WORKING DRAFT FOR DISCUSSION

Guidance to Support the Provision of Healthcare Public Health Advice to Clinical Commissioning Groups

Introduction

1. Good population health outcomes, including reducing health inequalities, rely not just on health protection and health improvement, but on the quality and accessibility of healthcare services provided by the NHS. That is why the Department of Health intends to reserve a key role for local public health teams in providing public health expertise for the NHS commissioners of healthcare services, using a regulation-making power in the Health and Social Care Bill. Subject to Parliament, local authorities will from April 2013 have a duty to provide a core service of specialist public health expertise and advice to NHS commissioners.

2. This guidance is intended to support local public health teams and clinical commissioning groups (CCGs) in operationalising the new function. It has no legal force, but is intended as good practice to aid planning for delivery of this function.

3. The guidance explains how we developed the proposed content of core public health advice from local authorities to CCGs. It sets out an estimate of the capacity which will be needed to deliver it at the local level, and some suggested criteria CCGs could use to assess the quality of the service provided. The elements of the proposed service are set out at Annex 1. We also include some Frequently Asked Questions (FAQs) and examples of memorandums of understanding currently used in different parts of the country to set out expected public health input into NHS commissioning.

4. This guidance is a working document, which will inform guidance to accompany regulations on mandatory functions which will come into force in April 2013. We would be grateful for feedback, comments and questions. Please contact:

Anya Tahir
020 7972 4772
anya.tahir@dh.gsi.gov.uk

How we developed the proposed content of the core Healthcare Public Health Advice Service

5. In order to develop recommendations on the content of the healthcare public health advice service (sometimes referred to as the “core offer”) that local authorities would need to provide, the Department of Health established a working group to advise us, building on existing work across the country. That group was co-chaired by Paul Johnstone, Cluster Director of Public Health of NHS North of England, and Paul Jennings, who is currently working for the NHS Commissioning Board

Authority. The membership included representatives from the Association of Directors of Public Health, the Faculty of Public Health, British Medical Association, Royal College of General Practitioners, GPs from emerging clinical commissioning groups (CCGs), the Local Government Group and the Association of Directors of Adult Social Services.

6. The group decided to develop the content of the service by linking specialist public health advice to elements of the commissioning cycle, from assessing needs for health services through to planning capacity and managing demand. In discussing the content of the core service the group were careful to focus on what genuinely required specialist public health expertise, rather than what public health trained individuals might happen to do in a given area.

7. The scope of the specialist core service as outlined is limited specifically to healthcare public health support from Local Authorities to CCGs. Other aspects of ongoing joint working between GPs and local public health teams – including screening, immunisations, healthcare acquired infections, GP practices as providers of preventive services, local authority commissioning of public health services, and joint strategic leadership through the Health and Wellbeing Board – are not covered here.

8. The group's recommendations for the content of the core healthcare public health advice service, based on examples of good practice from around the country, and aligned against the stages of the commissioning cycle, are attached at Appendix 1.

9. Local authorities will be free to deliver this obligation in a variety of ways, for example in relatively small authorities it may make sense to locate a team in a single authority, which will deliver the service on behalf of several local authorities. Public Health England will also play an important role in supporting the work of local information and intelligence specialists in the public health team.

10. There is nothing to stop local authorities from agreeing locally to offer a wider range of services over and above the free core service. This would need to be agreed locally.

Public health capacity to deliver the Service

11. Annex 1 seeks to set out what, subject to Parliament, local authorities will need to provide in delivering this function. Local authorities will need to ensure that they have the appropriate resources in place to deliver this function to the appropriate quality standards. This resource will include not just Directors of Public Health/public health consultants (accredited specialists), but also wider intelligence and analytical resources. How this will be delivered in future is very much a local issue.

12. The Association of Directors of Public Health surveyed Directors of Public Health to establish how much of their and their accredited public health specialists' time was currently spent undertaking the tasks set out at Annex 1. The estimate was somewhere between 25% and 50%. Based on the outputs of that survey, for planning purposes we would suggest that something in the region of 40% of the local public health specialist team might be engaged in this work, with a rough coverage of 1 wte specialist per 270,000 or so people. It is important to remember that this will vary from place to place, and input will vary across the year and there will need to be local agreement of the inputs and outputs through local planning arrangements, reflecting for example, the number of CCGs. This is one of the many aspects of technical public health delivery where the cost saving benefits across the system can far exceed the professional input.

13. The scope of the core offer has been developed by considering existing NHS provision and best practice. Nationally we do not expect the overall cost of public health advice to cost more than that currently provided within the NHS, so the transfer of resources to local government will cover the associated new burden.

Criteria for the provision of a high quality specialist Healthcare Public Health Service to NHS commissioners

14. It is important that there are clear expectations of the quality of the healthcare public health advice service, to ensure that it meets the needs of CCGs.

15. The quality of the service can be measured by using a combination of both process and outcome measures. To be a valid measure of quality a process must be strongly linked to an outcome that is important for both clinical commissioners and the local authority. It is also important to recognise the importance of service quality variables such as reliability and reputation.

16. The core criteria for a high quality service as recommended by the task and finish group are:

- Inputs are led by appropriately trained and accredited public health specialists, as defined by the Faculty of Public Health

- Inputs are sensitive to the needs of, and individual priorities of, CCGs

- Inputs result in clear, understandable and actionable recommendations to assist clinical commissioners, sources appropriately referenced where applicable, and based on public health analysis/skills.

- Requests for input receive a timely response

- The inputs are closely linked to the outcomes in National Outcome Frameworks, and the priorities of the JSNA and Joint Health and Wellbeing Strategies, and analysis of effectiveness of the service demonstrates the contribution of the advice to the achievement of those outcomes.

17. We recommend the development of a local service agreement agreed with CCGs via a compact or Memorandum of Understanding between the local authority and CCG, specifying public health inputs and outputs, and outlining the reciprocal expectations placed upon the CCG. This agreement might not just focus on the core Healthcare Public Health Advice Service, but include other aspects of public health links with CCGs e.g. health protection planning. The 'shadow' period from April 2012 to March 2013 will be useful developing appropriate agreements. Annex 2 provides examples of currently agreed Memorandums of Understanding for information.

18. These agreements can be underpinned by an annual work plan for the core healthcare public health service agreed by both the CCG and the Director of Public Health specifying the particular deliverables for the twelve month period.

19. Further accountability could be provided through an annual report drawn up by the Director of Public Health and the CCG setting out how the service had been provided that year. This might cover the process for engaging with public health expertise, names and teams, how the time had been spent, how statistically robust any data had been, lessons to be learnt for next year. It is envisaged that this report would be presented to the relevant Health and Wellbeing Board.

20. CCGs will be under a duty to obtain advice from a broad range of professionals, including those with expertise in the protection or improvement of public health, and so will want to make full use of the expertise in local public health teams as well as in clinical networks and senates.

21. Where there are concerns about the quality of the advice received we would expect this to be raised at the local level initially with the local authority.

Further Work

22. Further work is in hand to analyse what role local public health advice may play in supporting the NHS Commissioning Board in its responsibilities, for example with respect to the commissioning of primary care services.

PUBLIC HEALTH DEVELOPMENT UNIT
FEBRUARY 2011

Annex 1

[SUBJECT TO PARLIAMENT]

The Core Specialist Healthcare Public Health Advice Service to Clinical Commissioning Groups

Stages in the Commissioning Cycle	**Core Specialist Healthcare Public Health Service**	**Examples of Outputs**
Strategic planning - Assessing Needs	Using and interpreting data to assess the population's health, this may include	
	– Supporting CCGs to make inputs to the Joint Strategic Needs Assessment and to use it in their commissioning plans.	JSNA and joint health and wellbeing strategy with clear links to CCG commissioning plans
	- Development and interpretation of neighbourhood/locality/practice health profiles, in collaboration with CCGs and local authorities	Neighbourhood/locality /practice health profiles, with commissioning recommendations
	- Providing specialist public health input to the development, analysis and interpretation of health related data sets including the determinants of health, monitoring of patterns of disease and mortality	Clinical commissioners supported to use health related datasets to inform commissioning
	- Health needs assessments (HNA) for particular conditions/disease groups – including use of epidemiological skills to assess the range of interventions from primary/secondary prevention through to specialised clinical procedures.	HNA for condition/disease group with intervention / commissioning recommendations
- Reviewing Service Provision	- Identifying vulnerable populations, marginalised groups and local health inequalities and advising on commissioning to meet their health needs. Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups, including the protected population characteristics covered	Vulnerable and target populations clearly identified; PH recommendations on commissioning to meet health needs and address inequalities.

Stages in the Commissioning Cycle	**Core Specialist Healthcare Public Health Service**	**Examples of Outputs**
	by the Equality Duty	
	-- Support to CCGs on interpreting and understanding data on clinical variation in both primary and secondary care. Includes PH support to discussions with primary and secondary care clinicians if requested - PH support and advice to CCGs on appropriate service review methodology	PH recommendations on reducing inappropriate variation PH advice as appropriate
- Deciding Priorities	- Applying health economics and a population perspective, including programme budgeting, to provide a legitimate context and technical evidence-base for the setting of priorities - Advising CCGs on prioritisation processes - governance and best practice. - Work with CCGs to identify areas for disinvestment and enable the relative value of competing demands to be assessed - Critically appraising the evidence to support development of clinical prioritisation policies for both populations and individuals - Horizon scanning: identifying likely impact of new NICE guidance, new drugs/technologies in development and other innovations within the local health economy and assist with prioritisation	Review of programme budget data Review of local spend / outcome profile Agreed CCG prioritisation process Clear outputs from CCG prioritisation Clinical prioritisation policies based on appraised evidence for both populations and individuals. PH advice to clinical commissioners on likely impacts of new technologies and innovations
Procuring Services - Designing	Taking into account the particular characteristics of a specified population: - Providing PH specialist advice	

Stages in the Commissioning Cycle	**Core Specialist Healthcare Public Health Service**	**Examples of Outputs**
shape and structure of supply	on the effectiveness of interventions, including clinical and cost-effectiveness (for both commissioning and de-commissioning)	PH Advice on focussing commissioning on effective/cost effective services
	- Providing PH specialist advice on appropriate service review methodology	
	- Providing PH specialist advice on medicines management	PH advice to medicines management eg ensuring appropriate prescribing policies
Planning capacity and managing demand	- Providing specialist input to the development of evidence-based care pathways, service specifications and quality indicators to improve patient outcomes	PH advice on development of care pathways/ specifications/ quality indicators
	- PH advice on modelling of the contribution that interventions make to defined outcomes for locally designed and populated care pathways and current and future health needs	PH advice on relevant aspects of modelling/capacity planning.
Monitoring and Evaluation - Supporting patient choice - Managing performance - Seeking public and patient views	- PH advice on the design of monitoring and evaluation frameworks, and establishing and evaluating indicators and benchmarks to map service performance	Clear monitoring and evaluation framework for new intervention/ service PH recommendations to improve quality, outcomes and best use of resources
	- Working with clinicians and drawing on comparative clinical information to understand the relationship between patient needs, clinical performance and wider quality and financial outcomes	
	- Providing the necessary skills and knowledge, and	Health equity audits. PH advice on Health Impact

Stages in the Commissioning Cycle	Core Specialist Healthcare Public Health Service	Examples of Outputs
	population relevant health service intelligence to carry out Health Equity Audits and to advise on Health Impact Assessment and meeting the public sector equality duty	Assessments and meeting the public sector equality duty.
	- Interpreting service data outputs, including clinical outputs	PH advice on use of service data outputs.

Annex 2

Examples of existing Memorandums of Understanding

Nottingham City
Reproduced with kind permission from Dr Peter Cansfield, Deputy Director of Public Health, NHS Nottingham City

Public Health Directorate – Clinical Commissioning Group

Memorandum of Understanding

Author[1]	Dr Chris Packham, Executive Director of Public Health and Ms Alison Challenger, Consultant in Public Health.
Date	August 2011
Introduction	1. The purpose of this Memorandum of Understanding is to establish a framework for relationships between NHS Nottingham City's Public Health Directorate and Nottingham City Clinical Commissioning Group for 2011/12 and beyond subject to further national and regional guidance.
Context	2. Since 1974, within the NHS, specialist public health staff have assumed the lead for the three core public health responsibilities on behalf of the NHS and local communities: • Health improvement e.g. lifestyle factors and the wider determinants of health. • Health protection e.g. preventing the spread of communicable diseases, the response to major incidents, and screening • Population healthcare e.g. input to the commissioning of health services, evidence of effectiveness, care pathways. 3. With the implementation of the Health and Social Care Bill 2010, primary responsibility for health improvement and health protection will transfer at the national level from the NHS to Public Health England, and at local level from PCTs to Local Authorities. Responsibility for strategic planning and commissioning of NHS services will transfer

[1] With thanks to Worcestershire PCT and Dr Robert Wilson at Lincolnshire PCT who developed previous versions of this document

to the NHS Commissioning Board and to Clinical Commissioning Groups.

4. The ultimate fate of, and organisational 'home' for, public health professional staff, particularly medical staff, is not clear at present. Until the statutory role of the DPH in the NHS is lost from the NHS in April 2013, NHS employed public health staff will continue to provide a skilled multi-disciplinary public health workforce to the CCG and increasingly to appropriate Local Authority functions

5. Currently, at a senior level NHS Nottingham City employs a Director of Public Health (a joint appointment with the City Council) and 5.0 wte public health consultants, of whom 4 are medical appointments and one a nurse, plus a number of other staff of different grades and functions.

6. Some public health tasks are delivered most effectively and efficiently at a county-wide level e.g. screening or emergency planning, and as such will be delivered by teams that may work across existing boundaries.

7. Public Health support is aligned to specific commissioning priority areas as indicated in Appendix 1. This includes PH support to future joint commissioning arrangements with the LA

Health improvement

8. The Health and Social Care Bill will give the Nottingham City Council statutory duties to improve the health of the population from April 2013. CCGs will also be given duties to secure improvement in health and to reduce inequalities utilising the role of health services, which will require action along the entire care pathway from prevention to tertiary care. Therefore, Nottingham City Council and Nottingham City CCG have a collective interest, and are likely to have individual and collective responsibility for health improvement, both during the transition period and subsequently. For 2011/12:

NHS Nottingham City Public Health Directorate will:

- *Refresh its delivery and lead role in current strategies and action plans to improve health and reduce health inequalities, with input from the CCG.*
- *Maintain and refresh as necessary metrics to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of key NHS and LA strategies.*
- *Work with Nottingham City Council to further embed ownership and leadership of health improvement*

through the Decade of Better Health Programme..

- *Support primary care with health improvement tasks appropriate to its provider healthcare responsibilities - for example by offering training opportunities for staff, targeted behaviour health change programmes and services.*
- *Lead health improvement partnership working between the CCG, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention.*
- *Embed public health work programmes around improving lifestyles into frontline services towards improving outcomes and reducing demand on treatment services*

Nottingham City CCG will:

- *Contribute to strategies and action plans to improve health and reduce health inequalities.*
- *Ensure that constituent practices maximise their contribution to disease prevention – for example by taking every opportunity to address smoking, alcohol, and obesity in their patients and by optimising management of long term conditions.*
- *Ensure primary and secondary prevention is incorporated within commissioning practice*
- *Commission to reduce health inequalities and inequity of access to services*
- *Support and contribute to locally driven public health campaigns*

Health protection

9. The Health and Social Bill will be followed by regulations which are likely to give Nottingham City Council and the Director of Public Health a series of responsibilities in respect of health protection, on behalf of Public Health England. These are likely to include preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of environmental hazards, and NHS resilience.

10. The Bill gives CCGs a duty to ensure that they are properly prepared to deal with relevant emergencies. The Secretary of State retains emergency powers to direct any NHS body to extend or cease functions, and is likely to discharge these through Public Health England.

11. Therefore, to ensure robust health protection arrangements for 2011/12:

NHS Nottingham City Public Health Directorate will:

- *Lead on and ensure that local strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, major incidents.*
- *Ensure that these plans are adequately tested.*
- *Ensure that the CCG has access to these plans and an opportunity to be involved in any exercises.*
- *Ensure that any preparation required – for example training, access to resources - has been completed.*
- *Ensure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements.*
- *Ensure adequate advice is available to the clinical community via Public Health England and any other necessary route on health protection and infection control issues.*

Nottingham City CCG will:

- *Familiarise themselves with strategic plans for responding to emergencies.*
- *Participate in exercises when requested to do so.*
- *Ensure that provider contracts include appropriate business continuity arrangements.*
- *Ensure that constituent practices have business continuity plans in place to cover action in the event of the most likely emergencies.*
- *Assist with co-ordination of the response to emergencies, through local command and control arrangements.*
- *Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and through action by constituent practices.*

Population healthcare

12. The Health and Social Care Bill establishes CCGs as the main local commissioners of NHS services and gives them a duty to continuously improve the effectiveness, safety and quality of services. The Nottingham City Health and Well-being Board has been established as the primary mechanism of ensuring the responsibilities around health improvement and health and social care provision to identify the needs of the population and ensure that these are to be addressed through GP Commissioning Consortia, public health and social care commissioning plans and activities.

13. Public health specialist staff currently provide a range of support for specific NHS commissioning functions (Appendix 1); the requirement for this support will not

diminish, and DH guidance indicates that this support should be obtained from an appropriately skilled local public health specialist team. The functions required of CCGs include domains where significant public health science skills are required to perform competently (Appendix 2).

14. The expectations for 2011/12 should be that:

NHS Nottingham City Public Health Directorate will:

- *Provide specialist public health advice to the CCG including working up a more defined specification for comprehensive public health support.*
- *Assess the health needs of the local population, and how they can best be met using evidence-based interventions*
- *Ensure the reduction of health inequalities are prioritised in the commissioning of services, including utilising health equity audit*
- *Support the Clinical Commissioning Groups in developing evidence based care pathways, service specifications and quality indicators to improve patient outcomes*
- *Set out the contribution that interventions make to defined outcomes (modeling) and the relative return on investment across the portfolio of commissioned services*
- *Design monitoring and evaluation frameworks, collect and interpret results*
- *Providing a legitimate context for setting priorities using 'comparative effectiveness' approaches and public engagement and identify areas for disinvestments including using programme budgeting and marginal analysis (PBMA) in this process.*
- *Support clinical validation of data where necessary for commissioning purposes*
- *Support the CCGs in the achievement of the indicators in the NHS outcomes frameworks for Domain One – preventing people from dying prematurely*
- *Promote and facilitate joint working with local authority and wider partners to maximise health gain through integrated commissioning practice and service design*
- *Support the clinical effectiveness and quality functions of the CCGs including input into assessing the evidence e.g. NICE guidance*
- *Support the development of public health skills for*

CCG staff

- *Lead the development of, and professional support for, the Nottingham City Health and Wellbeing Board.*
- *Through the Joint Strategic Needs Assessment (JSNA), refresh the needs assessment of the population and ensure that this is relevant to the city. The production of the JSNA will be complemented by a programme of targeted needs assessments (eg health of prisoners, and the pharmaceutical needs assessment). CCGs will be co-participants n the production of the JSNA..*
- *Lead production of the Joint Health and Wellbeing Strategy and ensure that the CCG is fully involved in the production of this strategy*
- *Lead the co-ordination of appropriate health commissioning work between the NHS, PHE and LA at a local level.*
- *Work on care pathways, including review of the evidence of effectiveness, predictive modelling of effects, and supporting documentation to aid clinicians in decision-making..*
- *Provide specialist technical reports and support in relation to named patient funding requests.*

Nottingham City CCG will:

- *Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.*
- *Support a process for defining public health support to CCGs beyond 2013*
- *Utilise specialist public health skills to target services at greatest population need and towards a reduction of health inequalities*
- *Contribute intelligence and capacity to the production of the JSNA*

Public and patient involvement in planning and delivery of NHS services

15. The Health and Social Care Bill establishes HealthWatch as a new consumer champion for health and care services. HealthWatch will ensure that the public, patients and carers can effectively influence local NHS, public health and adult social care services, and help people make informed choices about their care. The Bill gives the CCG statutory duties to promote involvement of patients and carers in decisions about health services, and to enable patients to make choices about the services provided to them.

16. The CCG will therefore need to establish systems to promote public and patient involvement in planning and delivery of NHS services and to facilitate patient choice. This should be fully supported with input from HealthWatch and the Local Authority. The expectations for 2011/12 should be that:

NHS Nottingham City Public Health Directorate will:

- *Ensure that an operational model for HealthWatch is established, involving all relevant stakeholders*
- *Endeavour to ensure that HealthWatch arrangements integrate with CCG and individual practice arrangements for public and patient involvement*

Nottingham City CCG will:

- *Contribute a CCG perspective on the most appropriate operational model for Healthwatch.*

Specifying the quality of the public health team

17. NHS Nottingham City will ensure that an appropriately skilled public health workforce will be maintained and supported to allow delivery of the technical and leadership skills required of the function. This will include:

18. ensuring the current WTE resource is no diminished without agreement from the CCG

19. a majority of public health specialists remain from clinical backgrounds (Medical, Nursing and Allied Health Professionals) to mirror the requirements of the CCGs and social care commissioning, unless agreed with the CCG

20. all public health specialists will be appointed according to AAC rules including a rigorous assessment centre process for all candidates to run in parallel and inform that process

21. All public health specialists to be fully qualified with the FPH and be subject to all existing NHS clinical governance

rules, including those for continued professional development

22. The assumption in the document is that the current staffing skill mix is retained in the Local Authority and that the particular skill sets required to operate this MOU are not put at risk by staff loss or regarding / terms and conditions changes. Were that to happen, the MOU offer may not be deliverable and quality issues could not be assured as written.

Wider working arrangements

23. The specialist staff will, as necessary, contribute to the developing Commissioning Support arrangements and link geographically to support functions at different population levels which may be wider than a local CCG / LA base, including working with PHE and the NHS CB as required as part of the overall support function for the CCG and health community.

Appendix 1: Public health science functions to support NHS commissioning

Public health support for NHS commissioning
1. Public health information and analysis
• Use and interpretation of the data to assess the health needs of populations and how they can be best met using evidence based interventions • In collaboration with the Consortia and local authorities, oversee the production and development of the Joint Strategic Needs Assessment and in line with national guidance • Support commissioning practice towards the reduction of local health inequalities and the specific needs of vulnerable and marginalised groups • Analysis and utilisation modelling of service activity including health equity audit • Predictive modelling of activity against outcomes • Geo-demographic profiling to identify association between need and utilisation and outcomes for defined target population groups. • Identification of service and organisational outcome measures towards the improvement of the public's health and achievement of indicators within the NHS and public health outcomes frameworks
2.Clinical Commissioning and service planning
2.1 Clinical effectiveness • Critical appraisal of the research and application to support the CCG in developing evidence-based care pathways, service specifications and quality indicators to improve patient outcomes as required and in particular in the absence of NICE or other national guidance • Establishing and evaluating indicators and benchmarks to map service performance • Identify and assess population impact of implementing NICE guidance/guidelines • Support the CCG in the identification, assessment and implementation of national policy and best practice guidelines e.g. national service frameworks, national strategies • Design monitoring and evaluation frameworks, collect and interpret results • Predictive modelling of activity against outcomes for locally designed and populated care pathways. **2.1 Quality improvement** • Support the CCG work programme on the quality improvement and QIPP agenda • Provide public health input to the development of quality indicators • Support the development of public health awareness and competencies of the CCG • Facilitate and provide support towards the CCG strategy for health improvement and disease prevention

3.Prioritisation and resource allocation
• Apply health economics and a population perspective to provide a legitimate context and technical evidence-base for the setting of priorities • Identify the contribution that interventions make to defined outcomes and the relative return on investment across the portfolio of commissioned services • Identify areas for disinvestment and enable the relative value of competing demands to be assessed • Critically appraise the evidence and provide clinical support to appropriately respond to individual funding requests
3. Engagement - Public and Partners
• Through objective analysis, providing the impartiality necessary to communicate and defend difficult decisions to the public • Support the CCG to progress joint commissioning and provision plans with the local authorities and other statutory and non statutory organisations to maximise health gain through commissioning practice and service design
4. Objective independence
• Providing through the JSNA or other technical material, and in an independent role, to act as broker in relation to deciding on competing demands for funding as required. Protecting the ability of GPs to act, and to be seen to act, in the best interests of their individual patients.
5 **Research, innovation and teaching**
• To provide a professional source of expertise for research and evaluation of local health care as required and to contribute to innovation and development of locally sensitive solutions to help meet healthcare need. • To provide teaching and support for the use of public health science skills in the appropriate functional domains of CCG responsibility
6. Health Protection
• To provide local leadership and support for key NHS health protection functions: o Childhood vaccination o Adult vaccination including influenza immunisation programmes o Blood borne virus prevention and case identification (Hepatitis B, C and HIV) o Tuberculosis strategy and disease prevention • To provide support for the CCG in all dealings with local health protection issues handled by Public Health England including infectious and non-infectious hazards • To provide leadership and co-ordination for a health community approach to Emergency Planning and Response

Appendix 2: Clinical Commissioning Group functions

GPCC functions **[NHS (2011). The functions of CCGs (working document)**
1. General
• To exercise their functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience. • To co-operate with local authorities and participate in their Health & Wellbeing Boards. • To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available. • To have regard to the need to reduce inequalities in access to healthcare and healthcare.
2. Planning services
• Assessing people's healthcare needs and identifying likely trends in healthcare needs, building on the JSNA. • Identifying inequalities in access to healthcare services, quality and outcomes. • Working with the Directors of Public Health and their teams, to take account of public health advice in the development of commissioning plans. • Redesigning services and/or pathways to deliver improved outcomes and better meet patients' needs. • Determining the nature, volume and range of services that will need to be available locally to meet needs. • Identifying which services will be most effective and cost effective and planning both new investments and disinvestments, drawing on evidence and experience. • Consulting with the public, and working with local Healthwatch and local authorities. • Involving groups representative of patients and carers in the planning of services.
3. Agreeing services
• Developing service specifications and incorporating them into contracts • Making arrangements for managing individual funding requests, • Determining arrangements for making decisions on the funding of specific treatments including high-cost drugs and new interventions.
4. Monitoring services
• Working with clinicians and patients to review the effectiveness of services and improve patient pathways. • Using the Commissioning Outcomes Framework and other intelligence to benchmark • improvements in quality and outcomes.
5. Improving the quality of primary care
• Drawing on comparative practice level information to understand the relationship between patient needs, practice performance and wider

quality and financial outcomes.
6. Specific duties of co-operation
• Working with Directors of Public Health and their teams to identify opportunities to work better together to improve people's health and wellbeing.

Worcestershire
Reproduced with kind permission from Dr Richard Harling, Director of Public Health, NHS Worcestershire

South Worcestershire GP Commissioning Consortium

Public health – GP Commissioning Consortia Memorandum of understanding

Author	Dr Richard Harling, Director of Public Health
Date	04 July 2011
Introduction	24. The purpose of this document is to establish a framework for relationships between the Worcestershire public health directorate (PHD) and GP commissioning consortia (GPCC) for 2011/12 - with a view to developing arrangements suitable for the new system from April 2013 onwards.
Context	25. Public health has resided within the NHS since 1974, most recently within SHAs and PCTs. During this time the profession has assumed the lead for three major responsibilities on behalf of the NHS and local communities: • Health improvement. • Health protection. • Service improvement. 26. With the implementation of the Health and Social Care Bill, primary responsibility for health improvement and health protection will transfer at national level from the NHS to Public Health England (PHE), and at local level from PCTs to Local Authorities. Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to GPCC. The ultimate organisational 'home' for public health professional staff is not clear at present - and may ultimately vary across the country. 27. During transition, the Worcestershire PHD will continue to maintain a skilled multi-disciplinary workforce which collectively will lead and support delivery of the three areas

of public health responsibility, working across organisational boundaries.

Health improvement

28. The Bill gives Worcestershire County Council a statutory duty to improve the health of the population from April 2013. GPCC will be given duties to secure continuous improvement and reduce inequalities in the outcomes achieved by health services – which will require action along the entire care pathway from prevention to tertiary care. In addition the local NHS QIPP programme is predicated on successful implementation of preventive measures to reduce the burden of disease including from smoking, alcohol, obesity and falls.

29. The Council, PHD and GPCC therefore have a collective interest in health improvement, both during the transition period and subsequently. The expectation for 2011/12 should be that:

The PHD will:

- *Refresh the strategy and action plans for improving health and reducing health inequalities, and seek GPCC input into these.*
- *Develop and publish a set of metrics to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of the NHS QIPP programme.*
- *Work with the Council to embed ownership and leadership of health improvement.*
- *Support primary care to improve health - for example by offering training opportunities for staff, and through targeted health information campaigns.*
- *Facilitate partnership working between GPCC, local*

partners and residents to integrate and optimise local efforts for health improvement and disease prevention.

GPCC will:

- *Contribute to the strategy and action plans for improving health and reducing health inequalities.*
- *Encourage constituent practices to maximise their contribution to disease prevention – for example by taking every opportunity to address smoking, alcohol, obesity in their patients and by optimising management of long term conditions.*

Health protection

30. The Bill will be followed by regulations which are likely to give the Council and DPH a series of responsibilities in respect of health protection, on behalf of PHE. These are likely to include preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of environmental hazards, and NHS resilience. The Bill gives GPCC a duty to ensure that they are properly prepared to deal with relevant emergencies. The Secretary of State will retain emergency powers to direct any NHS body to extend or cease functions, and is likely to discharge these through PHE.

31. Again the Council, PHD and GPCC have a collective interest in ensuring that arrangements for health protection are robust. The expectations for 2011/12 should be that:

The PHD will:

- *Ensure that strategic plans are in place for responding to the full range of potential emergencies – e.g. pandemic flu, major incidents.*
- *Ensure that these plans are adequately tested.*
- *Ensure that GPCC have access to these plans and an opportunity to be involved in any exercises.*
- *Ensure that any preparation required – for example training, access to resources - has been completed.*
- *Ensure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements.*
- *Along with the HPA provide specialist advice to GPCC and constituent practices on health*

protection issues.

GPCC will:

- *Familiarise themselves with strategic plans for responding emergencies.*
- *Participate in exercises where relevant.*
- *Ensure that provider contracts include appropriate business continuity arrangements.*
- *Encourage constituent practices to develop business continuity plans to cover action in the event of the most likely emergencies.*
- *Assist with co-ordination of the response to emergencies, through local command and control arrangements.*
- *Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements and by encouraging action by constituent practices.*

Service improvement

32. The Bill establishes GPCC as the local commissioners of NHS services and gives them a duty to continuously improve the effectiveness, safety and quality of services. A Worcestershire Health and Well-being Board (HWB) will be established, in shadow form initially, to identify the needs of the population and ensure that these are to be addressed through GPCC, public health and social care commissioning plans and activities.

33. The role of public health in support of NHS commissioning is well-recognised - but is not specifically covered by the Bill. Public health provides a range of support for specific NHS commissioning functions currently (Appendix 1) and the requirement for these will not diminish. The BMA, RCGP, NHS Alliance and House of Commons Health Select Committee have all highlighted that public health support to GPCC will be crucial to their success. And the DH's initial outline of GPCC functions includes many which have historically been carried out by the PHD (Appendix 2).

34. Whilst it remains with the PCT, public health support for GPCC will be available from the PHD. Further consideration is required for how GPCC will access public health skills and expertise beyond this time. *Healthy Lives, Healthy People* indicates that some support will be available from DsPH within local authorities. Whether this will be at current levels or whether GPCC will have to secure additional support - either locally or from elsewhere - remains to be seen. The expectations for 2011/12 should be that:

The PHD will:

- *Provide specialist public health advice to GPCC and help them determine their requirements for additional public health support.*
- *Provide specialist public health advice to the Adults' and Children's Joint Commissioning Units and the DAAT.*
- *Make public health intelligence resources available in support of GPCC.*
- *Lead development of the shadow HWB.*
- *Through the Joint Strategic Needs Assessment, begin to specify the needs of the population and ensure that this is relevant at GPCC level.*
- *Lead production of the Joint Health and Wellbeing Strategy and ensure that GPCC have the opportunity to influence it.*
- *Based on emerging policy and guidance produce an options paper for how GPCC will access public health advice and support beyond April 2013 – including funding arrangements.*

GPCC will:

- *Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.*
- *Support a process for defining public health support to GPCC beyond 2013 – with a view to making a decision in 2012/13, including a commitment to any funding required.*

Public and patient involvement in planning and delivery of NHS services

35. The Bill gives GPCC statutory duties to involve patients, carers and the wider public in decisions about health services, and to enable patients to make choices about the services they receive. There are many good examples of effective patient and public involvement already in place, and these should continue to be nurtured and supported.

36. The Bill also establishes HealthWatch as a new consumer champion for health and care services. HealthWatch will seek to ensure that the public, patients and carers can effectively influence their local NHS, public health and adult social care services. HealthWatch should also help people make informed choices about their care. HealthWatch will be commissioned by the Council, through the PHD.

37. The Council, PHD and GPCC will therefore need to establish systems to promote public and patient involvement in planning and delivery of NHS services and to facilitate patient choice. The expectations for 2011/12 should be that:

The PHD will:

- *Establish a steering group to allow stakeholders including GPCC to contribute to developing an operational model for HealthWatch.*
- *Endeavour to ensure that HealthWatch arrangements integrate with GPCC and individual practice arrangements for public and patient involvement*

GPCC will:

- *Contribute a GPCC perspective on the most appropriate operational model for Healthwatch.*

Signatures

Dr Richard Harling, Director of Public Health
……

Dr Jonathan Wells, Lead R&B GPCC
……

Dr Carl Ellson, Lead SW GPCC
……

Dr Simon Gates, Lead WF GPCC
……..

Appendix 1: Public health support for NHS commissioning

Public health support for NHS commissioning
1. Public health analysis
• Using data to assess the health needs of populations, to model service activity, to establish outcome measures, and to appraise the research to decide how best to address needs through evidence-based interventions.
2. Clinical effectiveness
• Appraising and applying research to support consortia in developing evidence-based care pathways, service specifications and quality indicators. Establishing the indicators and benchmarks to evaluate performance.
5. Resource allocation
• Applying health economics and a population perspective to legitimise the setting of priorities, support disinvestment, and allow the relative value of competing demands to be judged.
6. Engagement - Public and Partners
• Through objective analysis, providing the impartiality necessary to communicate and defend difficult decisions to the public. • Facilitating, supporting and discharging consortia duties and obligations to work with partner agencies – both statutory and non-statutory.
7. Objective independence
• Acting as an honest broker in relation to deciding on competing demands for funding. Protecting the ability of GPs to act, and to be seen to act, in the best interests of their individual patients.

Appendix 2: GP Consortia Commissioning functions

GPCC functions **[NHS (2011). The functions of GP commissioning consortia: a working document]**
7. General
• To exercise their functions with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience. • To co-operate with local authorities and participate in their Health & Wellbeing Boards. • To involve patients and the public in developing, considering and making decisions on any proposals that would have a significant impact on service delivery or the range of health services available. • To have regard to the need to reduce inequalities in access to healthcare and healthcare.
8. Planning services
• Assessing people's healthcare needs and identifying likely trends in healthcare needs, building on the JSNA. • Identifying inequalities in access to healthcare services, quality and outcomes. • Working with the Directors of Public Health and their teams, to take account of public health advice in the development of commissioning plans. • Redesigning services and/or pathways to deliver improved outcomes and better meet patients' needs. • Determining the nature, volume and range of services that will need to be available locally to meet needs. • Identifying which services will be most effective and cost effective and planning both new investments and disinvestments, drawing on evidence and experience. • Consulting with the public, and working with local Healthwatch and local authorities. • Involving groups representative of patients and carers in the planning of services.
9. Agreeing services
• Developing service specifications and incorporating them into contracts • Making arrangements for managing individual funding requests, • Determining arrangements for making decisions on the funding of specific treatments including high-cost drugs and new interventions.
10. Monitoring services
• Working with clinicians and patients to review the effectiveness of services and improve patient pathways. • Using the Commissioning Outcomes Framework and other intelligence to

benchmark • improvements in quality and outcomes.
11. Improving the quality of primary care
• Drawing on comparative practice level information to understand the relationship between patient needs, practice performance and wider quality and financial outcomes.
12. Specific duties of co-operation
• Working with Directors of Public Health and their teams to identify opportunities to work better together to improve people's health and wellbeing.

Annex 3

Frequently Asked Questions

Q - Why does the Healthcare Public Health Service to NHS Commissioners not focus on the duties and obligations of CCGs and local authorities?

A - The regulations will set out what local authorities will be required to deliver. Each CCG will be under a duty to "obtain advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in –

(a) the prevention, diagnosis or treatment of illness, and

(b) the protection or improvement of public health. "

The healthcare public health advice service provided by the local authority is intended to support CCGs in carrying out this duty.

Q- How will we be able to understand the 'volume of work' to be delivered?

A – We have set out above in very rough terms what an appropriate level of resource might be. But one of the key elements of a high quality Healthcare Public Health Service to NHS Commissioners is a local mechanism for agreeing, through dialogue between the public health team and CCGs, what deliverables can be measured and a process for assessing achievement. This may include:

- A local service agreement agreed with the Clinical Commissioners via a compact or Memorandum of Understanding specifying public health inputs and outputs, and outlining the reciprocal expectations placed upon the CCG.
- An annual work plan for the Core Public Health Population Healthcare Service agreed by both the CCG and the DPH specifying the particular deliverables for the twelve month period.
- An annual report drawn up by the DPH and the CCG setting out how the service had been provided that year.

Q - What will be the relationship with the Commissioning Support Organisations?

A - There has been some concern expressed at the apparent crossover between the Healthcare Public Health Service and what has been defined as some of the work of commissioning support services; in the case of needs assessment for instance. It is important to note that although there are some similarities in the nature of these services they will have a different focus. We envisage that public health teams will provide largely a population focus, synthesizing data from a wide variety of sources and applying their public health skills to draw the implications of that data for the local population, and that population's need for and use of healthcare services. Commissioning support services will have focus more on commissioning processes and

clinical systems, including detailed analysis of referrals and activity, procurement and business processes. Both are essential for driving improvements in services.

However it is not for us to attempt to prescribe how this may work in the future. There is a very clear intention that commissioning support services will become free standing organisations and that CCGs will be free, within the usual rules of procurement, to purchase what they need in any combination and from any organisation they choose to enter into partnership with.

Q - Considerable concern has been expressed about the risk of losing existing good relationships within local systems.
A - Existing good relationships in local systems should be the foundation for building and developing better ones. We have been aware of a number of examples of agreements that have been articulated between at least two of the three parties; the existing public health service, currently in PCTs, the local authority and the emerging CCGs. With the permission of the authors a number of these agreements are included in Appendix 2

Q – Will Local Authorities provide appropriate levels of public health input and employ staff with appropriate experience or qualifications?
A - Regulations will prescribe that advice can only be given by appropriately qualified public health specialists and Public Health England will be jointly involved in the appointment of Directors of Public Health.

Q- How will disputes between the parties be managed?
Where there are concerns about the quality of the advice received we would expect this to be raised at the local level initially with the local authority.

Q – Why aren't Individual Funding Requests specifically identified within the core service?
A – Whilst not specifically identified, the critical appraisal of evidence to support the development of clinical prioritisation policies for both populations and individuals is a key component of the core Healthcare Public Health Service. This would cover Individual Funding Requests where public health advice is sought locally.

Q - How will this service operate where a local authority relates to a number of CCGs or where one CCG relates to more than one local authority?
A – The mandated core Healthcare Public Health Service will be available to each CCG within a local authority boundary and, through dialogue between the public health team and CCGs, it is envisaged that a compact or Memorandum of Understanding covering that service would be developed. It is however possible for a particular CCG to request additional services from the Local Authority; these may be at an additional cost.

Local authorities will also be free to meet this obligation in a variety of ways so for example where a CCG relates to more than one local authority, it may

make sense to locate a team providing the core Healthcare Public Health Service in a single authority, acting on behalf of several.

Q – Will we [CCGs] have to pay for the core service?
A - The financial resources to provide the 'core service' will be transferred to local authorities, within the ring-fenced budget. There would be nothing to stop local authorities from agreeing locally to offer a wider range of services; however, these additional services may not be free of charge.

Q – How will we know we are receiving a quality service?
A –The quality of the service can be measured by using a combination of both process and outcome measures, which have been developed as a set of criteria for a high quality Healthcare Public Health Service to NHS Commissioners. We would envisage that an annual report drawn up by the DPH and the CCG would set out how the service had been provided that year. This might cover the process for engaging with PH expertise, names and teams, how the time had been spent, how statistically robust any data had been, lessons to be learnt for next year. It is also envisaged that this report would be presented to the relevant Health and Wellbeing Board