REPORT FOR: CABINET

Date of Meeting:	14 February 2013
Subject:	Shared Public Health Team – Transfer Scheme for Assets, Liabilities and HR
Key Decision:	Yes
Responsible Officer:	Paul Najsarek, Corporate Director of Community, Health and Wellbeing
Portfolio Holder:	Councillor Margaret Davine, Deputy Leader and Portfolio Holder Adult Social Care, Health and Wellbeing
Exempt:	No
Decision subject to Call-in:	Yes
Enclosures:	Appendix A – Harrow Public Health Contracts Appendix B – Draft CCG Core Offer Memorandum of Understanding

Section 1 – Summary and Recommendations

This report sets out the current position in respect of the establishment of a shared public health team to support the London Boroughs of Harrow ('Harrow') and Barnet ('Barnet').

This report also informs the progress made on the draft MOU agreement for the CCG Core Offer.

Recommendations:

Cabinet is requested to:

1. Note the list of contracts that are to transfer to Harrow Council on 1st April 2013.
2. Note the progress on the MOU (Memorandum of Understanding) and the CCG (Clinical Commissioning Group Core Offer)
3. That Cabinet delegate the allocation of any unallocated contingency/additional grant arising from the Public Health grant to the portfolio holder for Adult Social Care, Health and Wellbeing, in consultation with the Finance portfolio holder and the Children, Schools and Families portfolio holder and advised by the Corporate Directors of Community, Health and Wellbeing, Children's Services and Resources
4. Authorise the Corporate Director of Community, Health and Wellbeing in consultation with the Portfolio Holder for Adult Social Care, Health and Wellbeing to:
    1. Agree the finalised transfer scheme for the contracts and liabilities and the transfer order for the public health staff.
    2. Sign off of the final CCG Memorandum of Understanding for the Core Offer.

Reason: (For recommendation)

The purpose of this report is to advise members that as of April 2013, public health responsibilities, together with a ring fenced grant will transfer from the Department of Health to local authorities. Local authorities will have a duty to promote the health of their population and will also take on key functions requiring robust plans to be in place to protect the local population and to provide public health advice to NHS commissioners.

This report details the areas of work that are taking place, in conjunction with NHS North West London and NHS North Central London, to complete the transfer of the public health function by April 2013.

The recommendations of this report focus on the transfer of contracts and staff for the public health services that will become the council's responsibility, and are based on current available NHS guidance and the legal and contracting arrangements required of the Council.

Section 2 – Report

1. Introductory paragraph

In June 2012 Harrow and Barnet Council's approved the outline business case and agreed in principle to the development of a shared public health service.

1.1. The decision to pursue a shared Public Health Service reflects Barnet and Harrow's common position that it is vitally important to establish a centre of Public Health expertise with a sufficient critical mass of Public Health specialists. A combined specialist team will create the necessary capacity and skill mix to effectively manage the Local Authorities' new statutory public health responsibilities and provide the necessary leadership to place public health at the heart of policy development, commissioning and service delivery. This will also enable us to focus resources on frontline services and minimise staffing expenditure.

1.2. To ensure safe and effective legal transfer of clinical contracts from the PCT to the local authority the Department of Health produced shift guidance, which set out the process of transferring liabilities, assets and contracts from the PCT to the new commissioning organisations.

1.3. The process of transfer of assets and liabilities, including contracts, will be through a Transfer Scheme which will incorporate a schedule – in which the PCT will identify relevant public health contracts to be transferred to Harrow. The PCT has provided a draft Transfer Scheme, including a list of contracts, to transfer to Harrow and other Authorities. Harrow is reviewing the draft Transfer Scheme with a view to reaching full agreement on the assets and liabilities, and the contracts that will transfer to Harrow on 1 April 2013.

1.4. The Transfer Scheme will transfer responsibility for the provision of the services provided under the relevant NHS contracts to Harrow.

1.5. All contracts and staff listed in the Transfer Scheme and Transfer Order will transfer to the new commissioner(s) on 1st April 2013.

1.6. DoH recently published further guidance on the closedown and handover process, which outlined the intention to transfer liabilities that correspond to a function or policy that is being moved. The guidance states that any outstanding obligations, disputes, claims by third parties under a contract or monies owed by the Harrow PCT public health function will be transferred to Harrow Council. This also includes liabilities arising in respect of obligations under expired contracts within 6 years of the date of breach.

1.7. Harrow has requested a list of expired contracts and detail on any historic debt outstanding or active claims from Harrow PCT to determine the level of risk to the Council.

1.8. Harrow is continuing to lobby DoH, Local Government Association and the NHS against transferring these liabilities to the Council.

1.9. There will be a similar transfer of responsibility from NHS Barnet to Barnet which Harrow will then manage under the Inter-Authority Agreement relating to the shared service.

2. Public Health Allocation Announcement

2.1. The ring fenced grant for public health, which was announced on the 10th January provides Harrow with £8,874,000 for 13/14 and £9,146,000 for 14/15. This provides a better allocation than the baseline figure that we had been working with of £7,862,000 for 13/14, however Harrow is still relatively low funded compared to other London Boroughs.

2.2. The average increases for London authorities was 4.7% and 4.3% each year compared to England averages of 5.5% and 5.0%. Harrow received an increase of 3.5% and 3.1% each year from the 2013/14 opening baseline of £8,576,000.

2.3. Funding per head in 2013/14 ranges from £29 (Bexley) to £132 (Westminster). Harrow in 2013/14 funding per head is £36 which is the third lowest in London. This is compared to the initial shadow allocations where we were the 5th lowest at £33 per head of population.

2.4. While the majority of spend will be commissioned and therefore controllable to a large extent, Members should note that genitourinary medicine (GUM) services will continue to be provided through the national arrangement, whereby anyone can access GUM services in any part of England and Wales. This presents a budgetary risk to the council.

2.5. Officers are currently working to assess the full implications of the recent allocations. It is not yet clear what additional commitments are being placed on public health and therefore the financial implications of these e.g. infection control.

2.6. There are also still some uncertainties on the contracts which will not be clarified until negotiations have been completed with providers in March.

2.7. Recent work undertaken by the public health team and the NHS North West London (NWL) with providers of public health services have calculated Harrow contract values for 2013/14 to be approximately £4.8m and staffing costs of £1.1m. The public health team are now finalising the proposed commissioning intentions.

3. The Transfer Scheme

3.1. The Transfer Scheme is made by the Secretary of State to deal with the transfer of staff, assets and liabilities from the NHS to Councils.

3.2. The purpose of the transfer scheme is to:

- Ensure that Senders and Receivers satisfy their statutory and other governance obligations;
- Ensure that no Sender asset or liability remains unaccounted for in the NHS Transition;
- Create an appropriate audit trail and record of how the NHS Transition was achieved;
- Provide certainty and clarity to all affected entities and people affected by the NHS Transition;
- Enable the legal documents necessary to implement the NHS Transition to be drafted;
- Implement the NHS Transition; and
- Assist with the close down of SHAs (Strategic Health Authority) and PCTs (Primary Care Trust)

3.3. There will be two separate transfers. One for staff and the other for liabilities/ assets and contracts. The Transfer Order relating to staff is still awaited.

3.4. Barnet Public Health contracts will be transferred directly to Barnet and Barnet will hold accountability for these contracts although they will be managed by Harrow under the terms of the shared service agreement. This report therefore does not look at the Barnet Public Health contracts.

3.5. The first Transfer Scheme submission from DH for contracts and assets was received on the 14th December. Harrow was given the opportunity to provide comments to NWL Cluster Board by the 8th January. This document was then 'locked down' and subject to change control from this point forward. It is not yet known at the time of writing this report what the change control process will be.

3.6. Transfer Scheme (Contracts/Assets/Liabilities) Timeframe

14/02/13	February Transfer Scheme return submitted to DH
15/02/13	February Transfer Scheme return circulated to Receivers to provide comments/updates for inclusion in FINAL March Transfer Scheme return
20/02/13	All inputs/comments for FINAL March Transfer Scheme return completed
14/03/13	FINAL March Transfer Scheme return submitted to DH
01/04/13	Transfer Schemes come onto effect and all liabilities are transferred to commissioning organisation

3.7. The final opportunity for Harrow to make any amendments to the transfer scheme will be between 15th February and the 20th February. The Final Transfer Scheme will then be submitted to DH by NWL Cluster by the 14th March to enable the legal transfer of assets and liabilities by 1st April 2013.

4. Transfer of Liabilities/Assets and Contracts to Harrow

4.1. The Transfer Scheme for Harrow includes all contracts, assets and data that will be transferred to Harrow on the 1st April 2013. Harrow is not expecting to receive any assets or estates as part of the transfer scheme. The total value of contracts listed for the public health service is £4,859,802. The contracts that are to be transferred are listed in Appendix A. In addition, there are a number of Local Enhanced Schemes [LES] contracts which are provided by GP's and Pharmacies which total approx £473k.

4.2. The contracts will be managed by the public health commissioning team and this team will report regularly to the DPH and relevant LA Director's on progress against KPI's, PH outcomes and on financial performance.

4.3. As part of the Public Health Contracts Transition process Harrow undertook a full review of all its current commissioned services. The purpose for this review was to ensure all Duplication of Non Value Added Exercises are removed from the current Health and Local Authority contracts, and maximum value for money is achieved – this work is ongoing.

4.4. Task and Finish groups have been set up to ensure that the most efficient Commissioned Services are provided across the Borough within the following areas:-

a) Alcohol and Substance Misuse
b) Healthwise and Exercise on Referral (Including Mental Health Trainers)
c) Sexual Health and School Nurses

4.5. During the month of February it is intended to engage with the incumbent supplier base and finalise the service and costs/charges

4.6. Contracts will then be signed by both parties during March with a clear plan to commence the recommissioned services from 1st April 2013

4.7. The aim of consolidating existing public health contracts with council contracts is to maximise all efficiencies over the total value of local authority contracts. There will be further work during 2013-14 to ensure efficiencies across contracts providing services to both Barnet and Harrow.

5. Proposed Approach for Harrow Public Health Contracts

5.1. As with most other boroughs Harrow is looking to take a pragmatic approach and not retender. Harrow's approach is to novate some contracts directly from the NHS to Harrow, to sign new contracts on Harrow terms and conditions of contract with providers where existing NHS contracts expire before 1 April 2013, and merging or combining some contracts where, for example, Harrow already has contracts in place with those providers and there are synergies and sound commercial and/or operational reasons to combine the transferred services with existing service provision.

5.2. In 2013/14 once the contracts have been novated we will undertake a more thorough review of the contracts and decommission or recommission as appropriate.

Genitourinary (GU) contracts

5.3. Due to the clinical nature of the services and the number of service providers accessed by Harrow residents, we are investigating keeping GU services within the Standard NHS contracts with the relevant acute providers and for the local authorities to be named as associate commissioners to the contracts. This means that contracts will be negotiated by the NWL Commissioning Support Unit (CSU). This position is shared by the NWL boroughs.

5.4. We are recommending seeking 'cap and collar' contracts with providers for GU in 13/14 to ensure that financial risk is managed and limited to the resources available. This means that there will be a maximum rate (cap) and a minimum rate (collar) applied. This will provide Harrow with the certainty of not paying more than the maximum rate. In addition, we are seeking better data reporting as many providers are not reporting activity on the GUM monthly access system and under current guidance and NHS commissioning rules, providers are not required to provide patient level data to commissioners due to the additional level of patient confidentiality attached to sexual health.

North West London Hospitals Trust (NWLHT)

This provides family planning services for Harrow including 'Clinic in a box'.

5.5. The contracting options available are:

- To keep the services within the standard NHS Contract with Harrow listed as an associate commissioner.
- To move the services onto a contract with Harrow Council. This could involve negotiating a new contract with NWLHT for these services or adding the family planning service line to the contract Harrow currently holds with NWLHT.

5.6. The recommended option is to move the family planning service onto the existing contract Harrow hold with NWLHT.

Ealing Hospitals Trust (Integrated Care Organisation) (ICO)

5.7. Ealing Hospitals Trust currently provides the school nursing service for Harrow. As well as the Child Measurement Programme, school nursing are responsible for delivering the Healthy Child Programme for 5-19 year olds and provide the main health input to child protection cases.

5.8. The work for 0-5 year olds is delivered by the Health Visiting service, which will be commissioned by the NHS Commissioning Board in 13/14 and 14/15. Responsibility for the Health Visiting service will be moving to the council in April 2015.

5.9. Some London boroughs have already decided to leave the School Nursing services in NHS contracts for 13/14 and be associate commissioners to those contracts.

5.10. It is likely that the NHS Commissioning Board (NHSCB) will ask Clinical Commissioning Groups (CCGs) to keep Health Visiting within existing NHS contracts and be an associate commissioner to those rather than entering into separate contracts.

5.11. The public health commissioners are currently working towards understanding the plans the NHSCB have for commissioning Health Visiting in Harrow and to understand better the reasons behind the decision in other areas for the borough to be associate commissioners to NHS contracts for School Nursing.

5.12. Work is still in progress to agree an approach to commissioning school nursing for Harrow. The Council is keen to ensure that all future contracts however are under the terms and conditions of the Council and the contract clearly links to the expected deliverables.

All other contracts

For the most part, contracts held with non NHS providers are for single service lines and are generally straightforward transfer to the Council. The steps taken for these contracts have included:

- Reviewing council contract terms to ascertain if any additional schedules are needed
- Drafting new contracts for each provider and reviewing service specifications and contract schedules
- Agreeing costs, data requirements, KPIs and quality standards for 2013/14
- Aggregating contracts with existing provider contracts where appropriate
- Locally Enhanced Contracts are shared between GP Consortiums and local pharmacies and are currently valued at £473,000. Harrow is seeking to develop a framework with a call off period for the LES contracts and officers are liaising with the current service providers. Further guidance from Department of Health is anticipated to provide further clarity on these specific contracts.

6. Transfer of Staff: Transfer Orders

6.5. Harrow is the 'receiver' organisation for all staff from the NHS Barnet and Harrow. NHS public health staff are transferring direct to Harrow. The terms of this transfer are not yet known but it is anticipated they will reflect those required by TUPE. A final list of staff transferring will be submitted to DH in January.

6.6. Three of the public health staff have been displaced through the recruitment process to the new structure and are therefore at risk of redundancy. The NHS are working to redeploy these staff before 1st April and if unable to will make them redundant at no cost to the Council.

6.7. There is still some uncertainty on the destination of Harrow's eight Health Trainers. The Health Trainers are currently on a zero hours contract and have a total budget available of £10,000. The Public Health team are developing an options paper, which will be reviewed before April.

6.8. We are anticipating receiving the HR Transfer Order by 12th March 2013.

6.9. The transfer order will include a list all public health staff (across Barnet & Harrow) who will be transferred to Harrow on 1st April 2013 to deliver the Joint Public Health Service).

7. Memorandum of Understanding (MOU) for the Clinical Commissioning Group (CCG) Core Offer

7.5. One of the mandatory roles of the public health function is to provide support to the Clinical Commissioning Group.

7.6. The MOU documents the understanding between Harrow and Barnet and their respective Clinical Commissioning Groups concerning how they will work together to ensure improvements in population health and wellbeing, through effective disease prevention, health improvement and commissioning of health and other services.

7.7. The Memorandum of Understanding (MOU) outlines a framework which sets out a series of principles for the relationship between Harrow and Barnet and their Clinical Commissioning Group (CCG). The MOU outlines the expectations and responsibilities of each Party, the principles and ways of working and sets out the boundaries of provision. It will be accompanied by an agreed CCG-Council work-plan for each year.

7.8. Harrow and Barnet Council are also looking at developing a schedule of rates which can be applied to any work requests that fall outside the scope of the core offer for the CCG.

7.9. Although Barnet will enter into an MOU with its CCG this will be operated by Harrow on its behalf under the terms of the Inter-Authority Agreement.

7.10. Initial discussions with both Barnet and Harrow CCGs have occurred on the draft agreement (attached as Appendix B).

7.11. Barnet CCG has agreed in principle to the agreement and discussions are still occurring with Harrow CCG.

7.12. The final agreement will consist of two separate agreements for both Barnet CCG and Harrow CCG but the content will be the same.

7.13. It is recommended that the Corporate Director of Community, Health and Wellbeing in consultation with the Portfolio Holder for Adult Social Care, Health and Wellbeing is authorised to sign off of the final CCG Memorandum of Understanding for the Core Offer.

8. Options Considered

8.1 The Health and Social Care Act 2012 – as a legal requirement, require the transfer of the public health function to the council there are no other options to consider.

8.2 To ensure all duplication and non value added exercises are removed from the current Health and Local Authority contracts a full review was undertaken and efficiencies were identified. As a result negotiations are underway with the providers to determine whether the identified public health contracts could be consolidated with existing local authority contracts. This would thereby reduce the total contract price.

8.3 Following the transfer of functions and their related contracts, as outlined in this report, there will be further opportunities to shape future commissioned services.

9. Legal Implications

This report sets out further information regarding the statutory responsibilities of the Council for the delivery of public health services from 1 April 2013; the future proposed working relationships with CCGs and recognises the effect of the inter-authority agreement in providing the shared Harrow/Barnet public health service.

As detailed in the guidance provided by the DH, Harrow and Barnet cannot refuse the transfer of assets and liabilities from the PCTs, once the Transfer Schemes have been finalised. Therefore it is essential that we engage fully with the NHS in this process to ensure that the final agreed Transfer Scheme accurately captures the assets and liabilities that will be transferring to the Local Authorities

10. Financial Implications

The ring fenced grant across the shared service for 13/14 is £22,673,000. Of this the staffing structure for the joint public health teams for Harrow and Barnet are estimated to be in the region of £2.5m, with contracts for services estimated in the region of £14.5m.

It has not been possible at this stage to fully assess the implications of the increases in the grant funding, in particular to identify whether additional commitments have been placed on public health services e.g. infection control and therefore whether there are additional costs which will need to be included in operational plans and financial commitments. In addition, there is the potential for outstanding liabilities to be transferred to Harrow and potential claims for prior years without the transfer of any balance sheet reserves held by the PCT.

The process of reviewing contracts is ongoing and some contracts which are based on national arrangements i.e. GUM services; will not be fully controllable by the Council. As a consequence, it would be prudent, therefore, to hold a contingency within the grant allocation as advised by the Council's section 151 officer to mitigate these risks.

The publication of the two year grant settlement provides the Council with more certainty in planning public health services to March 2015. In announcing the grant allocation, the DoH have also published the grant conditions which allow under spends to be carried forward as part of a public health reserve into future financial years, however, where there are repeatedly large under spends it is likely that the Department will consider whether allocations should be reduced in future years.

The model and associated structure aim to deliver a robust, comprehensive and specialist public health service that is more cost effective and efficient than the current two separate teams. The structure is anticipated to achieve a reduction in staffing budget and overhead costs in the region of 15%. This is largely through the removal of vacant positions, the sharing of the Director of Public Health and reduced overhead costs. An actual cost of the structure will not be available until the interview process has been completed by North West London and North Central London Clusters.(by the time this goes to Cabinet we should have this info.)

Work is ongoing to consolidate existing public health contracts across the shared service but also with existing council contracts. Service contracts will be linked to performance and contracts monitored to ensure delivery, and as a result are expected to contribute towards efficiencies, particularly in the longer term.

Given the level of risk around the liabilities and potential for prior year claims it is considered prudent to hold a contingency provision or earmarked reserve specifically for public health, funded by the grant, to mitigate any risks that materialise during 2013/14.

Officers will ensure that the final commissioning intentions reflect the public health outcomes and are budgeted accordingly within the grant in setting the final budget for public health.

11. Performance Issues

As the Public Health function is integrated into the Council the requirement to deliver the Public Health Outcomes Framework will be fully integrated into the Council's existing performance management framework. Although the Council is not yet accountable for delivery of this function it is already reviewing the performance data through the Improvement Boards and will continue to do so for the remainder of the year, in order that this will support synergies with other Council services early rather than waiting until the 1st April 2013.

Once the final outcomes framework is published this will be integrated with the existing work to ensure that system and data access will be fully up and running on the 1st April. The existing framework can be found at www.dh.gov.uk

The public health contracts will include detailed specifications which will be monitored by the public health commissioners. The performance of the contracts will be used to feed into future contract reviews and will also link into any financial implications.

12. Environmental Impact

The majority of staff will be based in Harrow council premises. This will mean that energy and carbon costs will be largely borne by Harrow. (unless this can be recharged through the overhead).

The new shared public health team will seek to minimise its environmental impact by implementing agile working practices, cutting down on the need for journeys to and from work. The shared public health team will be involved in the initial mobile and flexible working pilot.

13. Risk Management Implications

A full risk register has been maintained throughout this project and mitigations and controls have been put in place to ensure the risks have a low likelihood of occurring.

Risks identified include:

- IT and data transfer issues as files are moved to Harrow and ongoing connection to NHS data
- Failure to integrate Public Health with established Council processes
- Lack of co-ordination on governance arrangements for the shared service
- Insufficient funding to cover the cost of transition
- Lack of timely information from DoH around key requirements, in particular the staff transfer
- Lack of transparency around contracts and values transferring to the Council
- Low levels of grant funding to deliver public health services in Harrow (although the increase in grant announced would appear to mitigate this risk)
- Potential for prior year claims and outstanding liabilities to be transferred to the Council

14. Equalities implications

An Equality Impact Assessment was carried out on the shared public health target operating model. The focus of the assessment was on the process of change needed in developing a Target Operating Model to establish transfer of public health services and functions to Barnet and Harrow Councils. The intention of the transfer is to ensure the delivery of statutory Public Health responsibilities to improve wherever possible the public health and wellbeing of residents in both boroughs.

The new shared public health function will not have any adverse impacts on any group.

15. Corporate Priorities

The report incorporates the following corporate priorities:

- United and involved communities: A Council that listens and leads.
- Supporting and protecting people who are most in need.

Section 3 - Statutory Officer Clearance

Name: Julie Alderson Date: 18 January 2013	X	Chief Financial Officer
Name: George Curran Date: 18 January 2013	X	Monitoring Officer

Section 4 – Performance Officer Clearance

Name: Alex Dewsnap Date: 21 January 2013	X	Divisional Director Strategic Commissioning

Section 5 – Environmental Impact Officer Clearance

Name: Andrew Baker Date: 18 January 2013	X	on behalf of the Divisional Director (Environmental Services)

Section 6 - Contact Details and Background Papers

Contact: Trina Thompson, Senior Policy Officer, 0208 4209324

Background Papers:

Shift Guidance - http://www.dh.gov.uk/health/2012/11/shift-phase-planning/
Handover and Closedown Guidance – Transfer of Claims, Liabilities and related Financial Assets
Health and Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
NWL Transfer Scheme spreadsheet – Contracts/Liabilities and Assets

Call-In Waived by the Chairman of Overview and Scrutiny Committee	**NOT APPLICABLE** *[Call-in applies]*

Appendix A – Harrow Public Health Contracts

Harrow Contracts

Provider	Service	Service Description	Value	Transfer Option	Type
Harrow Leisure Centre [GLL]	Obesity &Physical Activity	Exercise on Referral	14,900	LBH tender	D
Sherwood Clinic	Obesity &Physical Activity	Exercise on Referral	7,000	novate	D
Aspire	Obesity &Physical Activity	Exercise on Referral	10,553	novate	D
Jane Elizabeth Walters Eon Walters	Obesity &Physical Activity	MH Personal Trainers	17,500	novate	D
Compass	Drug & Alcohol	Substance Misuse	1,122,615	Consolidate	M
Each	Drug & Alcohol	Substance Misuse	321,440	Consolidate	M
Westminster Drug Programme	Drug & Alcohol	Substance Misuse	397,769	Review Barnet	M
Blenheim CDP	Drug & Alcohol	Substance Misuse	112,125	novate	M
Short term alcohol detox [Westminster framework agreement]	Drug & Alcohol	Substance Misuse	145,000	novate	M
C Card [emergency hormonal contraception?]	Sexual Health	Sexual Health	5,000	novate	D
Clinic in a box [NWLH]	Sexual Health	Sexual Health	84,000	Consolidate	M
SRE [NWLH]	Sexual Health	Sexual Health	12,000	novate	M
Harrow Leisure Centre [GLL]	Health Improvement	Healthwise	146,000	LBH tender	D
WLA	Sexual Health	GUM	1,421,000	New contract	M
NWLH	Sexual Health	Family Planning	621,000	novate	M
North 51 Ltd	Smoking Cessation	Licenses	8,400	novate	D
NWLH	School nurses	School nurses	410,000	novate	M
Private Trainers	Obesity &Physical Activity	Cardiac Personal Trainers	3,500	Novate	D
			4,859,802		

Type **E = Excluded** **M = Mandatory**

Appendix 2 – Clinical Commissioning Group Draft Memorandum of Understanding – Core Offer

MEMORANDUM OF UNDERSTANDING

between

LONDON BOROUGH of HARROW

and

HARROW CLINICAL COMMISSIONING GROUP

This agreement documents the understanding between London Borough of Harrow (the Council) and Harrow Clinical Commissioning Group (CCG) concerning how they will work together to ensure improvements in population health and wellbeing, through effective disease prevention, health improvement and commissioning of health and other services.

INTRODUCTION

The Health and Social Care Act (2012) (the Act) establishes new arrangements in England for health protection, health improvement and for commissioning health services.

Commissioning:

Clinical Commissioning Groups (CCGs) will be the main local commissioners of NHS services and the Act gives them a duty to continuously improve the effectiveness, safety and quality of services. The NHS Public health currently provides a range of support for NHS commissioning. The requirement for this support will not diminish under the new arrangements, and Department of Health guidance indicates that this support should be obtained from and made available to the Clinical Commissioning Group by an appropriately skilled, local authority public health specialist team.

Health Improvement:

The Act gives local authorities, such as the Council, statutory duties to improve the health of the population from April 2013. The CCG will also have a duty to secure improvement in health and to reduce health inequalities, utilising the role of health services. This will require joint action between the Council and the CCG along the entire care pathway from prevention to end of life.

Health Protection:

Under the Act, local authorities (LA) must appoint Directors of Public Health (DPH) who have local responsibilities in respect of health protection, in conjunction with Public Health England. These include preventing and responding to outbreaks of communicable disease, planning for and mitigating the effects of environmental hazards, and NHS resilience. The Act gives the CCG a duty to ensure that they are properly prepared to deal with relevant emergencies.

The Council, will by 1 April 2013, have established arrangements for the discharge of their statutory public health functions. The Council and the Clinical Commissioning Group (CCG) share the common aims of improving the health of the population and tackling health inequalities in the borough. Robust partnership working between the Council and CCG will be essential to achieve these.

PURPOSE

The purpose of this Memorandum of Understanding (MOU) is to establish a framework for relationships between the Council and the Clinical Commissioning Group (CCG), outlining the expectations and responsibilities of each Party and the principles and ways of working. It will be accompanied by an agreed CCG-Council public health work-plan for each year.

IT IS AGREED AS FOLLOWS:

A. Principles and Values

The Council and the CCG will

- Work in partnership to achieve agreed outcomes and ensure that a productive and constructive relationship continues to be developed and maintained
- Recognise and respect each other's roles in improving the health of the population
- Support each other in finding the most efficient ways to deliver project requirements.
- Be honest, constructive and communicative in all dealings with each other.
- Have reasonable expectations of each other, consistent with agreed arrangements.
- Use the content and terms of this MOU to help in resolving any conflicts that arise in the working relationship.
- Be responsive to each other'sneeds during the year, within the flexibility of a planned programme of work
- Owe each other a duty of confidentiality regarding business sensitive issues.

B. Objectives

The Council and the CCG will work together

- to deliver improvements in the health of the borough's population, through disease prevention, health protection and commissioning health services;
- to maintain performance on national and locally agreed outcome measures and priorities;
- to ensure that local commissioning fully reflects the population perspective;
- to implement a mutually agreed joint work plan to deliver both NHS commissioning and public health priorities for the local population

C. Governance and Accountability

- The Barnet and Harrow Public Health Governance Board will be the governing body for this agreement
- The DPH or nominated representative will attend the Clinical Commissioning Group Governing Body, as a non-voting member, to provide PH advice, support and challenge to commissioning discussions and decision-making.
- The DPH or nominated representative may attend other CCG committees, if requested.
- CCG clinical directors as members of the Health and Wellbeing Board will provide clinical input to partnership strategies and priority setting.
- There will be one named public health consultant to act as the key relationship manager to the CCG.
- The CCG will designate a clinical director to be the lead for population health
- The work-plan will be developed by negotiation and be based on CCG priorities drawn from their commissioning intentions and strategies.

- **Population Healthcare/ Health Services**

This core offer is based on the Department of Health issued guidance (July 2012) and includes the generic activities, listed below. The specific offer is defined and limited by the work-plan, which is mutually agreed and consistent with the needs of the CCG and capacity and other public health priorities of the Council .

- Provide specialist, objective public health advice to the CCG in its strategic, commissioning and decision-making processes.
- Assess the health needs of the local population, through use and interpretation of the data and other sources, and analysis of how the needs can best be met using evidence-based interventions.
- Lead production of the joint strategic needs assessment (JSNA)
- Support actions within the commissioning cycle to prioritise and reduce health inequalities and better meet the needs of vulnerable/ excluded communities, for example including use of health equity audit; geo-demographic profiling, etc.
- Support the clinical effectiveness and quality functions of the CCG, including input into assessing the evidence in commissioning decisions, e.g. NICE or other national guidance, critical appraisal and evidence review.

- Support the CCG in its work in developing health care strategies, evidence based care pathways, service specifications and quality indicators to monitor and improve patient outcomes.
- Provide support to the QIPP (Quality Innovation Productivity Prevention) programme and other strategic commissioning plans and processes.
- Design monitoring and evaluation frameworks to assess services for the impact of commissioning policies;support collection and interpretation of the results
- Provide a professional source of expertise for research and evaluation of local health care as required and contribute to innovation and development of local solutions to help meet healthcare need.
- Assist in the process for setting priorities or making decisions about best use of scarce resources, for example through decision-making frameworks, benchmarking/ 'comparative effectiveness' approaches linked to population need.
- Support the CCG in the achievement NHS Outcomes Frameworkindicators, particularly as regards action on Domain One – preventing people from dying prematurely, and in support of its contribution to the Public Health Outcomes Framework.
- Support the development of public health skills for CCG staff.
- Promote and facilitate joint working with the Council and wider partners to maximise health gain through integrated commissioning practice and service design.
- Lead the development of, and professional support for, the Health and Wellbeing Board (HWB)and Joint Health and Wellbeing Strategy.

The CCG will:

- Seek specialist public health advice to ensure that prioritisation and decision making processes are robust and based on population need, evidence of effectiveness and cost effectiveness.
- Work with the Council to develop its public health commissioning intentions in line with the HWBpriorities, as informed by the JSNA.
- Utilise specialist public health skills to identify and understand high risk and/or under-served populations in order to target services at greatest population need and towards a reduction of health inequalities
- Utilise specialist public health skills to support development of its commissioning strategies, pathways and service improvement plans
- Contribute intelligence and capacity to the production of the JSNA, including through data-sharing agreements
- Ensure necessary arrangements are in place to enable the Council to deliver the core public health offer and facilitate joint working, including sponsorship arrangements for NHS mail and Athens, accommodation/hot-desking, etc. (see Appendices 3 & 4)
- Mediate an agreement between the Council and the Commissioning Support Service to ensure clear communication and full access to required NHS data for the delivery of the Council's public health functions

- **Health Improvement**

The Council will:

- Refresh its delivery and lead role in current health improvement strategies and action plans to improve health and reduce health inequalities, with input from the CCG
- Maintain and refreshmetrics, as necessary, to allow the progress and outcomes of preventive measures to be monitored, particularly as they relate to delivery of key NHS and Council strategies
- Support primary care to deliver health improvements(appropriate to its provider healthcare responsibilities)– e.g. by offering training opportunities for staff and through targeted health behaviour change programmes and services
- Ensure commissioned health improvement services support the CCG in its role of improving health and addressing health inequalities
- 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 health improvement programmes, such as stop smoking services, into front-line clinical services, with the aim of improving outcomes for patients and reducing demand

The CCG will:

- Contribute to strategies and action plans to improve health and reduce health inequalities
- Encourage constituent practices to maximise their contribution to disease prevention – e.g. by taking every opportunity to encourage uptake of screening opportunities
- Encourage constituent practices to maximise their contribution to health improvement – e.g. 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 are included within all commissionedpathways
- Commission to reduce health inequalities and inequity of access to services
- Support and contribute to locally driven public health campaigns

- **Health Protection (this section may be revised, subject to further guidance from DH and/or PHE)**

The Council will:

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

The CCG will:

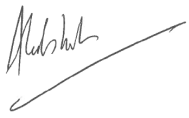
- Familiarise themselves with strategic plans for responding to emergencies
- Participate in emergency planning exercises when requested to do so
- Ensure that provider contracts include appropriate business continuity arrangements
- Ensure that constituent practices have business continuity plans in place to cover action in the event of the most likely emergencies
- Ensure that providers have and test business continuity plans and emergency response plans covering a range of contingencies
- Assist with co-ordination of the response to emergencies, through local command and control arrangements
- Encourage constituent practices to maximise their contribution to health protection, e.g. by taking every opportunity to promote the uptake of and providing immunisations

- Performance
  - The Council and the CCG will work together to deliver their public health outcomes
  - The Council will support the CCG in achievement of non-public health outcome indicators, where possible.
  - The CCG will support achievement ofPH outcome indicators, where possible, through support and challenge to member practices, as well as through commissioning health services.
  - The CCG and the Council will co-operate on achieving performance outcomes in the NHS and the Public Health Outcomes Frameworks

- The work-plan will include agreed key performance indicators for each work-stream/project by which progress will be monitored and both parties held to account.

- Term

  This agreement commences on the date signed by both parties and will continue until 31st March 2016 or until reviewed by mutual agreement.

Signature: 

Name: Dr Amol Kelshiker

Position: Harrow CCG Chairman

Organisation: NHS Harrow PCT

Date: 25th January 2013

Signature: _____

Name: _____

Position: _____

Organisation: _____

Date: _____