TOWER HAMLETS

**Meeting of the**

# HEALTH SCRUTINY PANEL

**Tuesday, 22 January 2013 at 6.30 p.m.**

**A G E N D A**

**VENUE**
**Room C1, First Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG**

| **Members:** | **Deputies (if any):** |
|---|---|
| **Chair: Councillor Rachael Saunders**<br>**Vice-Chair: Councillor Denise Jones** | |
| **Councillor Dr. Emma Jones**<br>**Councillor M. A. Mukit MBE**<br>**Councillor Lesley Pavitt**<br>**Councillor Gulam Robbani**<br>**1 Vacancy** | Councillor Peter Golds, (Designated Deputy representing Councillor Dr. Emma Jones)<br>Councillor Zenith Rahman, (Designated Deputy representing Councillors Rachael Saunders, Denise Jones, Lesley Pavitt and Mohammed Abdul Mukit, MBE)<br>Councillor Motin Uz-Zaman, (Designated Deputy representing Councillors Rachael Saunders, Denise Jones, Lesley Pavitt and Mohammed Abdul Mukit, MBE)<br>Councillor Abdal Ullah, (Designated Deputy representing Councillors Rachael Saunders, Denise Jones, Lesley Pavitt and Mohammed Abdul Mukit, MBE) |

**[Note: The quorum for this body is 3 Members].**

| **Co-opted Members:** |
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|---|
| – **THINk representative**<br>– **THINk representative** |

If you require any further information relating to this meeting, would like to request a large print, Braille or audio version of this document, or would like to discuss access arrangements or any other special requirements, please contact: Alan Ingram, Democratic Services,
Tel: Alan Ingram 020 7364 0842, E-mail: alan.ingram@towerhamlets.gov.uk

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# LONDON BOROUGH OF TOWER HAMLETS

## HEALTH SCRUTINY PANEL

## Tuesday, 22 January 2013

## 6.30 p.m.

## 1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

## 2. DECLARATIONS OF INTEREST

To note any declarations of interest made by Members, including those restricting Members from voting on the questions detailed in Section 106 of the Local Government Finance Act, 1992. See attached note from the Chief Executive.

| | | PAGE NUMBER | WARD(S) AFFECTED |
|---|---|---|---|
| **3.** | **UNRESTRICTED MINUTES** | **3 - 8** | |
| | To confirm as a correct record of the proceedings the unrestricted minutes of the ordinary meeting of Health Scrutiny Panel held on 13 November 2012. | | |
| **4.** | **REPORTS FOR CONSIDERATION** | | |
| **4.1** | **Barts Health NHS Trust Engagement Strategy - Oral Update** | | |
| **4.2** | **Tower Hamlets Health and Wellbeing Board Engagement and Communication - Oral Update** | | |
| **4.3** | **Update on Public Health Transition** | **9 - 16** | |
| **5.** | **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT** | | |

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# DECLARATIONS OF INTERESTS - NOTE FROM THE CHIEF EXECUTIVE

This note is guidance only. Members should consult the Council's Code of Conduct for further details. Note: Only Members can decide if they have an interest therefore they must make their own decision. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending at a meeting.

## Declaration of interests for Members

Where Members have a personal interest in any business of the authority as described in paragraph 4 of the Council's Code of Conduct (contained in part 5 of the Council's Constitution) then s/he must disclose this personal interest as in accordance with paragraph 5 of the Code. Members must disclose the existence and nature of the interest at the start of the meeting and certainly no later than the commencement of the item or where the interest becomes apparent.

You have a **personal interest** in any business of your authority where it relates to or is likely to affect:

(a) An interest that you must **register**

(b) An interest that is not on the register, but where the well-being or financial position of you, members of your family, or people with whom you have a close association, is likely to be affected by the business of your authority more than it would affect the majority of inhabitants of the ward affected by the decision.

Where a personal interest is declared a Member may stay and take part in the debate and decision on that item.

**What constitutes a prejudicial interest?** - Please refer to paragraph 6 of the adopted Code of Conduct.

**Your personal interest will also be a prejudicial interest in a matter if (a), (b) and either (c) or (d) below apply:-**

(a) A member of the public, who knows the relevant facts, would reasonably think that your personal interests are so significant that it is likely to prejudice your judgment of the public interests; AND
(b) The matter does not fall within one of the exempt categories of decision listed in paragraph 6.2 of the Code; AND EITHER
(c) The matter affects your financial position or the financial interest of a body with which you are associated; or
(d) The matter relates to the determination of a licensing or regulatory application

The key points to remember if you have a prejudicial interest in a matter being discussed at a meeting:-

i. You must declare that you have a prejudicial interest, and the nature of that interest, as soon as that interest becomes apparent to you; and

ii. You must leave the room for the duration of consideration and decision on the item and not seek to influence the debate or decision unless (iv) below applies; and

iii. You must not seek to improperly influence a decision in which you have a prejudicial interest.

iv. If Members of the public are allowed to speak or make representations at the meeting, give evidence or answer questions about the matter, by statutory right or otherwise (e.g. planning or licensing committees), you can declare your prejudicial interest but make representations. However, you must immediately leave the room once you have finished your representations and answered questions (if any). You cannot remain in the meeting or in the public gallery during the debate or decision on the matter.

**LONDON BOROUGH OF TOWER HAMLETS**

**MINUTES OF THE HEALTH SCRUTINY PANEL**

**HELD AT 6.30 P.M. ON TUESDAY, 13 NOVEMBER 2012**

**ROOM C1, FIRST FLOOR, TOWN HALL, MULBERRY PLACE, 5 CLOVE CRESCENT, LONDON, E14 2BG**

**Members Present:**

Councillor Rachael Saunders (Chair)

Councillor Denise Jones (Vice-Chair)
Councillor M. A. Mukit MBE
Councillor Lesley Pavitt
David Burbridge

**Other Councillors Present:**
Nil

**Co-opted Members Present:**

David Burbridge

**Guests Present:**

| | | |
|---|---|---|
| Jean Taylor | – | THINk (Deputy) |
| Dr Sam Everington | – | (Chair, NHS Tower Hamlets Clinical Commissioning Group) |
| Adrienne Noon | – | (Barts Health NHS Trust) |
| Dr Sheila Adam | – | (Interim Director of Public Health, Barts Health NHS Trust) |
| Simon Twite | – | (Tower Hamlets Public Health) |
| Hannah Falvey | – | (NHS Tower Hamlets Clinical Commissioning Group) |
| Lisa Vaughan | – | (Senior Strategist, Tower Hamlets Public Health ) |
| Jackie Applebee | – | (GP Representative, Local Medical Committee) |
| Dr Steve Ryan | – | (Barts Health NHS Trust) |
| Esther Trenchard-Mabeere | – | (Assistant Director, Tower Hamlets Public Health) |

**Officers Present:**

| | | |
|---|---|---|
| Robert Driver | – | (Strategy, Policy and Performance Officer, One Tower Hamlets, Chief Executives) |
| Deborah Cohen | – | (Service Head, Commissioning and Strategy, Adults Health and Wellbeing) |
| Frances Jones | – | (Service Manager One Tower Hamlets, Chief Executive's) |
| Wesley Hedger | – | (Strategy & Policy Officer, Children, Schools & Families, LBTH) |

Alan Ingram – (Democratic Services)

**COUNCILLOR RACHAEL SAUNDERS (CHAIR), IN THE CHAIR**

## 1. APOLOGIES FOR ABSENCE

Apologies for absence were submitted from Councillor Dr Emma Jones and Dr Amjad Rahi (Co-opted Member).

## 2. DECLARATIONS OF INTEREST

No declarations of Disclosable Pecuniary Interest were made.

## 3. UNRESTRICTED MINUTES

**RESOLVED** that the unrestricted minutes of the meeting of the Panel held on 11 September 2012 be agreed as a correct record of the proceedings.

### MATTERS ARISING

Councillor Pavitt sought clarification regarding information that had been requested for Members regarding the numbers of Health Visitors in the Borough (Item 4.1) and diabetes patients (item 4.3). The Chair indicated that the requests for information would be followed up accordingly.

## 4. REPORTS FOR CONSIDERATION

### 4.1 Health Priorities for Children Living in Tower Hamlets

The Chair welcomed those present and indicated that it was her intention that the meeting should focus on Children and Public Health issues.

At the request of the Chair, Wesley Hedger (Strategy, Policy & Performance Officer) gave a detailed presentation in support of the Council's Children and Families Plan (CFP) 2012-15, as circulated with the meeting agenda pack. He commented that the Plan was targeted at meeting the most vulnerable children and families. A life-course approach had been taken, at stages of five year blocks with appropriate interventions proposed for each stage from birth to 24 year olds.

He indicated that, given the level of health inequalities within the Borough, a focus on maternity and early years within the Health and Wellbeing Strategy was vital to ensure that health and wellbeing outcomes were improved in future. The governance structure of the Children and Families Partnership would support the Maternity and Early Years principle of the Joint Health and Wellbeing Strategy. The Maternity, Early Years and Childhood

Commissioning and Delivery sub-group of the CFP would report back on delivery activity to the Health and Wellbeing Board.

Esther Trenchard-Mabeere (Public Health Tower Hamlets), commented further on the presentation, indicating that:

- 9% of babies were of low birth rate but infant mortality was not high, possibly due to low rates of smoking and alcohol use.
- There were high levels of obesity and dental decay in under 5s but there had been some reductions in both. Obesity levels seemed to have plateaued and it was hoped there would be further decreases.
- There had been a significant reduction in under 18 conceptions.
- The Borough had the highest child vaccination rate in London.
- Emergency hospital admissions due to unintentional or deliberate injuries were very high and more information on causes of injury was required. Asthma, epilepsy and diabetes also resulted in hospital admissions of children.

Officers then responded to questions put by Members of the Panel, including the following information:

- Consideration of nutritional problems was broadening beyond obesity issues towards vitamin deficiencies and malnutrition. A wider, holistic view was being taken as obesity comprised only one indicator of risk.
- The part played by schools in children's health required a whole systems approach including food and physical activity/play as 13% of children entered primary school obese, which had risen to over 25% on leaving aged 10.
- The incidence of female genital mutilation was under investigation with other partner organisations and would be one of the issues taken up by the recently-appointed Violence Against Women and Girls Co-ordinator.
- Healthy Families ambassadors were helping address lack of parental knowledge throughout communities in the Borough.
- It was acknowledged that some reductions in the Public Health budget were likely and it would be necessary to work creatively and closely with partnerships and other agencies in the Borough.
- Access to the maternity service at the target stage of 12 weeks and 6 days had improved from under 60% 6 years ago to about 92% currently. There was a very low take-up of home births at less than 2%. The Barkantine Centre was a popular choice for births but could only be used for low risk instances.

A presentation was then made by Dr Sheila Adam (Interim Director of Public Health, Barts Health NHS Trust) on the Barts Health vision for population health and reducing working in partnership with the wider public health community. Work was ongoing to make the hospital become a recognised part of the community by contact with local groups and building on initiatives from the legacy Trust's.

Dr Adam further indicated that the Children's Clinical Academic Group (CAG) had gone live on 1 October 2012 and was based at Newham University. Its

main priorities would be neonatal mortality and morbidity; breast feeding initiation and continuation; immunisation; Hepatitis B prevention and immunisation; smoking cessation; childhood obesity; childhood diabetes; psychosocial morbidity (gang involvement, school non-attendance, young people's health, sexual health).

Briefing meetings would be arranged between the CAG leadership team and Councillors over the next few weeks. Barts Health would have a focus on lifetime transitions, which would be progressed by the Public Health and Equalities Committee as part of the Trust's core business.

In response to queries from the Panel, Dr Adam and Dr Steve Ryan (Medical Director, Barts Health NHS Trust) commented that:

- Attempts would be made to build a new relationship with the community, provide opportunities and support candidates for jobs to the interview stage. Early apprenticeship programmes would also be increased. The Trust Board was also aiming to access schools and sixth form colleges to encourage young people into employment.
- There were 15,000 staff in the Trust and many lived locally. Their health and wellbeing was also a priority accordingly. They would be encouraged to be more active during work hours and would be supported to stop smoking, eat healthily and combat stress. All patient interactions were opportunities for staff to promote healthy living.
- There was an aspiration to appoint a Young Persons' Ambassador to sit on the Board of the Children's CAG but it was recognised that this would take some time to develop.

A wide-ranging dicussion then ensued and the following comments and information emerged:

- GPs were only a small part of the whole sector of children's health provision and needed to work in partnership with schools, who had much more direct contact with children. It was hoped that partnerships with schools would extend to all GP practices.
- Driving up the health of the population as a whole would be much more successful than concentrating mainly on those people who were most in need.
- Pathway work was essential around long-term conditions such as asthma, diabetes and epilepsy and families needed to be engaged to promote self-care as far as possible and managing minor ailments.
- Ongoing work on links between dampness in housing and asthma should include social landlords and Tower Hamlets Homes in particular. The major influence of housing conditions on overall health must be addressed and ways found to influence private landlords.
- Planning conditions were now available to affect the location of fried chicken shops in the vicinity of schools, etc. and an award scheme had been introduced for shops offering healthier food.
- GPs now shared data widely between practices, with league tables available for all areas of work undertaken. The principle should also be extended to schools, e.g. in terms of providing swimming and

tackling obesity. It was noted that Headteachers would be provided with details of schools' banding on child obesity numbers.

- Competition between schools in expanding health provision could be useful in driving up standards but would be better expressed in accreditation terms, rather than "name and shame".
- Communities and parents should be involved in the development of strategies for delivering children's health measures, together with inclusion of all relevant partnerships.
- There had been improvements made in the face of difficulties of helping one of the most deprived communities in the country, although there were no grounds for complacency.
- The NHS needed to improve bringing children into the decision-making process.
- A Fairness Commission had been established and would run for six months and there would be a themed session in February 2013 on the subject of people falling through social safety nets. Information arising could be made available to the Health Scrutiny Panel.

The Chair stated that particular points had been made regarding:

- the wider definition of malnutrition;
- the need to build on measures such as the Young Mayor to ensure young people's voices were heard;
- the need to address damp housing conditions;
- banding in schools to address obesity on the basis of celebrating achievement and accreditation awards;
- development of relational states to be able to help people.

She then thanked those who had attended to make presentations.

**4.2 Update on Healthy Community Project**

Ms Dianne Barham (THINk Director) presented an update on the development of community led health projects in the wards of Whitechapel, Stepney Green and St Katharine's and Wapping, which aimed to set up a Healthy Community Group of at least 200 people who would be provided with information, training, support and resources in return for their providing information on their experience of services, ideas on improving services and taking part in healthy lifestyle activities.

She tabled a report in that respect concerning:

- A summary of key issues raised by patients and the community.
- How THINk had or proposed to engage with patients and the community to tackle those issues.
- What impact THINk hoped to achieve as an outcome.

Ms Barham added that the aim was to have at least 3,000 members involved in HealthWatch and there would be a report to the Clinical Commissioning Group in December 2012 on the possibility of rolling out the scheme to the

rest of the Borough. She confirmed that community mapping information would be included in the report and asked that Panel Members contact her direct with any comments they wished to put forward.

The report was **noted.**

**5. ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS TO BE URGENT**

**Visit to Royal London Hospital**

The Chair expressed the view that a date should be arranged for Panel Members to visit the Hospital new-build and have clarification of any associated teething problems.

**Action by:**
**Robert Driver**

**Healthy Borough**

The Chair indicated that evidence sessions were to be held on 19th and 21st November 2012.

**To note**

The meeting ended at 8.50 p.m.

Chair, Councillor Rachael Saunders
Health Scrutiny Panel

| Committee | Date | Classification | Report | Agenda Item No. |
|---|---|---|---|---|
| **Health Scrutiny Panel** | **22 January 2013** | **Unrestricted** | | **4.3** |

| Reports of: | Title: |
|---|---|
| Assistant Chief Executive, Legal Services London Borough of Tower Hamlets<br><br>**Presenting Officer:** Deborah Cohen Service Head, Commissioning and Strategy | Update on Public Health Transition<br><br>**Ward(s) affected:**<br><br>All |

## 1. SPECIAL CIRCUMSTANCES AND REASON FOR URGENCY

1.1 The deadline for this report was missed due to wider consultation being required from the Resources Directorate and the Adults Health and Wellbeing Directorate on the content of the report.

1.2 This report is required to be presented to the Health Scrutiny Panel on the 22 January 2013 due to the formal transition of Public Health being due to take place on the 1 April 2013. This date is before the next Health Scrutiny Panel meeting on the 23 April 2013. It has been requested by the Health Scrutiny Panel to have an update on preparations for the transition prior to the formal transfer.

## 2. SUMMARY

2.1 This report updates the Health Scrutiny Panel on the progress of work to effect the transfer of public health functions and staff from the Primary Care Trust which closes down on 31st March 2013 to the Council.

## 3. RECOMMENDATIONS

3.1 Note and comment on the report.

## 4. COMMENTS OF THE CHIEF FINANCIAL OFFICER

4.1 This report describes the progress of the work to transfer public health functions from Tower Hamlets Primary Care Trust to the Council.

4.2 From 1st April 2013, local authorities take over responsibility for public health provision from the NHS. A ring-fenced grant will be provided to fund these activities from the government and the 2013-14 Council budget assumes that the additional costs of public health services transferring to the Council will be contained within this grant which has been announced as £31.3 million for 2013-14.

4.3. The report also indicates that it should be possible to make better use of resources and find efficiencies from bring Council and in the context of the financial challenge facing the Council this needs to be seen as an opportunity to make savings. In order to achieve this, appropriate targets will need to be set and in the wake of the financial settlement officers are currently assessing the potential for these.

4.4 There are no other specific financial implications emanating from this report. However, if the Council agrees further action in response to this report's recommendations then officers will be obliged to seek the appropriate financial approval before further financial commitments are made.

## 5. CONCURRENT REPORT OF THE ASSISTANT CHIEF EXECUTIVE (LEGAL)

5.1 The report outlines the current position regarding the transfer of public health functions to London Borough of Tower Hamlets under the Health and Social Care Act 2012 ("the 2012 Act").

5.2 From April 2013 local authorities will have a duty to improve the health of the people in their area and will have responsibility for commissioning appropriate public health services. Many of these services are currently commissioned by PCTs and accordingly local authorities will take ownership of relevant public health service contracts that have an expiry date beyond 1 April 2013 or will be responsible for commissioning public health services to commence from 1 April 2013

5.3 The transfer of pre-existing arrangements for public health services is to be made through a 'transfer scheme' as set out in a statutory order which will list the staff and contracts being transferred to the Council. These contracts have different end dates and differing notice periods and although the public health staff will transfer on their current terms and conditions there is some uncertainty on how long these are to be maintained. Once the draft order is received this should clarify the position.

5.4 The Transfer of Undertakings (Protection of Employees) ("TUPE") Regulations 2006 will apply to transferring staff in circumstances where there is the transfer of an identifiable undertaking or a service change within the meaning of those Regulations. Unfortunately, not all staff transfers under the 2012 Act will involve the transfer of an undertaking or a service delivery change and those situations will require special provision by the Secretary of State. As indicated in this report, work is being done to clarify the appropriate regime which is to apply to all transferring staff. If the applicable process is not under the TUPE Regulations, it is nevertheless expected to be a "TUPE-like" procedure.

5.5 Section 73A of the National Health Service Act 2006 governs the appointment by the Council of a Director of Public Health. The appointment is to be made jointly with the Secretary of State and the Council is required to have regard to guidance issued by the Secretary of State, elements of which are referred to in the report.

## 6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The transition of Public Health to the local authority will support the organisation in tackling inequality, strengthening cohesion and promoting community leadership. Specifically, the transition will strengthen the local authority's capacity to tackle existing health inequalities in the borough. The Tower Hamlets Joint Strategic Needs Assessment demonstrates the stark health inequalities and poor health outcomes which exist in the borough and the detrimental effect these have on the quality of life and life chances of local people. The public health function has played a key role in the development and delivery of interventions to reduce health inequalities in the borough, including delivering significant improvements in increasing rates of smoking cessation and take up of childhood vaccinations. At this stage it appears that the ringfenced budget allocated to support the transition of the public health function to the local authority will ensure that there will be no reduction in the financial or human resources capacity of the service during the transition year. In transferring to the local authority there is potential for better embedding the expertise of public health professionals into the council's work on improving the wider determinants of health for local people and driving improvement across a range of health outcomes.

## 7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 There are no Sustainable Action for a Greener Environment implications.

## 8. RISK MANAGEMENT IMPLICATIONS

8.1 There are no Risk Management Implications

## 9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 There are no Crime and Disorder Reduction Implications.

## 10. EFFICIENCY STATEMENT

10.1 There are no specific efficiency implications arising from the recommendations in the cover report as yet but following the transfer of the service to the Council these be considered at a high level the most efficient use of resources to deliver health outcomes.

## 11. APPENDICES

Appendix 1 - Update on Public Health Transition

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**Local Government Act, 1972 Section 100D (As amended)**
**List of "Background Papers" used in the preparation of this report**

| Brief description of "background papers" | Name and telephone number of holder and address where open to inspection. |
|---|---|
| **None** | **n/a** |

## 1. Summary

1.1 This report updates the panel on the progress of work to effect the transfer of public health functions and staff from the Primary Care Trust which closes down on 31st March 2013 to the Council.

## 2. General Update

2.1 Under the Health and Social Care Act 2012 public healthfunctions transfer to the Council on 1st April 2013 as part of a major reorganisation of health services. The transition programme in Tower Hamlets is well-advanced and from January 2013 there is an accelerating shift into the new systems.

2.2 Most of the anticipated national guidance on the public health transition has now been issued. The main outstanding information required to progress the transfer with full confidence is the announcement of the public health grant for 2013-14 that local authorities will receive. This announcement was expected on 19th December but did not take place and there is a promise that the announcement will be made in early January and will cover two years to give local authorities more financial certainty. [It may therefore be possible to give the Panel a further update on this when the panel meets.] In the interim the lack of clear budgetary information from April 2013 forwards adds considerable uncertainty to the transition process and increases risk to the receiver organisations.

2.3 The programme is otherwise generally on course against national milestones and externally Tower Hamlets is considered to be in a good position compared to some other local authorities.

## 3. Transfer of Public Health Contracts

3.1 A Report that sets out how it is proposed to handle the large volume of contracts/commissioning responsibilities being transferred to the Council on 1st April is being considered by the Cabinet on 9th January. The plan requires for a significant number of contracts that would otherwise end on 31st March 2013 to be extended by the NHS and then together with other contracts which have an end date beyond April 2013 can be transferred to the Council by means of a statutory order allowing time for a reprocurement process to take place in accordance with Council procurement procedures. This will ensure a smooth transition of the service and allow members and the community the opportunity to influence the redesign of the services before they are procured.

3.2 The preferred option to commission clinical services from GPs, is to do this through the Clinical Commissioning Group, and a proposal is being developed to enable this to be in place by April 2013. Contracts with pharmacies, dentists and the acute trust will transfer to the Council and be managed by the Council from April. In the case of sexual health services, a high risk area that accounts for approximately one–third of the public health

commissioning budget, options are being developed for joint commissioning with other east London boroughs in order to share risk more widely.

3.3 The mechanism for the transfer to of contracts and other public health assets/liabilities that might need to transfer from the PCT to the Council is that a statutory scheme signed off by the Secretary of State will list all the contracts and these will then transfer to the Council on 1st April 2013.

## 4. Appointment of Director of Public Health (DPH)

4.1 As the substantive DPH for Tower Hamlets is now taking up another job within the NHS it is proposed to commence a recruitment process for the Tower Hamlets DPH post. There is a substantial body of guidance about the role of the DPH and the process for recruitment.

4.2 The Health and Social Care Act makes clear that the DPH will be responsible for all the new public health functions of local authorities. The Act makes it a statutory requirement for the DPH to produce an annual report on the health of the local population, and for the local authority to publish it.

4.3 To reflect the importance of the new role, the Act adds DPH to the list of statutory chief officers. The guidance on appointing DPH is part of statutory guidance on the responsibilities of the DPH, in the same way that guidance is currently issued for directors of children's services and directors of adultservices. To enable the DPH to carry out their role the guidance says that there must be direct accountability between the DPH and the local authority chief executive for the exercise of the local authority's public health responsibilities and that they must have direct access to elected members otherwise they will not be able to carry out their duties effectively.

4.4 In practice, there has been reluctance in many local authorities to create another first tier officer, especially as many authorities move to slimmed down top structures. In cases where the DPH does not have a direct management line of responsibility to the Chief Executive, it is possible to put a protocol in place that sets out lines of accountability and access to members that ensures compliance with this expectation.

4.5 The regulations set out a process for the appointment to DPH positions including the role of Public Health England and the Faculty of Public Health in appointments, the composition of the appointments committee, and an expectation that the appointments committee be chaired by a lay member such as a local authority elected member, for example the cabinet member of the Health and Wellbeing Board.

## 5. Transfer of Public Health Staff

5.1 A national timetable for the staff transfer has been published and names of staff in the 42 posts expected to transfer to LBTH have been provided to the Department of Health. LBTH will formally have sight of the list

in January and there is a monthly process of agreeing the list before it is finalised in mid-March. The Council will expect to send a letter to all transferring staff by the end of January setting out transfer terms and at the same time will carry out due diligence checks on the staff information provided by the PCT.

5.2 At the time of writing there is no agreement on how long and in what circumstances transferring staff will have the right to remain in the NHS pension scheme. Further HR guidance is also expected on the future terms and conditions of transferring NHS staff that will transfer on NHS T&Cs and it is not yet determined at what point such staff would be expected to transfer to LA T&Cs. The exact form of the staff transfer has yet to be clarified - whether a TUPE transfer or a statutory transfer - and there has been a disagreement between employers and trade unions at national level about this which is still being resolved. The final details of the transfer scheme have not been published yet in light of this.

5.3 Transferring public health staff will have the right to remain in the NHS pension scheme and to retain their NHS terms and conditions. Further HR guidance is expected on the terms and conditions that are offered to public health staff that are recruited by the local authority after April 2013. The staff transfer is expected to be in the form of a statutory transfer scheme and The final details of the scheme are expected to be published in mid-January.

## 6. Health Protection

6.1 New guidance has been issued on Emergency Planning, Response and Resilience, a significant area of public health responsibility in respect to health risks such as pandemics. The Councils civil emergency and business continuity plans are being checked to identify where any amendments needs to be made. A desktop exercise is planned for the end of January to test the new systems and identify any risks that need to be further addressed.

## 7. Public Health Intelligence

7.1 Analysing public health data from diverse sources, many of which will remain within the NHS, is an important function of public health teams that will become a Council responsibility from April. This includes the responsibility to advise the borough`s Clinical Commissioning Group on population wide health issues and there will be a memorandum of understanding to provide for this.

7.2 There are significant data governance and technical issues which are still being worked through nationally as well as locally in order to embed this new role within the Council.

## 8. Conclusion

8.1 The transfer of public health responsibilities to local government from the health service has been broadly welcomed. LBTH in the initial exercise to work out financial baselines had the highest per capita allocation in the country (closely followed by Hackney but nearly double Newham). This is a reflection of the high priority and investment put into Public Health by the PCT over a long period of time. It also means that the Borough will acquire a highly skilled workforce in a field where there is generally a shortage of qualified public health personnel.

8.2 The levels of health inequality and poor health outcomes, although improved over the years, with some stellar success stories (smoking cessation, childhood vaccinations to give two examples) remain challenging and public health is the engine of improvement.

8.3 There are likely to be many opportunities to bring together Council and Public Health services, making better use of resources, and focussing these resources in line with the Joint Strategic Needs Assessment and the Improving Health and Wellbeing Strategy, which is being developed by the Health and Wellbeing Board. The Director of Public Health has a place by statute on the Health and Wellbeing Board.

8.4 One of the terms of the transfer is that Councils will have a responsibility to provide public health services to the local clinical commissioning group to support and planning and commissioning of services – which should also track back to the Improving Health and Wellbeing Strategy. Tower Hamlets CCG has a position on its Board for the Director of Public Health which is seen as being hugely important.

8.5 Finally, Barts Health has recently established a post of Director of Public Health/Deputy Medical Director, which it is believed to be a first. This is borne out of the fact that the Trust is an employer of over 20,000 people and has an opportunity to engage in health promotion activities with staff and patients. This development has been welcomed by us as a means to strengthen health promotion. A good example of this is the need to improve numbers taking up cancer screening and encouraging awareness to improve early detection rates which remains an issue in Tower Hamlets (and was highlighted in an earlier Health Scrutiny report a few years back).