported by GM HPU. The interim service has already achieved stronger joint working of health protection staff, improved resilience through cross cover arrangements and a GM wide update of prescribing group directions as well as sector led reform for infection control.

12.3 Alongside this approach GM DsPH have been developing a future transformational shared operating model for this service with separate but aligned work streams for immunisations and infection control. Proposals for a future GM shared service have been scoped to assess the potential for the formation of a pooled budget and flexible workforce for a health protection function across Greater Manchester. This will recognise the importance of local delivery and relationships, minimise risks and ensure resilience through the transition period and beyond. The plans cover the full range of Health protection functions and links into GM population wide strategies for example TB, Hep C, and TB.

12.4 The shared service proposals are flexible enough to respond to future policy announcements and have included consideration of a range of receiver organisations for the proposed service. The work has included tracking health protection funding which is split between the 50% of funding for existing PCT “surveillance and control of infectious disease” functions transfers to

local authorities and 50% to PHE. All staff working in these areas have been identified through the work force tracker. A range of possible delivery options have been evaluated and a paper describing the preferred option for delivery across GM will be presented to DsPH on 30/3/12. The option will be flexible enough to change and will be confirmed when national policy decisions are announced.

12.5 Immunisation and vaccination are included in the shared service plans to ensure resilience, however the work stream is clearly defined and staff are clearly identified through the tracker. Plans recognise that the funding for immunisation and vaccination will transfer to the NCB. Following policy announcement the final delivery plans will be confirmed.

12.6 The established links with GMHPU continue to be a key component of all plans and the Unit Director is fully engaged. Current incident reporting arrangements continue to be in place for the reporting of SUI's and incidents.

12.7 Joint working with GMHPU and GM NHS Resilience has commenced with a table top exercise to test resilience in relation to health protection incidents planned for 24/4/2012. The generic outbreak plan will be reviewed following this exercise and any amendments finalised by 29/5/12. GM DsPH have initial STAC training planned for April 2012.

12.8 Health protection on call is a long standing arrangement provided by GMHPU, this service is manned by a team of experienced first on call staff many have come from an infection control background many currently working in PCT health protection teams whilst on call they are supported by the Consultant in Health Protection on call.

## 13 Drug and alcohol services

13.1 The Director of Public Health will continue to provide public health leadership and advice on the commissioning of local drug and alcohol services through transition.

13.2 Drugs and alcohol commissioning is currently undertaken through the local DAAT. The DAAT has been in place for many years and currently reports to the Community Safety Partnership (CSP). The commissioning of drug and alcohol services will continue to be led by the Director of Public Health. The Director of Public Health is a member of the DAAT Commissioning Group and sits on the CSP.

## 14 Infection, prevention & control

14.1 The Director of PH will continue to have strategic oversight of the shared service model (section 13) arrangements both locally and through GM DPH Group, in transition.

14.2 Bury currently commissions the provision of infection prevention and control services from Salford NHS as part of a shared service model arrangement. This emergent model is subject to further development as described in paragraph 12.3.

## 15. Health Intelligence

15.1 The DPH will continue to provide strategic leadership and oversight of public health information and intelligence.

15.2The continued resilience of the public health information and intelligence system throughout the transition period and beyond is being overseen at the GM level through a specific workstream that is managed by the GM PH network with a designated lead DPH.

15.3There is widespread agreement among DsPH in GM of the need to take a more joined-up approach to the development of an effective and resilient public health intelligence system across GM, which consists of a strong public health intelligence presence within LAs, backed up by more formalized mechanisms for joint working across the conurbation. Discussions are taking place to determine which public health intelligence functions are best delivered at a local level and which might be delivered at a GM level, either directly through the public health intelligence network or in partnership with other agencies, such as the Greater Manchester Commissioning Support Service or PHE.

15.4The public health intelligence work forms part of the wider Greater Manchester Transition Plan that allows public health intelligence to be considered alongside other parts of the public health system across GM.

15.5As part of the new public health system for Bury, it has been agreed that the public health intelligence function will align with the LA corporate intelligence team. Discussions are progressing on a range of specific issues to be addressed locally through the transition plan; collectively at cluster level and those areas to be addressed nationally by PHE.

## 16 Governance & accountability

16.1 Significant progress has been made during 2011/12 with regard to the transition process across all ten Greater Manchester Public Health Functions. Each PCT area has been encouraged to build on existing strong relationships with their Local Authority colleagues to develop change programmes which reflect current stages of development and fit local circumstances.

16.2 As we move towards the formal transfer of accountabilities from April 2013, NHS GM will work with GM LAs to ensure that all localities are progressing to meet national milestones and that appropriate assurance mechanisms are in place to ensure performance is maintained during 2012/13. These will be based on the key themes below:

- accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate – Memorandums of understanding are already in place in a number of locality areas, with other forms of agreement in place elsewhere. An audit process is taking place during March 2012 to support the robustness of these arrangements as we move into 2012/13. Strategic performance monitoring takes place at the NHS GM Board with associated remedial and recovery plans being mandated as part of this process. Operational performance continues to be monitored and managed at locality level and escalated to GM as necessary.
- clinical governance arrangements during transition including for example arrangements for the reporting of SUIs/incident reporting and Patient Group Directions – The reporting of Serious Untoward Incidents and Patient Group Directions will be the subject of locally based management and monitoring but will be reported at a GM level via the Direct Commissioning Board
- risk sharing based approach to transition – Each locality has established transition management processes with their LA. The outcomes and risk issues from these processes will be managed at a GM level via the Greater Manchester Public Health Transition group as described above. The risk related to the management of the transition forms part of the NHS Greater Manchester Board Assurance Framework and is reported to the Board, (at both GM and Locality level), at each meeting.

16.3 The NHS Greater Manchester Board resolved at its November 2011 meeting that, during the transitional year of 2012/13, the statutory responsibility for the public health function would be managed at a Greater Manchester level. This is designed to ensure that the necessary accountabilities and assurances remain in place, whilst providing the appropriate headroom for LAs to progress the operational transition and prepare for formal transfer of responsibilites from April 2013.

16.4 In terms of specific arrangements and reporting lines, the following will be in place from 1 April:

- A Direct Commissioning Board, established as a committee of the NHS Greater Manchester Board, taking lead responsibility for the functions which will ultimately form part of the National Commissioning Board, together with the management of the public health transition process.
- A Greater Manchester Public Health Transition Group. This group will be a joint NHS/ Local Government Group and will be chaired by the AGMA Chief Executive Lead for Health. It will report to the Direct Commissioning Board. Its terms of reference will include workforce, finance, IM&T, legal and risk, workstreams/ themes.
- Public Health Performance reports will continue to be presented to each meeting of the NHS Greater Manchester Board.
- The Greater Manchester Directors of Public Health will continue to meet, ensuring focus on managing delivery across GM during the transition

## 17 Transition work programme

17.1 Each task & finish group has developed a detailed action plan, including risk and mitigation plans, to meet the requirements of the transition process. These plans define the range of actions and timescales for completion, and identify designated leads responsible for mobilizing action and delivery, and reporting progress to the PHTB.

17.2 Task and finish group action plans:

**Supporting document : 17.2 : Task & Finish Group Action Plan refers**