Havering
LONDON BOROUGH

CABINET

21 November 2012

Subject Heading:	Public Health Transition to Havering Council
Cabinet Member:	Councillor Steven Kelly, Lead Member for Individuals and Deputy Leader
CMT Lead:	Lorna Payne, Group Director, Adult & Health
Report Author and contact details:	David Jones and Julie Brown
Policy context:	The Health and Social Care Act 2012 requires the transfer of most public health functions to upper tier / unitary local authorities. This is part of a number of major changes mainly affecting the NHS but which will have a significant impact on local government.
Financial summary:	An indicative baseline spending estimate was announced in February 2012, based on the 2010/11 spend. On this basis, the allocation will be one of the lowest in London. A formal announcement on the 2013/14 ring fenced grant allocation is expected during December 2012. It is anticipated that the grant will fund the transferring responsibilities and there will not be a call on any corporate budgets.
Is this a Key Decision?	Yes
Is this a Strategic Decision?	Yes
When should this matter be reviewed?	12-18 months (Sept 2013 – March 2014)
Reviewing OSC:	Individuals and Health

The subject matter of this report deals with the following Council Objectives

Ensuring a clean, safe and green borough	X
Championing education and learning for all	[]
Providing economic, social and cultural activity in thriving towns and villages	[]
Valuing and enhancing the lives of our residents	X
Delivering high customer satisfaction and a stable council tax	X

SUMMARY

1.1. From April 2013, it is anticipated that most public health responsibilities will transfer from the Department of Health to local government. Local authorities will have a duty to promote the health of their population and will also take on key functions to ensure that robust plans are in place to protect local populations and provide public health advice to NHS commissioners.

1.2. There will be a ring-fenced public health grant to support local authorities in undertaking these functions. Although the 2010/11 baseline spend estimate has been announced, the final grant figure will not be known until December 2012.

1.3. This report informs Cabinet of the new responsibilities, including the employment of a specialist Director of Public Health, together with the opportunities and risks. It draws on the work of PHAST (Public Health Action Support Team) which was commissioned to review the options. The report seeks approval for the work being undertaken and the initial plans to take on public health functions.

RECOMMENDATIONS

2.1 Note the content of the report including the work that has been undertaken on the transfer of the public health responsibilities and the opportunities and risks this presents, particularly financial risks.

2.2 Agree that when the public health services functions transfer, the Council will, in principle, take over the existing managerial structure, personnel and contracts pending further work on future options.

2.3 Note that the Constitution will need to be amended to provide for the creation of a chief officer level post of the Director of Public Health, but to authorise the immediate commencement of a recruitment process for that prospective post.

2.4 Agree to establish a specialist Director of Public Health for Havering at chief officer level from 1st April 2013 and to commence the recruitment process immediately.

2.5 Note that further work will be undertaken to explore shared functions and joint working with neighbouring boroughs.

REPORT DETAIL

3 Background

3.1 It is anticipated that the Health and Social Care Act 2012 will transfer public health responsibilities from the Department of Health to local government from 1st April 2013. Local authorities will have a duty to improve the health of their population and will also take on key functions to ensure that robust plans are in place to protect local populations and provide public health advice to NHS commissioners.

3.2 These responsibilities were with local government until 1974 so the 'return home' has been broadly welcomed as an opportunity to combine services and expertise to tackle the determinants of ill health and challenges such as the increase in obesity. It is also designed to support the strategic responsibilities vested in the Health and Wellbeing Boards which are anticipated to become council committees from April 2013.

3.3 "Local authorities already make a difference to health and wellbeing through their emphasis on people, places and empowerment. They are well-placed to tackle the wider determinants of health and to promote better health and wellbeing across the life course, for example through early years services, education, culture, sports and leisure, spatial planning, transport, housing, economic development and regeneration." (Improvement and Development Agency).

3.4 The generally accepted definition of Public Health is:

'The science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society' (Faculty of Public Health)"

3.5 There are three domains of Public Health:

- Health improvement (including people's lifestyles as well as inequalities in health and the wider social influences of health)
- Health protection (including infectious diseases, environmental hazards and emergency preparedness)
- Healthcare public health advice to support commissioning (relating to service planning, efficiency, audit and evaluation)

3.6 From April 2013, local authorities will have statutory responsibility for leading on local health improvement and prevention activity.

3.7 Public Health will be expected to continue to make a valuable contribution to the continuing development of the Joint Strategic Needs Assessment and delivery of the priorities of the local Joint Health and Wellbeing Strategy summarised below:

Themes	Priorities for Action
Prevention, keeping people healthy, early identification, early intervention and improving wellbeing	1. Early help for vulnerable people to live independently for longer
	2. Improved identification and support for people with dementia
	3. Earlier detection of cancer
	4. Tackling obesity
Better integrated support for people most at risk	5. Better integrated care for the 'frail elderly' population
	6. Better integrated care for vulnerable children
	7. Reducing avoidable hospital admissions
Quality of services and patient experience	8. Improve the quality of health services to ensure that patient experience and long-term health outcomes are the best they can be

3.8 It will be essential to adequately resource work on these priorities together with the statutory requirements detailed in paragraph 3.13 below; therefore other work may need to be reduced or discontinued if it is not mandatory or statutory. Currently Havering funds DAAT services which are not mandatory under statute.

3.9 The future arrangements are not as simple as Public Health transferring to local councils 'as is'. Some functions such as health protection and screening and immunisations, terminations and sterilisations will in future be the responsibility of other organisations such as the NHS Commissioning Board (NCB) and Public Health England (PHE). However, local authorities will take over access to services such as genitourinary medicine (GUM), sexual and reproductive health (SRH), Chlamydia, contraception, psychosexual counselling, and young people's services.

3.10 From April 2013, whilst responsibility for public health commissioning for adults transfers to Local Authorities, the responsibility for children's commissioning follows a different timetable. Responsibility for 5–19 year olds will transfer from the NHS to local authorities from April 2013 but responsibility for public health commissioning for 0–5s will not transfer to local authorities until 2015. Until this time, it will be the responsibility of the NCB.

Therefore, the responsibility for some care pathways will be split between different organisations.

3.11 The Director of Public Health will be expected to hold PHE and the NCB to account for some functions so will need a relationship with them together with the CCG via its Commissioning Support Service (CSS). The impact in terms of local posts is covered later in this report. Some of the relationships require further clarification and the new organisations are still developing their structures / recruiting staff who will interpret them.

3.12 There will be a requirement to provide public health advice to NHS commissioners – domain 3 (see paragraph 3.5) - for example on assessing needs, reviewing service provision, advice to assist on deciding priorities, planning capacity and demand management and monitoring and evaluation). Discussions are underway with Havering CCG on their needs and expectations. A draft Memorandum of Agreement (MoU) has been prepared and work is scheduled to finalise this by the end of 2012. The CCG is fully involved in the transition planning so is aware of the expected funding limitations.

3.13 In summary, as from April 2013, it is anticipated that regulations and guidance will make it **mandatory** for the London Borough of Havering to ensure:

- Appropriate access to sexual health services
- Steps are taken to protect the health of the population, in particular, giving the local authority a duty to ensure there are plans in place to protect the health of the population
- NHS commissioners receive the public health advice they need, such as health needs assessments and evaluating evidence to support the process of clinical prioritisation for populations, individuals and new drugs and technologies – this advice is referred to as the “Core Offer” from Public Health to a CCG
- The NHS Health Checks Programme for people 40–74 is delivered
- The National Child Measurement Programme is delivered.

4 The Director of Public Health’s role and responsibilities

4.1 Each local area is required to appoint an individual who will be responsible for the local authority's new public health functions. That individual will be an officer of the local authority, and known as the Director of Public Health. The role and responsibilities of that post have been set out in guidance which makes it clear that there can be local variation in a number of ways of appointing that individual, but that the appointment is a joint one by the local authority and the Secretary of State (in practice Public Health England), although their subsequent employment relationship is with the local authority exclusively.

4.2 The Department of Health expects that a Director of Public Health will be directly accountable to a local authority chief executive for the exercise of each local authority's public health responsibilities, as set out in the Act and associated Guidance, and that they will have direct access to elected members. The Director of Public Health will be the person elected members and other senior officers will consult on a broad range of health issues including health improvement of the population of the borough and concerns around access to local health services.

4.3 The Act requires Directors of Public Health to be members of the Health and Wellbeing Board, and have responsibility for all public health functions which are the responsibility of local government. Section 30 of the Act defines the responsibilities of Directors of Public Health, as, broadly, to implement all the health improvement and public health duties of local authorities conferred by the Act, including any conferred on local authorities by regulation under subordinate legislation.

4.4 An amendment to Section 2 of the Local Government and Housing Act 1989 will add the Director of Public Health to the list of statutory chief officers of Local Authorities giving them status equivalent to Directors of Children's Services and Directors of Adult Social Services.

4.5 The PHAST (Public Health Action Support Team) has reviewed emerging arrangements elsewhere and the options available to Havering. This has included different organisational options, the scope of the role, and whether there should be a dedicated or shared Director of Public Health. This has had to take account of developments and decisions taken in adjacent boroughs. The conclusions of the PHAST report on the employment of a Director of Public Health are supported.

4.6 The recommended option is to appoint a dedicated Director of Public Health for Havering at chief officer level, reporting direct to the Chief Executive. The funding and health challenges facing Havering require strong and effective leadership from a public health professional in order to make the best of the available resources and to improve outcomes for local residents.

4.7 Further work is to be undertaken on the scope of the role to maximise the benefits of the post and, in acknowledgement of the competitive environment highlighted in the PHAST report, to make it attractive to prospective applicants.

4.8 As the post is to be at chief officer level, Cabinet approval is required. The intention would be to commence the recruitment process as soon as approval has been given. This will be more complicated than with other posts (see 4.1 above) and requires following Faculty of Public Health guidelines and complying with the duty to act jointly with the Secretary of State. The plan would, therefore, be to have a Director of Public Health in post by 1st April 2013 to coincide with the anticipated transfer of the funding to the council.

4.9 It will also be necessary to amend the council's constitution to reflect the new statutory responsibilities.

5 Transition planning

5.1 The transition to the Council is being tightly project managed. The transition plan is regularly reviewed and a risk register and communications plans are in place to support the work.

5.2 There are monthly meetings of the Transition Steering Group, consisting of senior officers from the council and the NHS, including the CCG, which is chaired by the Group Director, Adults and Health.

5.3 There are five topic-specific sub groups: finance, workforce, ICT, commissioning and governance / legal, which report to the Transition Steering Group and progress the detailed work required to achieve transition.

5.4 There is a memorandum of understanding (MoU) between the council and the PCT, signed by Chief Executives of both organisations, which was sent to NHS London in April 2012. This was prepared in consultation with London Councils and local government members of the Public Health Transition Delivery Board. This provides a level of consistency and assists NHS London in providing reassurance back to the Department of Health of the robustness of the planning arrangements. The MoU also provides a method to ensure that the critical components necessary for successful shadow working are in place.

5.5 Regular assurance reports to NHS London and local government leaders are being submitted, ensuring that issues are raised and cooperation developed across the agencies and ultimately that timescales are met. There is close working with the other neighbouring boroughs; Barking and Dagenham, Redbridge and Waltham Forest. However clarity is still required on a number of issues and future funding continues to be uncertain until the announcement of the ring-fenced grant expected in December 2012.

6 Budget

6.1 The Public Health 2010/11 baseline spend estimate issued in February 2012 was £6.9m.

6.2 A further reconciliation exercise in July increased this to £8.2m (see financial implications section). The grant Havering will receive from April 2013 will be subject to 13/14 uplift as well as adjustments applied to calculate the final allocation. The baseline spend data is based on a range of public health responsibilities that may not all fall to Local Authorities, so funding would be adjusted in line with the responsibilities that transfer. Based on the initial £6.9m baseline, the bulk of the spend (£4.5m) is on services commissioned at Cluster level; the largest items are sexual health (approximately £2m, mostly with BHRUT, the Acute provider), drug services (very little spent on alcohol services) and children's and families services such as school nursing.

6.3 Based on the increased figure of £8.2m, given that an amount of £5.7m relates to existing commissioned services including sexual health which is mandatory, the actual amount expected is between £6.9m and £8.2m (a reasonable uplift to reflect 2013/14 prices should be applied).

6.4 Spending on drugs and alcohol misuse services is currently from a number of different sources. Work is being undertaken on the amount which will be part of the Public Health ring fenced budget from April 2013.

6.5 The London pattern is that around 35% of the overall total spend on public health in 2010/11 was on sexual health services and around 12% was on drug and alcohol misuse services. Clarity is also being sought on whether the Cluster level procurement staffing costs have been appropriately disaggregated.

6.6 Initially, the intention was to top slice 3% of the funding allocated to London for the London Health Improvement Board (LHIB). The identified priorities are: addressing the impact of alcohol, childhood obesity, prevention and early diagnosis of cancers and information transparency to drive improvement and choice. However, when the Leaders' Committee met on 16 October, members were not willing to give an in principle agreement at that stage to the funding of LHIB projects in 2013/14. They asked for this issue to be brought back to Leaders' Committee at a later date with fuller information about the planned outputs and outcomes for the projects that they were being asked to consider funding.

6.7 It proved a major challenge to identify public health expenditure within the NHS as these budgets have often been used to cover overspends. The indicative allocation was announced in February at £6.9m for 2012/13. Havering is the second lowest in London, which is problematic and disadvantages the area as it is the only one under the capitation amount (i.e. funding per head of population) in London.

6.8 Various representations have been made including providing evidence to London Councils which commissioned research on the baseline spending allocation in order to make the case for a more acceptable level of funding.

6.9 Figures have also been submitted as part of the lobbying for financial support to assist with transition costs. A sum of £84k has recently been allocated to Havering.

6.10 During the summer, the Department of Health published an update giving next steps on moving from the estimated baseline spending published in February 2012 to the actual allocations for 2013-14 which are expected to be published by the end of 2012. This announcement also included conditions on the ring fenced Public Health Grant together with proposed financial reporting requirements. There remain concerns about the likely amount and the final announcement may necessitate revising plans and structures.

7 Current services

7.1 As previously highlighted, the bulk of current spending is on services commissioned at Cluster level by the Primary Care Trust. Therefore, high priority has been given to gaining an understanding of each service and the options through a review and due diligence process that has been examining the specifications, performance monitoring information and outturn figures. There are various periods for notice of termination or variation but most will novate to the Council. Much of the expenditure is on mandatory services essential to meet performance targets.

7.2 A particular risk is that some services, including the most costly, sexual health, are statutory open access on demand services with some cross charging occurring. The main sexual health contract, mainly providing services to residents of Havering, Barking and Dagenham and Redbridge, is with BHRUT (value is £1.8m per year) and is a Service Level Agreement as part of a larger acute health contract.

7.3 The due diligence work is being shared amongst the Cluster councils to make best use of local expertise and avoid unnecessary duplication. The processes being followed comply with the council's usual contract procedure rules but it is being made clear the award is subject to formalisation of the transfer. Work so far provides reassurance that the vast majority of the contracts are delivering essential services and achieving value for money.

7.4 Rolling forward most contracts is seen as the most pragmatic response and this will give more time to assess performance and the potential for improvement as well as the possibility of any shared arrangements such as contact monitoring with neighbouring councils.

7.5 The authority for the Council to commission services for functions in respect of which it does not currently have statutory powers is found in its general powers of competency in section 2 Local Government Act 2000 and section 1 Localism Act 2011. It is considered reasonable and appropriate to exercise these powers because legislation is already in place to transfer the relevant functions to the local authority and it is anticipated that these will come into force from 1 April 2013.

8 Workforce

8.1 The summary shows that the full, direct staffing establishment costs amount to £1.3m. Whilst the current staffing structure consists of 27 established posts, only 16 staff, costing approximately £830k, are in post, and some of these staff are on secondment, acting-up or on maternity leave. It is expected that any vacant established posts as at 31 March 2013 would become established as Local Authority posts under Local Authority terms and conditions but not subject to any transfer arrangements. There are 2 substantive senior members of staff, the Associate Director of Health Care Improvement and the Associate Director of Health Improvement. Some of the staff in acting-up positions have been doing so for over 3 years and some have never formally occupied their substantive post.

8.2 As Public Health England will have the lead for screening, one of the established posts is expected to transfer to Public Health England rather than to the council.

8.3 The team are structured into three sections; Health and Wellbeing, Health Protection and Health Care Improvement.

8.4 In May 2012, it was announced that a Transfer Order (similar to TUPE) will apply protecting the terms and conditions of employed public health staff who are transferred. They will retain their NHS pensions; clarity is awaited on the pension arrangements for staff that change jobs following transfer. The NHS will be responsible for any redundancies until 31 March 2013 and possibly, in certain circumstance, during 2013/14.

8.5 The current acting up arrangements have been extended by the PCT until the end of March 2013. Staff will transfer on their substantive post. The council will review each previous acting up arrangement on a case-by-case basis to consider whether service continuity requires the acting up to resume for a specified period following transfer.

9 Organisational proposals

9.1 There are number of uncertainties, including those related to funding which all Unitary / Upper tier local authorities face. Therefore similar to many other councils, it is recommended that the local public health team should be transferred as it is; this is being termed as a “lift and shift / drop” approach.

9.2 The consultancy commissioned from the Public Health Action Support Team (PHAST) has been exploring options including the opportunity to work with the other Cluster boroughs in providing some services. For example, it will be essential that there is sufficient capacity and technical skills to undertake the procurement functions carried out at Cluster level; it may not be practical or cost effective to locate them in each council. Further work will be undertaken to explore shared functions and joint working with neighbouring boroughs.

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REASONS AND OPTIONS

Reasons for the decision:

It is anticipated that the Health and Social Care Act 2012 will transfer public health responsibilities from the Department of Health (DH) to local government from April 2013. This legislation necessitates the work summarised in the report and requires various decisions relating to implementation.

The 'lift and shift/drop' proposal is considered the most prudent because there continue to be a number of uncertainties, especially with regard to future funding and as proposals for transfer have to be finalised by 1st December 2012, more time is required to consider longer term proposals once final budgets are known later in December 2012.

The reasons for recommending a dedicated Director of Public Health for Havering are covered in section 4 of this report.

Other options considered:

Changes to the existing structure would be difficult as the Public Health Grant announcement is still awaited and decisions have to be confirmed over which staff will transfer to Public Health England rather than to the local authority.

The consultancy from the Public Health Action Support Team (PHAST) has explored different models including the opportunity to work with the other Cluster boroughs in providing some services.

There will be a statutory requirement to have a Director of Public Health. The PHAST report considered the different options (see section 4); the supported option is being recommended.

IMPLICATIONS AND RISKS

Financial implications and risks:

Public Health baseline spending estimates were issued in February 2012, as a result of a PCT data collection exercise carried out in September 2011. These figures gave the first indication of how Public Health resources could be distributed across Local Authorities. Havering's 2012/13 allocation was **£6.912m**. This equates to **£29** spend per head, the joint second lowest spend in London, compared to the average spend per head of £60.

Havering responded to this announcement by raising various concerns:

- The allocation is based on 10/11 spend. Therefore variations to budget and areas of budgetary pressure are not reflected.
- There were one off savings made to contribute toward the acute debt in 10/11, these totalled some £567k and are not considered.
- Some £500k funding for health checks is not reflected as Havering did not receive this in 10/11 as GP's were not ready at that point to implement.
- Demographics are not reflected.
- The baseline does not include monies to address key local priorities and unmet need.
- The treatment of overheads is not transparent.

London Councils have also lobbied Department of Health with various concerns, as have other Local Authorities.

In July a reconciliation of planned spend exercise was completed, whereby PCTs submitted a further return to the Department of Health to look to reflect any agreed adjustments. Havering's reconciliation is as below:

Adjustments	**£'000**
2010/11 Baseline	6,912
Adjustment for Sexual Health	292
DAAT funding change	185
DIP Funding from DH	106
Non-recurrent underspend	23
PCT underspend on DAAT	118
Mainstream PCT Substance Misuse spend	605
Total Public Health Expenditure	**8,241**

As can be seen, this acknowledges some amendments to the baseline. The adjustment for sexual health, DAAT funding change and the DIP funding adjustment were mandatory fields within the reconciliation, with the remaining adjustments being specific to the Local Authority. The purpose of this reconciliation was to pick up changes to the grant baseline and to consider any information that was not known at the time of the original data capture.

As the bulk of these adjustments are related to commissioned services, it is thought that these should be reflected within the grant allocation. The actual baseline figure to be applied is therefore expected to be somewhere between £6.912m and £8.241m.

Department of Health issued an update on Public Health funding on 14 June. This reported that the Advisory Committee on Resource Allocation (ACRA) had made some interim recommendations. ACRA is an independent committee of GPs, public health experts, NHS managers and academics who make recommendations on the relative distribution of resources to the Secretary of State for Health.

ACRA recommends that:

- A formula based on a measure of population health best meets the resource allocation criteria
- Standardised mortality ratio (SMR) is proposed as an indicator. SMR is a measure of how many more or fewer deaths there are in an area compared with the national average.
- An adjustment for unavoidable differences in the costs of delivering services due to location alone should be considered (an area cost adjustment).
- The ONS projected resident population for 2012 be used as the population base.

There will be a 'health premium' to set incentives for local delivery and performance related payments, which will apply only after mandatory services have been satisfactorily delivered.

It is not yet known what gradient would be applied to move towards a formula based allocation system as recommended by ACRA. Department of Health have committed that no Local Authority will be worse off in real terms in 2013/14, so formula changes to initial allocations could take some time to be applied, so as not to change allocations by untenable amounts in any one year (it is expected some form of cap would need to be applied).

London Councils anticipate these proposed changes would mean London as a whole would lose significant amounts of funding. A briefing issued on 18 June indicated that Havering's funding would increase under the ACRA proposed method, to £9.160m. However no assumptions on the ACRA method can be made at this stage.

The funding will be passed to Local Authorities from April 2013 in the form of a ring fenced grant. The exact allocation is expected to be announced by the end of December 2012. As demonstrated at 6.3, the majority of the budget is spent on commissioning arrangements; some £1.3m is related to the staffing establishment. The majority of the commissioned spend is related to sexual health and drug misuse services. These are demand led services that carry related financial risks. As contracts move to the Council the arrangements will need to be brought in line with our procurement framework.

As referred to in 6.6, there is a possible "top slice" to London for the London Health Improvement Board.

Local Authorities will be responsible for supporting Clinical Commissioning Groups. In terms of resources, it is not yet known what exactly this will mean in budgetary terms.

Department of Health has announced transition funding to support Local Authorities with costs incurred as a result of the transfer. Havering was awarded £84k as a one off grant, which will contribute towards one-off transition costs but is not expected to fully meet them. The transition costs include expenditure on consultancy, agency staff and ICT expenditure. Department of Health have indicated types of transition expenditure they expect the grant to fund.

Internally the transition process is being managed as detailed within this report by an overarching Transition Steering Group and sub groups that sit beneath this. There is a finance group which links in with the other groups, most notably commissioning given the size of the commissioning spend and potential contractual issues that could arise. There is also a finance group comprising the finance leads from the four ONEL boroughs (Redbridge, Waltham Forest, Barking & Dagenham and Havering) who meet monthly, then collectively meet with the ONEL non-acute Director of Finance.

The finance team will be responsible for ensuring public health is reflected within the Council's general ledger by April 2013. Accountancy wise, how Public Health is to be presented within the Councils' accounts is to be advised. It is anticipated that any post transfer accounting or debt management issues that relate to prior years will fall to the Cluster PCT to resolve.

The Council currently funds 50% of a Joint Director of Public Health post. From April 2013 the Director of Public Health will be funded via the specific grant, assuming there is sufficient capacity within the allocation. The Council may still need to bear some of the cost if the grant can not fully meet this. As recruitment will take place prior to 2013/14, related costs will need to be funded by the Council during the current financial year.

Financial Risks

The main risk is that the Council will not receive sufficient funding to carry out Public Health functions, which could result in budgetary pressure that is not accounted for. We do not presently have enough information to properly evaluate and quantify this potential risk. Work is ongoing to quantify and plan for this potential issue by obtaining as much pre-transfer information on potential commitments as possible. This has proved somewhat problematical due to the present integrated nature of some of the Health contracts.

The scope and implications of the "Health Premium" performance related payments, which will be targeted towards areas with the worst health outcomes and most need, are not yet known. Currently, it is proposed that any incentive scheme would apply from 2015/16.There have been concerns expressed over the precise working of such a scheme, which would apply to non mandatory services.

There are commissioning risks as the commissioning function could be quite different once responsibilities fall to local Authorities. The only resources transferring to the authority to carry out the commissioning function are those within the staffing resources. The Council would have the option to ask the Commission Support Service to continue to manage Public Health contracts, for which a fee would be payable.

Some economies of scale and the ability to manage large contracts across multiple boroughs could be lost once contracts transfer to local authorities. Demand led pressures in one area can presently be offset by underspends in another area, under the new arrangements we do not anticipate this will be the case. For some services, such as sexual health and smoking cessation where currently one contract covers many boroughs, there may be the option to consider "risk share"

arrangements to seek to manage demand across geographical boundaries and early discussions have taken place on this.

Overheads have been reflected within Havering's return as 27% pay and 10% non-pay expenditure. This is a notional figure. There is therefore the risk that funding will not adequately capture the true cost of necessary overheads.

Further analysis of financial statements and contractual information is on-going, and will continue as further information becomes available.

The impact of the staffing transfer on the pension fund is not yet quantified.

As Health staff are undergoing a restructure process, expertise may not be available for Local Authorities to draw upon post April 2013. This could result in resource implications, as well as possible operational issues.

Legal implications and risks:

Section 12 Health and Social Care Act 2012 will amend section 2 National Health Service Act 2006 and will impose a new duty under Section 2B as follows:

"Each local authority must take such steps as it considers appropriate for improving the health of the people in its area."

Whilst no date for implementation of this section has yet been formally set, it is widely anticipated that this will be 1 April 2013.

The steps that may be taken under this duty include:

(a) providing information and advice;

(b) providing services or facilities designed to promote healthy living

(whether by helping individuals to address behaviour that is detrimental to health or in any other way);

(c) providing services or facilities for the prevention, diagnosis or treatment of illness;

(d) providing financial incentives to encourage individuals to adopt healthier lifestyles;

(e) providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment;

(f) providing or participating in the provision of training for persons working or seeking to work in the field of health improvement;

(g) making available the services of any person or any facilities.

Detailed legal advice will need to be provided in relation to the legal agreements required for the transfer of staff, novation of contracts as appropriate and transfer of functions in due course.

The Local Authority has to make firm plans for the transfer of functions in order to ensure that the risk of failing to comply with the new statutory duties is minimised.

Human Resources implications and risks:

The Council will assume full employment responsibility for any Public Health NELC PCT employees who transfer in on 1 April 2013. The Transfer Order that will govern the transfer of these employees to the Council has been agreed with NHS Trade Unions and confers 'TUPE-like' features to the process that will be undertaken, though the TUPE Regulations do not apply in this transfer. Under this Transfer Order, the Council will be expected to protect the NHS terms and conditions of the transferring Public Health employees and to provide them with access to the NHS Pension Scheme post transfer.

As the proposal is the transfer of these employees in 'as is' in terms of their substantive roles and responsibilities, the Council will be required to enter into a consultation process with the transferring employees and their Trade Unions when it has confirmed its position on a new structure for the Public Health Services as it will sit within the Council's establishment. This will be done in line with the relevant organisational change policy applicable to the NHS staff transferring in on 1 April 2013. This approach poses significant risks for the Council with regard to retention of key staff who have essential skills and experience to maintain service continuity in this transition period.

Specialist Public Health professionals may constitute a 'hard to recruit' group in the NHS labour market and this is likely to impact on the progress and outcome of the recruitment exercise around the Director of Public Health post that will be added to the Council's establishment in order to lead the new service. The Council will need to develop and apply a robust resourcing strategy to enable a successful appointment to this senior post to take place and to ensure that the Public Health service is able to respond to demands both in the lead up to the transfer date and beyond. This will require the collective input from Council Members, the Council's senior management and HR staff, NELC PCT and relevant regional/Public Health England (PHE) advisers.

Equalities implications and risks:

The Public Health Transition Steering Group will ensure that all transition projects will be subject to robust Equality Analysis. Any related new and existing services, contracts, strategies, projects and functions coming from the transition and for which the Council is to be responsible will be equality impact assessed. This includes (non-exhaustive list), for example the Joint Health and Wellbeing Strategy, the Joint Strategic Needs Assessments and any significant changes in health services provision, particularly changes due to reduced funding. The robust Equality Analysis approach will ensure a seamless transition and that any identified differential equality impact (both negative and positive) on both employees and service users will be carefully considered and appropriately mitigated (respectively, negative impact will be eliminated/minimised and positive impact will be optimised. Further, any actual or potential impact of reduced funding will also be Impact Assessed. Currently a draft analysis is being prepared at PCT Cluster level; this will form the basis of the local work.

BACKGROUND PAPERS

- *The Public Health Outcomes Framework for England, 2013-2016; DH, January 2012*
- *Public Health Advice to NHS Commissioners; DH, December 2011*
- *Transition accountability statement between Local Government & the Department of Health; LGA, 31st May 2012*
- *Update on Public Health Funding; London Councils, 18th June 2012*
- *Havering Public Health Transition Plan; 6th July 2012*
- *The Role of the Director of Public Health in local government; DH, October 2012*
- *Havering Public Health Function Options; PHAST; October 2012*