CABINET

18 September 2012

<table>
<tr><td colspan="2">Title: Transition of Public Health to Local Authorities: Delivery of the Future Public Health Responsibilities</td></tr>
<tr><td colspan="2">Report of the Cabinet Member for Health</td></tr>
<tr><td>Open Report</td><td>For Decision</td></tr>
<tr><td>Wards Affected: All</td><td>Key Decision: Yes</td></tr>
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<tr><td colspan="2">Accountable Divisional Director: Matthew Cole, Director of Public Health</td></tr>
<tr><td colspan="2">Accountable Director: Anne Bristow, Corporate Director, Adult and Community Services</td></tr>
<tr><td colspan="2">Summary:
The purpose of this report is to describe the responsibilities and implications of the transfer of Public Health from the NHS to the Council under the Health and Social Care Act 2012. In line with the new responsibilities the Council will review its strategic priorities to ensure that ‘Health’ is appropriately aligned to the Council’s core business.

This report sets out the proposed arrangements for the transfer of the public health function for Barking and Dagenham from NHS North East London & the City (NHS NELC) to the Council.

It is proposed that the Council establishes its own Director of Public Health, Public Health team and, where appropriate, seeks to share functions with other local authorities

From 1 April 2013, every local authority will receive an annual Public Health Grant. The Council’s Public Health Grant is assumed for 2013/14 at £11.019m. The Department of Health has indicated that the Council could expect NHS inflation level uplift in the region of 2% for 2013/14. It is expected to be sufficient to cover existing staff and contracts.</td></tr>
<tr><td colspan="2">Recommendation(s)

The Cabinet is recommended:

(i) To authorise the Corporate Director of Adult and Community Services to make arrangements for the appointment of a Director of Public Health to serve Barking and Dagenham by means of transfer or TUPE arrangement, in line with Department of Health proposals following the Health & Social Care Act 2012 (paragraph 2.5 refers);

(ii) To authorise the Corporate Director of Adult and Community Services to explore options for sharing public health functions/services with other local authorities (paragraph 4.3 refers);</td></tr>
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(iii) To note the national approach taken to transferring staff from NHS organisations to the Council, including the implications for the initial transitional structure for the public health function at the point of transfer on 1 April 2013 (paragraph 5.4 refers);

(iv) To note the indicative Public Health Grant of £11.019 million for 2013/14 (paragraph 6.4 refers); and

(v) To note that in line with its new responsibilities the Council will review its strategic priorities to ensure that ‘Health’ is appropriately aligned to the Council’s core business (paragraph 12.6 refers).

Reason(s)

The Health & Social Care Act 2012 sets out the statutory requirement for local authority leadership of public health from April 2013. In approaching that deadline, the Department of Health has set out the terms under which it sees Directors of Public Health, the functions and resources transferring to local government. The decisions proposed to Cabinet in this report give effect to the Department’s proposals, and set out how those terms would apply in Barking and Dagenham. There is scope within the proposals for local determination of structures and any sharing arrangements with other local authorities, and authority is required from Cabinet to pursue those negotiations and decisions.

1. Introduction and Background

1.1 The Health & Social Care Act 2012 sets out substantial structural change to the organisation and delivery of health and social care services, including significant enhancement of the role of local authorities in health. After a gap of almost 40 years the Act has returned a leading public health role to the Council, bringing with it considerable new responsibilities.

1.2 The enhanced role for local authorities supports the response to Professor Sir Michael Marmot’s report *Fair Society, Healthy Lives*, bringing greater focus on the wider social determinants of health, with actions set in the context of a life course approach. The intention is to help people live longer, healthier and more fulfilling lives, and improve the health of the poorest, fastest.

1.3 In support of these new responsibilities, the Council must appoint a Director of Public Health to take responsibility for its public health functions, which include duties to improve the health of the people in the borough.

1.4 This enhanced role for local authorities includes:

- Leading joint strategic needs assessments to ensure coherent and coordinated commissioning strategies;
- Ensuring local peoples voices are heard, and the exercise of patient choice;
- Promoting joined up commissioning of local NHS services, social care, and health improvement; and
- Leading on local health improvement and prevention activity.

1.5 The focal point for the Council's health and wellbeing responsibilities is the Health and Wellbeing Board. The Board's responsibilities include:

- Assessing the health and wellbeing needs of the population and leading the statutory joint strategic needs assessment (JSNA);
- Promoting integration and partnership across areas, including through joined up commissioning plans across the NHS, social care and public health;
- Supporting joint commissioning and pooled budget arrangements; and
- Producing a Joint Health and Wellbeing Strategy.

1.6 The necessary authorisations will be sought later in the municipal year setting out proposed changes to the Constitution in respect of establishing the Board as an Executive Committee of the Council.

2. New Public Health Responsibilities

2.1 In April 2013, the Council will inherit from the PCT a raft of public health activity ranging from cancer prevention and tackling obesity to drug misuse and sexual health services. Council Officers have prepared for the transfer and are ready to take on these new public health responsibilities, which will be built into the Council's core business. It is intended that the Council and the information it provides on public health issues will become a source of trusted advice and guidance for our residents, the local NHS and others who might affect, or be affected by, the health of residents.

2.2 Initially, the Council's mechanisms for delivery of public health will be, broadly, the current responsibilities of the Director of Public Health and his team. Government policy documents, the public health profession and local government have all emphasised, however, that the transfer is an opportunity to transform public health, addressing the wider social determinants of health through the full range of Council functions and partnerships. An important aspect of improving health will be to pursue closer working and integration of health and social care, so that people's needs are recognised and responded to in a holistic way.

2.3 **Director of Public Health**
Under the Health and Social Care Act 2012 (the Act), every local authority will be required to appoint, jointly with the Secretary of State for Health, a person to be its Director of Public Health who must be a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers. This person will be required to be an appropriately qualified Public Health specialist. Under the Act, a local authority must have regard to any guidance issued by the Secretary of State for Health in relation to its Director of Public Health, including guidance as to appointment and termination, terms and conditions, and management.

2.4 The Department of Health has published a factsheet outlining the expected role and accountability of the Director of Public Health, and the Secretary of State will be publishing statutory guidance on the responsibilities of the Director, in the same way that guidance is currently issued for Directors of Children's Services and Adults' Services. The most fundamental functions of a Director of Public Health are set out in law, and these are described in Appendix 1. This means that direct accountability is expected between the Director of Public Health and the local

authority Chief Executive for the exercise of the local authority's public health responsibilities and that they will have direct access to elected members.

2.5 On the basis of these functions being set out in statute, Cabinet is recommended to authorise the Corporate Director of Adult & Community Services to establish and conclude the process for the transfer/appointment of the Director of Public Health as set out in Department of Health regulations or with due regard to guidance issued.

2.6 **Mandatory Functions**

The Act directly (i.e. on commencement, rather than through regulation) transfers certain specific public health activities to the Council relating to the schools medical programme (e.g. duties to weigh and measure school children). It also transfers the whole of the school nursing service, i.e. those nurses working in a public health role with school-aged children and their families. Members should note that, at present, these duties do not include children from 0-5 years. The NHS Commissioning Board will be responsible for public health in relation to 0-5 year olds until 2015, when the Secretary of State has indicated that responsibility for this group will transfer to local authorities.

2.7 In Department of Health policy documents it has been made clear that the provision of certain additional public health services will be mandatory for local authorities from April 2013. These include:

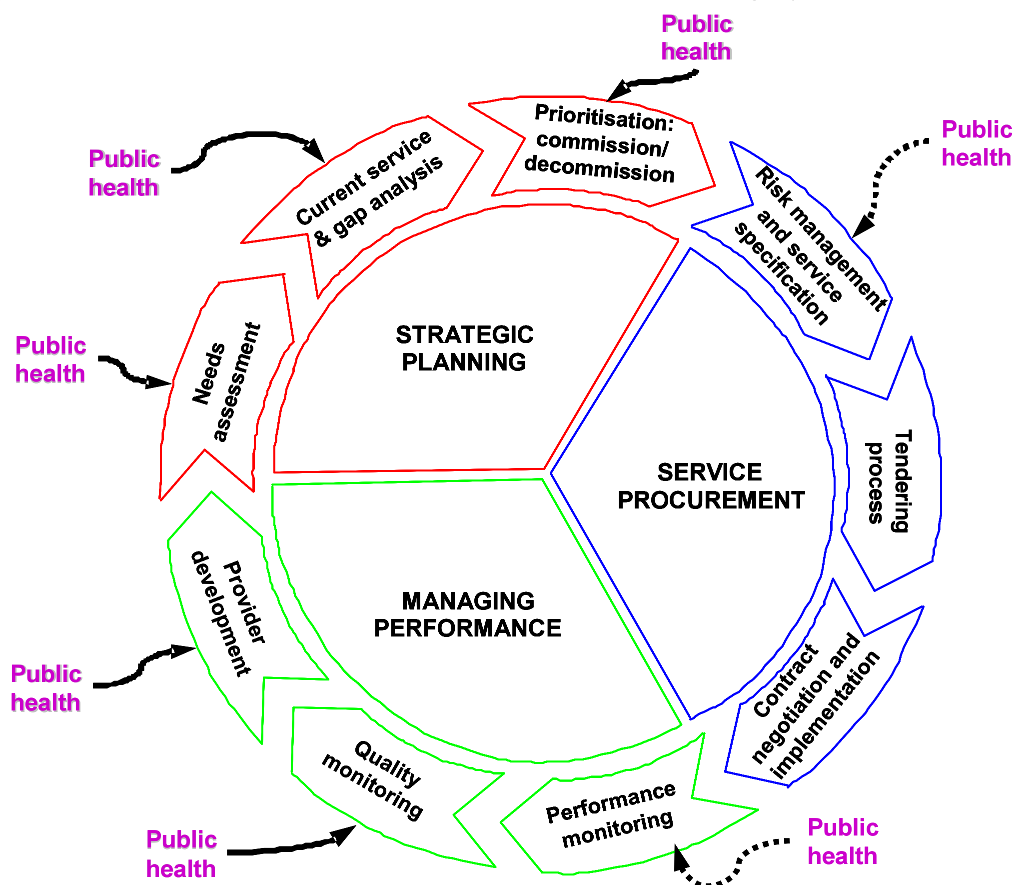
- Providing appropriate access to sexual health services;
- Ensuring there are plans in place to protect the health of the population, including immunisation and screening;
- Ensuring NHS commissioners receive public health advice on matters such as health needs assessments for particular conditions or disease groups, evaluating evidence to support the process of clinical prioritisation for populations and individuals and new drugs and technologies in development – this advice has become known as the 'core offer' from public health to Clinical Commissioning Groups; and
- The NHS Health Check programme for people between 40 and 74.

2.8 A late addition during the passage of the Act places a duty on local authorities to take on the duties of PCTs for appointing medical examiners and related activities, including funding and monitoring the work of medical examiners. These duties were created by the Coroners and Justice Act 2009, but have not yet commenced. Medical examiners scrutinise the Medical Certificates of Cause of Death issued by doctors who attend patients in their final illness, and this important responsibility arises from the enquiry into the case of Dr Harold Shipman.

2.9 **Public Health Advice to NHS Commissioners**

The Council as previously detailed is required through the Director for Public Health and other public health professionals, to provide public health expertise, advice and analysis to the Barking & Dagenham Clinical Commissioning Group (the CCG) as well as to the Health & Wellbeing Board and, for primary care and other directly commissioned services, to the NHS Commissioning Board. This support is likely to cover a number of aspects of health care commissioning as well as social care commissioning. Figure 1 depicts a model of commissioning and shows where public health input is particularly relevant.

Figure 1: The roles of public health in the commissioning cycle



2.10 The Council has agreed a memorandum of understanding with the CCG for the transition period specifying Public Health inputs and outputs, and outlining the reciprocal expectations placed upon the CCG. Key aspects of the core offer include:

- Strategic Planning – assessing need and supporting CCG input to the JSNA, practice profiling, specific disease monitoring and patterns, health needs assessments for specific conditions or disease groups;
- Reviewing Service Provision – supporting CCG analysis of local variation in outcomes and performance, providing specialist support for service reviews and pathway development;
- Deciding priorities – critical appraisal of evidence, advising on decommissioning and commissioning prioritisation, horizon scanning for impact of National Institute of Health and Clinical Excellence guidance and guidance from other sources; and
- Procuring services – specialist public health advice on the effectiveness of interventions, including clinical and cost-effectiveness, service review methodology, medicines management, pathway development, monitoring and evaluation.

2.11 In addition to the provision of public health technical support, Barking & Dagenham CCG will also look to the Director of Public Health to contribute to the governance and decision making of the CCG, as a formal non-voting Board member.

2.12 **Public Health commissioning responsibilities**
In the Public Health system the Council will have responsibility for commissioning a range of mandatory and non-mandatory services through the Public Health Grant (Appendix 2). The decision to commission non-mandatory services will be based on the *Improving outcomes and supporting transparency: A Public Health Outcomes Framework for England, 2013-2016*, our local Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

3. Establishing a Public Health Function

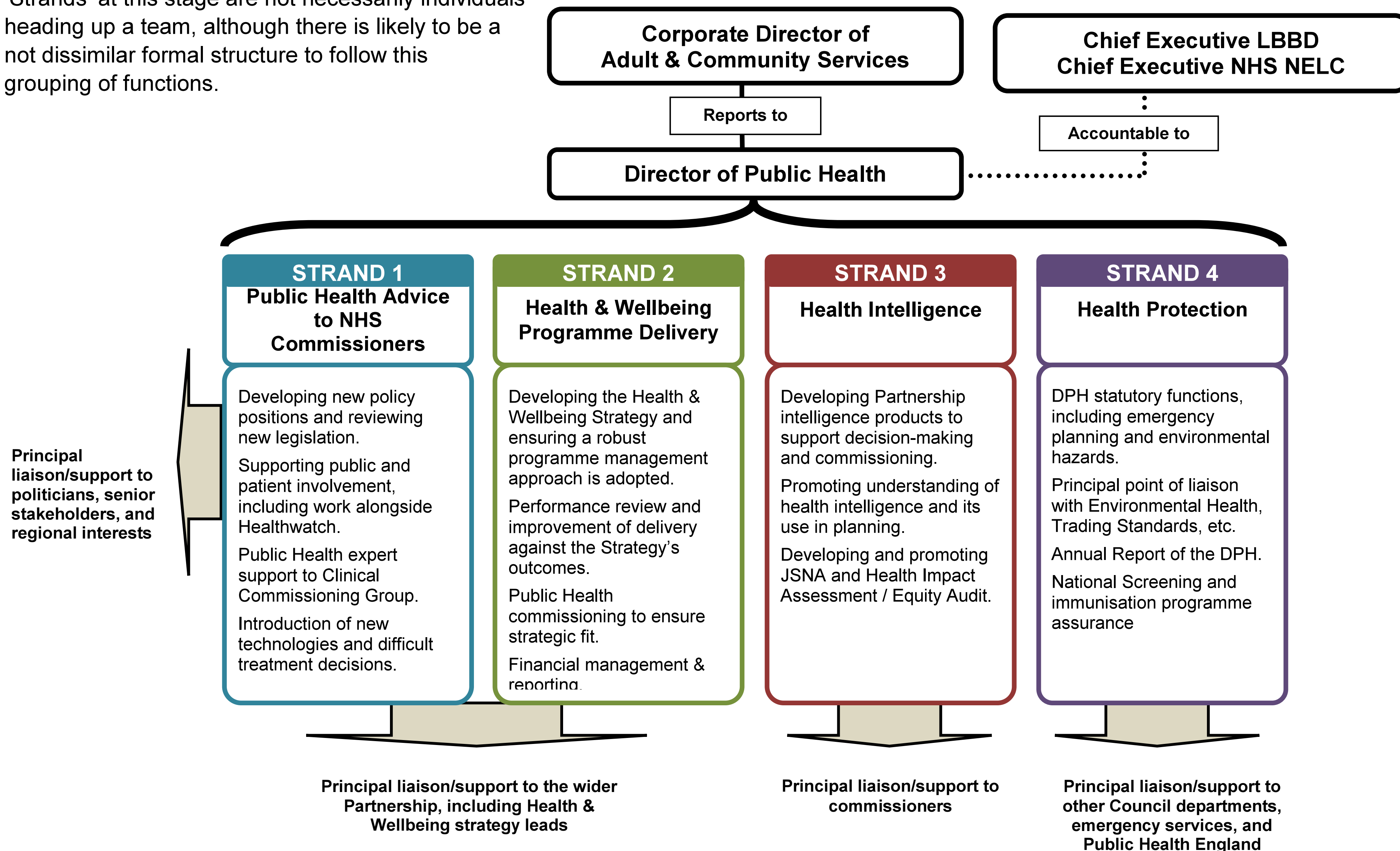
3.1 In order to fulfil its public health responsibilities, in addition to the Director of Public Health, the Council will require a small team to deliver the public health leadership, professional and technical capacities to ensure that statutory responsibilities are met. Some of this expertise will be available at no cost from Public Health England, particularly for health protection, although the leadership responsibility will lie with the Council. Other needs may be met through directly employed staff, access to a team shared with another local authority, or by commissioning experts as required.

3.2 At this stage, it is assumed that Public Health will operate, at least initially, as a distinct entity within the Council, and that there will be no additional corporate management responsibilities assigned to the Director of Public Health transferred from the existing council corporate directorates. However, the Director of Public Health will play their part in the running of the Council.

3.3 Figure 2 below outlines how the public health functions impact on the emerging Public Health transition structure for 2012/13.

Figure 2: Public health functions' impact on the emerging Public Health transition structure for 2012/13

'Strands' at this stage are not necessarily individuals heading up a team, although there is likely to be a not dissimilar formal structure to follow this grouping of functions.



4. Proposed Public Health Model

4.1 Having considered the new responsibilities and functions, the Council will need to determine the staffing structure that is affordable, efficient and effective. The model recommended is a single Director of Public Health and team with additional shared functions with other local authorities where services are commissioned across wider geographies or where expertise is scarce. This is ostensibly a ‘lift, drop and grow’ model based on the current informal arrangements between teams in outer north east London and wider. The advantages and disadvantages of this model are detailed in Appendix 3.

4.2 This model is recommended, bringing the greatest benefit of expertise both within the borough and across neighbouring local authorities, as well as economies of scale.

4.3 **Shared Services with other local authorities**
The Council over the coming months will be seeking out the opportunities for sharing services with other local authorities. The table below provides the starting position from which officers have begun to consider which services would be appropriate for direct sharing or contractual arrangements. Members’ are requested to note the current options with respect to sharing services, to provide guidance to officers and to authorise the Corporate Director of Adult & Community Services to continue negotiation with neighbouring boroughs on this basis.

Table 1. Services that can be possible models of shared or contracted services between local authorities

Shared Services / shared public health lead	***Jointly Commissioned Services***	***Traded Services***
Learning disabilities	Sexual and reproductive health services	Social Marketing
Health intelligence	Smoking cessation services	Health economic analysis
Mental health	Weight management services for children and adults	Public health advice to NHS commissioners
Individual Funding Requests	Oral health promotion	Health statistics
NHS Health Check programme	Breastfeeding/infant feeding	Community infection control and prevention
Environmental public health and planning (IPPR)	National Child Measurement Programme	Health Needs Assessments
Child Death Panel	Physical activity /exercise on referral	Health Equity Audits
Maternity / child public health	Phase 4 rehabilitation	Clinical audit
Safeguarding	Social Marketing	Pathway development support
Oral public health support		NHS Health Check programme
Planning and response to emergencies that involve a risk to Public Health		Planning and response to emergencies that involve a risk to Public Health
Clinical audit		Individual Funding Requests
		Environmental public health and planning (IPPR)

4.4 **Areas where there is still a need for national or regional guidance**
The following are areas where officers continue to push for greater clarity from central Government and its agencies to inform the shaping and approach at a local level, since they have implications both in terms of capacity and cost of the emerging structures:

- Access to NHS datasets, particularly in relation to the core offer and for the evaluation of NHS services for CCG;
- Clinical governance;
- NHS Indemnity;
- Clinical appraisal for medically qualified consultants;
- Research and development support for NHS related research;
- Terms and conditions and NHS pension rights within emerging structures; and
- Local implementation of programmes that are responsibility of NHS National Commissioning Board e.g. immunisation, screening, health visiting.

5. Transfer of Public Health Staff to the Council – Next Steps

5.1 NHS NELC have identified 16 posts (a combination of full-time and part time) at an establishment cost of approximately £950,000 associated with the functions and responsibilities transferring to the Council. All but two of the posts are already based at the Town Hall following the move in October 2011. This equates to 13 substantively employed persons (3 posts are currently vacant). In addition, two of the post holders are expected to transfer to the NHS Commissioning Board and Public Health England as they deliver the immunisation and screening functions respectively.

5.2 The Local Government Association (LGA) is developing HR guidance on the technical implementation of the transfer arrangements, which are governed by a document entitled *Filling of Posts in Receiving Organisations*. This document has been developed under the auspices of the National Concordat Steering Group, which brings together the LGA, Department of Health, NHS Employers and trade unions to discuss national aspects of the workforce transfer. The guidance will set out how councils should act as receiving organisations for these new members of Council staff.

5.3 There are two key points to draw to Cabinet's attention:

- ***The legal basis of the transfer***
  The national position, and Council officers' understanding, is that Transfer Schemes or Orders will be used to give effect to the transfer of staff to local authorities, including where there is a TUPE transfer. They will explicitly set out the terms of transfer including that the current terms and conditions of employment of the transferring staff are to be protected. It is expected the majority of staff currently undertaking relevant roles in the PCT's public health functions will transfer to local authorities.

- ***Development of Transfer Schemes or Orders for transfers to local authorities***
  The process of drafting appropriate Transfer Schemes or Orders is underway. Every local authority receiving staff will have a Transfer Scheme or Order from each sender PCT, which will detail individual members of staff who are identified for transfer to them. Guidance on the Schemes and the process for their completion is expected in September 2012.

5.4 Members are requested to note the approach being taken nationally, and also to note that discussions are taking place with NHS NELC to agree a secondment arrangement for members of the existing Public Health team to the Council prior to the transfer date of 1 April 2013.

6. Public Health Grant

6.1 On 14 June, an update on public health funding for local government was published by the Department of Health. The update supports officers' view that from 1 April 2013, the Public Health Grant will be sufficient to cover existing staff and contracts. The actual allocation for 2013/14 should be announced before the end of 2012. The update sets out current thinking on local authority public health finance. The key headlines are:

6.2 The Department of Health has re-committed to an actual allocation to local authorities in 2013/14 that will not be less in real terms than the indicative 2012/13 allocation "other than in exceptional circumstances". The Council's Public Health Grant is assumed for 2013/14 at £11.019m.

6.3 The Advisory Committee on Resource Allocation's (ACRA) has made interim recommendations on a formula for the allocation of the public health budget to local authorities. Their approach includes:

- It is based on standardised mortality ratio (SMR) for those aged under 75 years (SMR under 75).
- In addition, there is a weighting towards those 'super output areas' (geographical areas of about 7000 population with similar characteristics) with the highest standardised mortality ratios, i.e. the worst health outcomes. These areas will have a weighting three times greater per head than those with the lowest SMRs.
- There will be an adjustment for unavoidable cost differences in delivering services across the country e.g. higher staff cost. This will be called an Area Cost Adjustment.
- The formula for mandated and non-mandated services could be different. Mandatory services are those public health services which the local authorities are obliged to commission.
- There will be a 'Health Premium', which will set incentives for local delivery, with potential incentive payments for success. An expert group will produce recommendations on how these incentives for progress should be set. It should be noted that incentive payments (the health premium) will not be made if any of the mandatory services are not being appropriately delivered.
- There will be broad conditions set on the ring-fenced budget. The grant is to be spent on activities to significantly improve the health and wellbeing of local populations, to reduce health inequalities, to carry out delegated health

protection functions and to provide population healthcare advice. Ring-fenced monies will be able to be pooled with other local authorities' funding being used for similar purposes.

- There will be a standard reporting requirement.

6.4 Members are recommended to note the above developments, including the currently expected level of the Public Health Grant and the commitments already against it.

7. Contract Stabilisation and Novation

7.1 From 1 April 2013 the Council becomes responsible for the ring fenced Public Health Grant with a series of mandated responsibilities. The current known expenditure commitments against the proposed Public Health Grant are estimated at £9.5 million. These commitments have been calculated based on current staffing commitments, contract values as set out in the list currently being shared between the Council and NHS NELC on 20 August 2012, and specific assumptions listed where financial information has not been provided to date.

7.2 The current estimate of commitments is clearly well below the estimated baseline of £11.019m. This raises the possibility that commitments are missing, and a significant amount of works still needs to be done to establish commitments for 2013/14 to be funded from Public Health.

7.3 A range of contracts are currently held by NHS NELC which relate to the funding that will make up the Public Health Grant. All contracts will need to transfer to the Council's contract register by April 2013, or there will be an arrangement in place for sub-contracting through an NHS, or alternative, third party. Council Officers are still in the process of clarifying the contractual position with NHS NELC.

7.4 The Council needs to decide which, if any, contracts it wishes to re-commission outside of the existing NHS contract in order for NHS NELC to give the contractual notice (usually for a six month period) on those contracts, and for the procurement process to be initiated by the Council. The procurement of public health services is not part of the current procurement agreement with Elevate East London in respect of gain share, and consequently a flat-fee commission arrangement has been agreed in principle for this procurement activity.

8. Consultation undertaken or proposed

8.1 In respect of the staff transfer, consultation with public health staff currently employed by Barking and Dagenham PCT on the transfer to the Council is expected to be co-ordinated nationally and undertaken by NHS NELC. It is thought likely to be in November 2012. In addition any split of the team between local authorities will require consultation on the proposal and personal preference.

8.2 The Council as the 'receiving organisation' is involved in this developing process and is continually reviewing what it needs to do to support this transition process.

9. Options Appraisal

9.1 Much of the approach to transition of public health is, at present, set out in regulations issued by the Department of Health, or is contained in the Health & Social Care Act 2012. At this stage, therefore, the Council has relatively little local flexibility about its approach, particularly on matters concerning the staffing transfer.

9.2 The Council does have discretion over its approach to the sharing of functions with neighbouring authorities. The option recommended to Members, as set out above, is to investigate sharing opportunities on those elements of services for which it is deemed most relevant. The option exists to pursue sharing in no instances, or in all cases. To avoid sharing arrangements altogether, whilst increasing local responsiveness of services, will increase the pressure on the Public Health Grant, and officers' advice to Members is that a blanket approach such as this would not deliver good value for money, in principle, for the borough. Alternatively, to look to share all services risks entering into complex arrangements on some elements of public health function which would lose responsiveness with no significant gain in efficiency. Accordingly, this is also not recommended, and officers would suggest that a pragmatic set of options is before Members for decision.

10. Financial Implications

Implications completed by: Ruth Hodson, Group Accountant ACS Finance

10.1 On 7 February 2012 estimates were published of how 2010/11 spend by primary care trusts (PCTs) would be deployed under the new commissioning arrangements set out in the Health and Social Care Act 2012. The baseline estimates, which have been uplifted to 2012/13 values, provide local authorities with key information they need to support initial planning for the public health responsibilities they will take on in the future. The Council's baseline spend in 2010/11 for the elements of public health spending which would transfer to the council in 2013 was £11.019 million. This allocation will be finalised in December 2012.

10.2 Further work is being undertaken as part of transition planning to analyse contracts currently held by NHS NELC to identify the public health element of those contracts This work is also needed to identify potential risks to the council, for example, through commissioned services that are expected to be provided on demand once the budget and responsibility is transferred from the NHS to the Council (for example, some sexual health services) in 2013/14.

10.3 For future year funding, the Advisory Commission on Resource Allocation (ACRA) will be developing a distribution formula for the public health grant. There is a risk that the finances attributed to the Council in 2013/14 will not be the same as those awarded on historic data, and there could be a significant gap between current and future funding. Indicative amounts currently show a £2m headroom in the grant allocation, compared to current expenditure. The Council will need to be mindful in its commissioning decisions and expenditure plans that funding may reduce in future years.

11. Legal Implications

Implications completed by: Fiona Taylor, Group Manager, Legal Services

11.1 The Health and Social Care Act 2012 makes changes to the National Health Service Act 2006. The Act gives effect to the policies that were set out in the White Paper *Equity and Excellence: Liberating the NHS* which was published in July 2010. The main aims of the Act are to change how NHS care is commissioned. It makes significant changes involving local authorities in the delivery of public health. The proposed arrangements set out in this report will support the statutory requirements as set out in the Act.

11.2 Contracts/procurement issues: Under the proposed arrangements a significant number of contracts currently held by NHS NELC will need to transfer to the Council. The Council will need to undertake early meetings with NHS NELC to identify these contractual arrangements and determine which of these should properly be novated to the Council or, if not required, be terminated if possible. Alternatively if other arrangements are available such as the Council contracting through new or existing consortiums, appropriate agreements may need to be entered into. It is essential that the Report Author/Accountable Director commence some form of due diligence at an early stage to prepare for these new liabilities as the timeframe appears relatively short.

11.3 The Council will take on significant commissioning responsibilities. In conducting procurement processes the Council will need to comply with the requirements of the Public Contracts Regulations 2006. This can sometimes cause delay and accordingly the Council may need to prepare sufficiently prior to the transfer date to ensure that its commissioning needs are planned for as at the first day following the transfer, by engaging with NHS NELC immediately to determine any procurement processes currently being carried out, such that the Council can continue these if necessary over the transfer date.

11.4 There are identified significant employment liabilities which the Council will take with the transfer of staff to the Council. No doubt the Council will be involved with that process of transferring staff and identifying the full extent of these liabilities (including, for example, pension entitlements). We will obviously be inheriting staff and there are obvious ongoing employment obligations, some of which may be superior to the Council’s own terms and conditions but which we will nevertheless have to honour. I note that there is budget provision for this at least in the first year and possible regional adjustment to figures.

11.5 The law surrounding TUPE transfer of staff is well prescribed in the 2006 TUPE regulations, in terms of obligations transferring and how those obligations are defined. However there is almost no process information in the regulations so the establishment of terms of agreement will be useful for the Council in defining the full process. We have obligations of consultation to any transferring staff including informing them of any proposed changes to terms and conditions necessary for the Council's delivery of these services. It looks from this report as though the staff in question are already based at the Town Hall and that the transfer shouldn't involve fundamental changes to their contract but this will have to be ascertained through further consultation.

11.6 The report indicates that the position of Director of Public Health may be filled by way of TUPE transfer too. This presupposes that someone with the necessary qualifications is currently fulfilling a similar role for the council but under NHS employment. The statutory functions identified will have to be considered as it will not be possible to transfer an employee without minimum requirements prescribed by law.

12. Other Implications

12.1 **Risk Management -** Risks involved in the transfer of Public Health to the Council are reviewed by the Health Transition Group, chaired by the Corporate Director of Adult and Community Services. An entry has been made on the Corporate (and Directorate) Risk Registers, and these are reviewed by Directorate Management Team (DMT) and Corporate Management Team as appropriate. It is a risk shared by all councils in common, and there is considerable external support available from the Local Government Association, London Councils and professional bodies.

12.2 **Contractual Issues** - There are many contractual issues involved in the transfer which are fully outlined in this report. There is a considerable scrutiny of the information provided by NHS NELC on transferring contracts, and the Divisional Director for Adult Commissioning is leading on the negotiations for the Council and reporting to Adult & Community Services DMT and the Health Transitions Group as appropriate.

12.3 **Staffing Issues** - The transfer of staff is outlined in the body of the report, above. HR advice is being sought at all stages, and there is considerable guidance and regulation to support the Council in the transfer. TUPE will apply to those staff affected and therefore the Council must ensure that the obligations under the legislation are met. Any measures required to mitigate implications arising from the transfer will be identified as part of the due diligence process and as regulation and process become clearer.

12.4 **Customer Impact -** The transfer of public health functions to the Council will provide the Council with a greater range of opportunities to work with local residents to improve their quality of life. Council services will be challenged and supported to think more proactively and creatively about the opportunities that they have for improving the health and wellbeing of residents through their everyday service delivery. The driving theme underpinning the Health & Social Care Act 2012, and on which public health will provide advice and guidance, is integration of services between health and the local authority: our customers and residents can therefore expect different parts of the system to continue to improve the seamless service received by residents.

12.5 **Safeguarding Children and Vulnerable Adults -** These reforms come at a time when the numbers of children subject to child protection plans and in Council care, is rising and professionals in the health and social care fields are becoming responsible for more cases. The Public Health team within the Council will need to work more closely with designated safeguarding professionals to support investment in prevention and early intervention.

Many of the Child Death Overview Panels are the responsibility of Directors of Public Health and their teams. This has been a helpful shift, as public health

professionals are able to provide the population analysis required. However as public health team move into Council, this function and responsibilities need to be made more explicit in order for data to be collected systematically.

The Council, as a result of this transfer of public health functions, will have greater access to information on the quality and performance of health services, particularly where they work jointly with social care services. Accordingly, the management information available to the Council to support its practical work and leadership responsibilities in safeguarding vulnerable adults will improve, and the responsiveness of safeguarding systems can be expected to be enhanced.

12.6 **Health Issues -** There is an unprecedented opportunity to consider how the Council's community leadership role and all the powers and levers available to us can be used to improve the health and wellbeing of our population. Members are asked to note that this is an opportunity for a strategic review of the Council's priorities to ensure Health runs through the core business and appropriately positioned within strategies and plans. The Council's approach to these reforms, set out in this report, is intended to ensure that the Director of Public Health and team can capitalise on the Council's new responsibilities, and ensure that health and wellbeing is at the heart of everything the Council does.

12.7 **Crime and Disorder Issues -** Section 17 of the Crime and Disorder Act requires local authorities, as responsible authorities, to have regard to the prevention and reduction of crime and disorder in all their strategic planning and operational delivery. As public health becomes a local authority function that duty will further extend to this service. The Crime and Disorder Act also specifically states that responsible authorities should also specifically work to reduce the harm to the community caused by alcohol and drugs. The work of public health in identifying and addressing the needs of those who misuse drugs and alcohol will be intrinsic to this work.

The risk to the wellbeing of those who are victims of crime or who suffer prolonged abuse and anti-social behaviour and their families is well documented. The Council in discharging its public health duty along with its focus on community safety will ensure that the risks to individuals and communities are identified and that processes are in place to address these.

12.8 **Property / Asset Issues -** Accommodation has already been provided in Barking Town Hall for the public health team, and no significant further implications or pressures are therefore anticipated.

Background Papers Used in the Preparation of the Report:
The Department of Health has published a number of guidance papers relating to the transfer of public health responsibilities and the baseline spending estimate for public health. Key papers are available at:

- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131889
- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132535
- Local Government Association: Get in on the act - Health and Social Care Act 2012

- http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_134578
- http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf
- The Transfer of Undertakings (Protection of Employment) Regulations 2006)
- The Cabinet Office Statement of Practice, January 2000 (Revised November 2007)
- http://resources.civilservice.gov.uk/wp-content/uploads/2011/09/stafftransfers2_tcm6-2428.pdf

List of appendices:

Appendix 1: Statutory Responsibilities of the Director of Public Health
Appendix 2: Commissioning Responsibilities
Appendix 3: The advantages and disadvantages of the model of a single Director of Public Health and team with additional shared functions with other local authorities