Executive Decision Report

Decision maker(s) at each authority and date of Cabinet meeting, Cabinet Member meeting or (in the case of individual Cabinet Member decisions) the earliest date the decision will be taken	Cabinet Date of decision: 4 March 2013	h&f hammersmith & fulham
	Cabinet Date of decision: 21 February 2013	THE ROYAL BOROUGH OF KENSINGTON AND CHELSEA
	Cabinet Date of decision: 25 February 2013	City of Westminster
Report Title	**PUBLIC HEALTH: 2013-14**	
Reporting Officer	Melanie Smith, Tri-borough Director of Public Health	
Key decision	Yes	
Access to information classification	Open report. A separate report on the Exempt Cabinet agenda deals with information regarding risks in relation to contracts to be transferred to the Councils.	

1. EXECUTIVE SUMMARY

1.1. Under the Health and Social Care Act 2012, a range of public health responsibilities which currently fall to the NHS will transfer to local government on 1 April 2013.

1.2. Tri-Borough Councils have agreed to establish a single public health team, hosted by Westminster and headed by a Director of Public Health. The team will be responsible for providing public health advice to all three Councils, the Clinical Commissioning Groups and the public. It will commission public health services. A list of statutory duties and the scope of these services is at Annex A.

1.3. Many of the services to be commissioned will be mandated: required by the Department of Health. If the local authority is found to be commissioning these services on an inadequate basis, the Department of Health may withhold grant funding in future years. Officers will report back to members urgently if the Department of Health puts in place any other requirements or processes which constrain the way in which the three Councils meet their statutory duties.

1.4. This paper:

- outlines the duties to be transferred to the Council, and the function, activities, resources and proposed structure of the public health team (Annex A).

- provides a summary of the contracts due to transfer to Tri-Borough Councils in 2013-14 and the measures in hand to manage risks associated with those contracts.

- summarises the operating model for public health and recommends immediate modifications necessary (notably political governance) to manage public health business effectively within a Tri-Borough setting.

1.5. In making recommendations, the priority has been to retain the efficiencies associated with public health functioning as a single, integrated service across Tri-Borough while enabling each Council to set and follow its own priorities for public health, to make decisions about the way its own grant is spent and, where appropriate, to commission specific services.

1.6. Further information from the Department of Health and analysis by officers will be needed to make recommendations about the long-term operating model for public health, the Councils' priorities for commissioning public health services in 2014-15, and the most effective approach to procurement.

2. RECOMMENDATIONS

2.1 That Westminster City Council is the Tri-borough host for Public Health.

2.2 That the Executive Director of Finance and Corporate Governance (LBHF), the Town Clerk and Executive Director of Finance (RBKC) and the Chief Operating Officer (WCC), and the respective Heads of Legal be authorised to enter into a Tri-Borough Agreement in respect of Public Health in accordance with Section 113 of the Local Government Act 1972.

2.3 That the two Chief Executives, as accounting officers for the three Councils, delegate decisions about spending on public health services (within the scope of Annex A) to the Director of Public Health, subject to each Council's financial regulations.

2.5 That officers carry out a review of the current public health contracts, in close consultation with Members of all three authorities, once the new public health service is embedded within the Tri-borough.

3. REASONS FOR DECISION

3.1 Decisions are required by the Tri-Borough Councils to ensure a successful transition of the public health service from the PCT to local government on 1 April 2013.

4. FUNCTIONS TRANSFERRING TO LOCAL GOVERNMENT

4.1 The Tri borough Councils will have public health duties in all three domains of public health:

- Health improvement. This involves creating opportunities and removing barriers so that individuals, families and communities take positive action to maintain and improve their health through physical activity and diet (etc) as well as action to address the social determinants of health such as the built environment and worklessness

- Health protection. The Council's current responsibilities in protecting the health of the local population from threats to health will be expanded and enhanced by their employment of public health specialists who can draw upon the expertise of Public Health England.

- Health care public health. The Councils' public health staff will work with CCGs to ensure that services are commissioned on the basis of good evidence to prevent as well as treat disease and address local need.

4.2 Activities undertaken or commissioned by the Public Health Team will fall into one or more of the categories set out in Annex A. The list distinguishes between activities which are mandated – required by the Department of Health – and those over which Councils have discretion.

5. CONTRACTS TO BE TRANSFERRED TO LOCAL GOVERNMENT

5.1 In 2012-13, the Primary Care Trusts (PCTs) commissioned a wide range of public health services for Tri-Borough residents and visitors at a cost of £101 million.

5.2 Officers commissioned a detailed audit of these contracts before Christmas in order to decide which are primarily relevant to the new duties of the local authority, compared with those of the CCGs. Of the total spending on public health contracts, we can confirm that:

- 47 contracts (at a value of £23.9 million) will transfer to the local authorities and will be scheduled to continue into 2013-14 or beyond; and

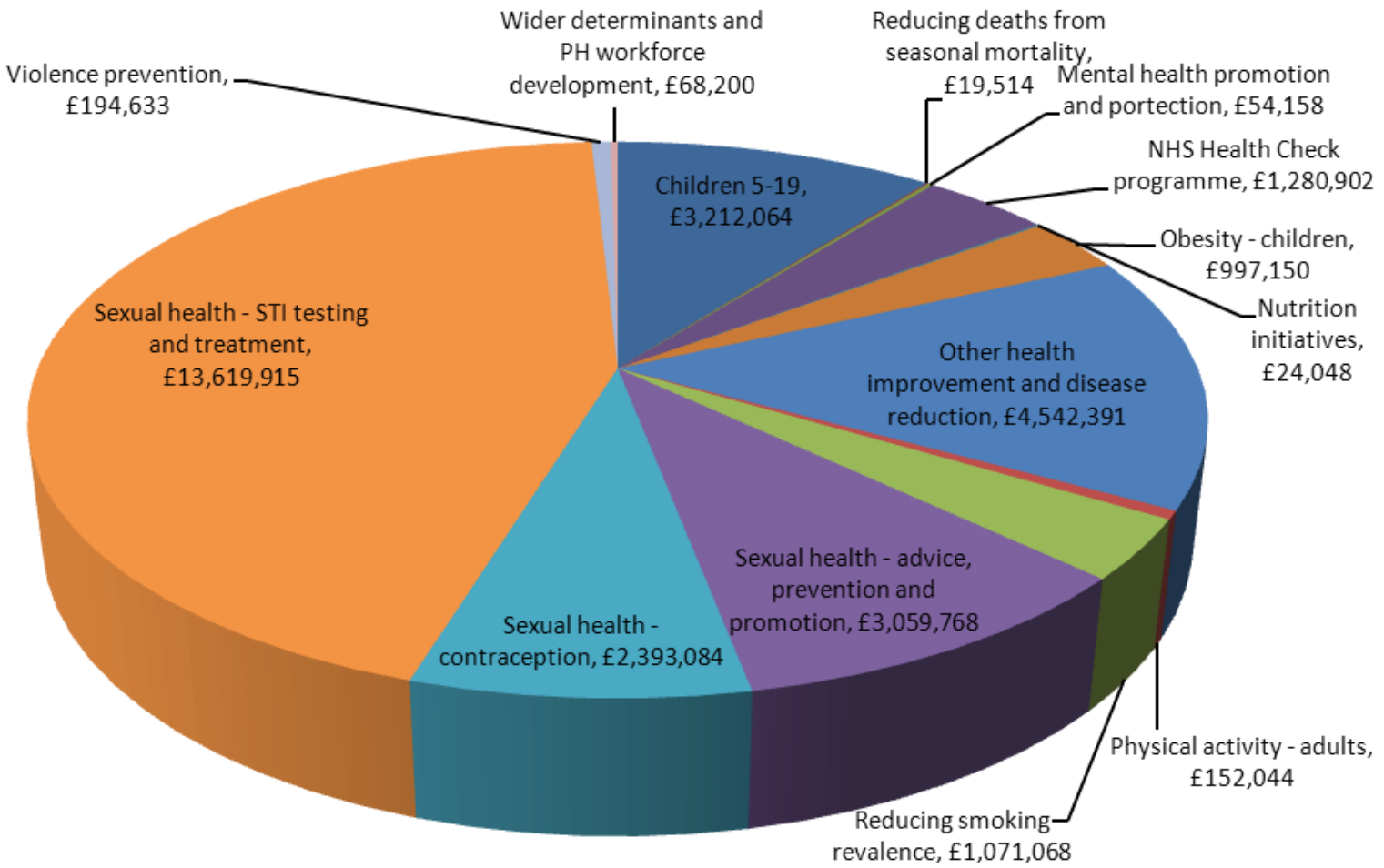
- a further 89 contracts (with a value of £6.7 million per year) fall within the local authorities' new public health duties, but will end on 31 March 2013.

5.3 Services to tackle substance misuse are currently managed by the Tri-borough Adult Social Care service.

5.4 Figure 1 (overleaf) summarises the value of Tri-borough public health contracts for 2012-13 (a total of £30,688,939) by function.

5.5 Decisions about whether to extend contracts due to expire on 31 March 2013 rest with the PCT. Officers have, however, secured an agreement with the PCT that no action will be taken on these contracts without the Council's agreement. Commissioners in the Public Health Team are in touch with the relevant providers to establish costs and, where appropriate, re-negotiate prices for 2013-14.

Figure 1: Value of public health contracts for Tri-Borough Councils, by function



6. FINANCIAL POSITION AND RISKS.

6.1. The Department for Health announced on 10 January 2013 that Tri-Borough Councils would receive £71.3 million in public health grant for 2013-14. This grant may not be used for purposes other than public health. It is proposed that these will be the only resources available for public health in 2013-14.

6.2. Figure 2 offers a measured assessment of the financial position, if PCTs were to extend all existing grants. It has been agreed by Finance officers in all three Councils. The assessment makes provision for a number of risks. These are set out briefly in the Exempt paper on this agenda, since the explanation uses information which is commercially sensitive.

Figure 2: Headline Public Health Budgets for 2013-14 (£k)

	WCC[1]	RBKC	LBHF	Total
	£k	£k	£k	£k
Grants	30,384	20,636	20,287	71,307
LA Funded (substance misuse)	1,008	1,182	236	2,426
Other income	1,166	74	826	2,066
Total income	32,558	21,892	21,349	75,799
Employee costs	1,467	1,156	1,068	3,691
Contracted services	30,227	20,089	19,073	69,389
Other costs	333	218	799	1,350
Total direct costs	32,027	21,463	20,940	74,430
Recharges	531	429	409	1,369

[1] The split of WCC's total income is subject to some further, minor change pending a review of relevant budgets. Any change is not expected to have an impact on the total amount receivable.

6.3. It is proposed that officers carry out a comprehensive review of all public health contracts in the first part of the new financial year, once the local authority has legal responsibility for expenditure. This review should take into account:

- the potential to make "back office" savings to protect front line services.
- potential to collaborate with neighbouring Councils in renegotiating contracts.
- the priority which should be given to ensuring continuity of mandated services.
- the relative effectiveness of particular interventions and whether there is sufficient evidence to put particular services on hold;

- the fit with existing council services and whether potential synergies could be better realised or managed

- the need to re-negotiate contracts where commissioners have some evidence that there is scope for efficiencies.

- the specialist or unique nature of services, where closure would leave Councils unable to meet their statutory duties, or where a provider's decision to wind up its business would damage the market and limit the Councils' opportunity to secure value for money in future;

- whether a break in service could lead to an immediate impact on public health.

6.4. If Members agree with these criteria, officers will prepare more detailed plans for the review to take place, beginning in April.

6.5. The Public Health team has work well in hand to re-negotiate large non-NHS contracts and is working with procurement experts on a timetable to reprocure those services - currently worth £8 million - during the course of 2013-14. This exercise reflects the scope to make efficiencies or concerns about the performance of the provider. The contract with CLCH will also be re-procured, given concerns about the costs of overheads. This process will need to be carried out jointly with the CCGs.

7. INITIAL OPERATING MODEL FOR PUBLIC HEALTH IN 2013-14

7.1. Cabinets have already agreed that Westminster City Council will host a Tri-borough Public Health function and that PCT staff will transfer to the employment of Westminster City Council. These staff will be managed and organised across Tri-borough functional portfolios and will not be allocated to individual boroughs. Each Cabinet will, however, retain responsibility for setting the budget for public health and for determining the way in which it should be spent.

7.2. Annex A includes an overview of the proposed team structure, its expected resources at 1 April and its main relationships with other organisations.

7.3. In total, 38 posts will move from Primary Care Trusts to local authority employment. This represents a reduction from 43.8 FTE in the previous PCT structures.

7.4. Detailed planning for the transfer of the Public Health team to Westminster City Hall is well-advanced.

- A programme of introductory meetings for staff is already under way, partly to familiarise PCT employees with the work of the Council, and partly to ensure that Council staff consider the links between their services and public health.

- Relocation to Westminster City Hall is planned in two phases. The Public Health Intelligence and Social Determinants teams will relocate from 4 March 2013, and remaining public health staff from 11 March. The Substance Misuse Services team currently operating through the Tri-Borough Adult Social Care Service will be based with the PH Service from 1 April 2013.

- Three consultants have been matched to the posts of Deputy Director of Public Health, and allocated to the three Councils with the agreement of the Chief Executives. Eva Hrobonova will be attached to Hammersmith and Fulham, Ike Anya to Kensington and Chelsea, and Helen Walters to Westminster.

- Information technology. The public health team will need to be connected to N3 in order to fulfil their functions. The current N3 connection at Westminster City Council, as provided by London Public Services Network (LPSN), will not have the capacity to meet requirements. A transitional solution will be for the public health Intelligence team to use an existing link between Westminster City Council and West London PCTs. The rest of the public health team will be able to use the existing LPSN 2MB N3 connection until a permanent 100mb solution has been procured and is in place by August.

8. DECISION-MAKING IN EACH COUNCIL

8.1. It is proposed that, in each Council:

- Cabinet should agree the priorities for public health, and a plan to achieve them. (This plan will, in part, help to deliver the relevant Health and Well Being Strategy). It should set out the framework for commissioning public health services in 2014-15 and beyond; the commissioning methodology; and any significant changes to the operating model (including resources) for public health.

- the Lead Cabinet member for public health will be responsible for scoping and developing these plans, commissioning work from the Public Health Team and other officers as necessary. Lead members will engage colleagues within their Cabinet on an informal basis. There will be links between public health and children's services, adult social care, finance, housing, planning, licensing, environment, leisure, libraries and sport.

9. THE MERITS OF A TRI-BOROUGH MEMBER STEERING GROUP

9.1. Some public health services already operate in all three areas through a joint contract with a single provider. If Tri-Borough is to achieve economies of scale and maximize its purchasing power, Cabinets may wish to explore the possibility of commissioning more services in this way.

9.2. It may help this process if the Director for Public Health were to prepare one annual report on the health of the people in Tri-Borough, rather than three separate reports. Clearly, the report would need to specify where and how public health and needs differ in each of the three authority areas. But it may also highlight common challenges which, in turn, may be tackled most effectively by some integrated or co-ordinated services across all three Councils.

9.3. Ultimately, Cabinets will need to be assured that any joint contracts are an effective way of meeting the public health priorities which each will set. And so it is not necessary to create a separate body to reach joint decisions.

9.4. It may, however, be helpful to establish a Tri-Borough Member Steering Group for public health. Informal discussions in this forum would help:

- ensure that there is practical collaboration across the three Councils where there are common needs and objectives;
- establish where the co-ordination of front line services is in all three Council's best interests;
- offer helpful peer review and challenge, particularly to ensure that the service is managed in a way which secures the best value for money.

9.5. Following the precedents set in Adult Social Care, the steering group might meet every six weeks, attended by the three lead members for public health and others as invited.

9.6. With or without a steering group, a Tri-borough agreement for Public Health is required and is currently being drafted by officers. Each authority will retain statutory responsibility for the exercise of its public health functions. The main principle underpinning the agreement is that of sharing staff using Section.113 of the Local Government Act 1972. Under this section, staff of one authority can be treated as the staff of another for the purposes of their statutory functions as opposed to a commercial arrangement whereby one authority provides professional services to another.

9.7. This mirrors the approach taken in Adult Social Care and Children's Services. In practice, this means that Westminster City Council (as the host borough) will employ the Director of Public Health and other public health staff and they will be

made available under the Section 113 agreement to the three boroughs accordingly.

10. OPERATIONAL MATTERS

10.1. The Public Health team have to date been commissioning services using one set of HR and Finance systems through the shared support service used by the three Inner North West London PCTs. They have also been operating within one set of procurement rules. This is viewed as being an efficient way to operate.

10.2. Following transfer to Tri-borough, some of this efficiency can be replicated from the start with employee costs and expenses flowing through Westminster City Council's HR and Finance systems and being recharged to the other two boroughs. In addition, procurement decisions can largely be managed through Westminster's procedures with only the final contract award decision needing to go through three different processes according to local borough schemes of delegation in order to respect sovereignty.

10.3. At present, Tri-borough will not, however, be able to replicate the efficiency of contract costs being processed on one set of financial systems in the first year of the transition. For a variety of technical reasons, such as financial reporting and VAT recovery on external contract costs, it is on balance more efficient for contracts to be transferred to, and directly held by, the boroughs they relate to and for payments to be processed through the local borough financial systems rather than through Westminster's. This is how the other Tri-borough services have operated since April 2012.

10.4. From 1 April 2014, this inefficiency will be removed with the implementation of Athena Managed Services. The three boroughs will share one set of HR and Finance systems from this date. This will return the Public Health team to the position they were in when using the INWL shared support services.

10.5. A Tri-borough agreement is currently being drafted. This will set out the various responsibilities of the three Councils in operating the Tri-borough Public Health service.

10.6. Westminster will host accountancy support for the Public Health team as well as providing other corporate support such as HR, office accommodation, legal services and communications. The cost of these services will be shared across the three boroughs on the basis of the NHS capitation calculations (largely driven by population).

10.7. Members may wish to consider at a future point if they wish to operate any pooled budget arrangements for Public Health contracts. This will be explored further through the re-commissioning work that is planned to take place during 2013/14.

10.8 It is necessary to embed the new public health functions into all the existing activities. Part of that process requires the Director of Public Health to have sufficient delegated authority, similar to those of other Chief Officers, to carry out their duties on behalf of the Council. Full Council approved the delegations on 29 February 2013, a copy of which is set out at Annex B.

11. PLANNING BEYOND 1 APRIL 2013

11.1. Having secured a safe landing for the public health function within Tri-Borough, it is proposed to undertake a programme of work comprising:

(a) devising the framework which the Public Health team will use to carry out a full review of all public health contracts during 2013-14 and re-commissioning of services as necessary. **Beginning in April**.

(b) a comprehensive analysis of way in which Council services can help to improve and protect public health and, therefore, the opportunities which the transfer of public health responsibility creates for Tri-Borough. We plan to do this through a process of engagement at different levels of management and at the front line, across Tri-Borough. Work is already under way to familiarise new staff with Tri-Borough services, and ensure that existing staff understand how this new function relates to their own work. We will report back on the results of initial workshops and ideas for further work by **the end of May**.

(c) an assessment of the priorities for public health in each of the Councils, taking into account the results of (b) and the JSNA. **By July**, for consultation.

(d) a mid-year review of public health commissioning, with recommendations about managing performance for the second half of the 2013-14 year and for re-commissioning in 14/15. The review should include an updated assessment of the headroom and contractual flexibility in each of the three authorities to move towards newly established priorities in-year, where desirable. **By mid-September.**

(e) a framework for commissioning in 2014-15 against the new priorities. **By October**.

(f) preparation of Commissioning Intentions, for consultation, **by November.**

(g) a detailed review of the public health operating model and resources, in the light of six months' experience, tri-borough developments (including plans to introduce managed services) and decisions about commissioning priorities. This review should include non-commissioning activities (such as providing

public health advice to CCGs) and will also need to reflect any changes to the role of Director of Public Health initiated by the Department of Health. It will need to engage both officers and members in giving feedback about the current approach, risks and likely pressures in future. **By December**.

12. LEGAL IMPLICATIONS

12.1 The Health and Social Care Act 2012 has made major changes to the National Health Service Act 2006, to reform the NHS. In relation to public health functions, the Act allows the Secretary of State to make Regulations requiring local authorities to exercise public health functions. Details of the Regulations are still awaited.

12.2 Authorities are also to be required to appoint, jointly with the Secretary of State, a Director of Public Health to be responsible for the discharge of public health functions. Each borough is, in accordance with its own Governance arrangements, currently progressing this appointment.

12.3 In the transition period to the transfer of functions in April 2013 PCT clusters are required to identify public health spends, contracts which have been commissioned to deliver public health functions and staff engaged in public health work, in preparation for the transfer. It is expected that Transfer Orders will be made by DH identifying staff and contracts transferring to local authorities. This process is being closely monitored and any issues or difficulties arising which may have financial consequences will be reported to Cabinet in due course.

12.4 Implications verified/completed by: Tasnim Shawkat, Director of Law 020 8753 2700

13. EQUALITY IMPLICATIONS

13.1 Equality impact assessments have been carried out:

- by the National Health Service in relation to the transfer of their current employees to the Councils

- by the Department of Health, in relation to the allocation of public health grant to local authorities

13.2 A balanced budget will be set in relation to public health. An Equality Impact Assessment will accompany recommendations about the Council's priorities for public health and changes to their commissioning intentions from 2013-14 onwards.

14. COMMUNICATIONS

14.1 The Councils will want to establish a clear public narrative about the opportunities created by the transfer of public health duties to the local authority, the pressures on grant across the health and social care portfolio, and the need to focus rigorously on priorities. The narrative will help to make it apparent to service providers and other stakeholders that commissioning intentions are likely to change as public health duties transfer to the three Councils.

15. FINANCIAL AND RESOURCES IMPLICATIONS

15.1 The Executive Director of Finance and Corporate Governance has been consulted and concurs with the proposals in this report.

15.2 The transfer of the public health function from the local PCTs to the Tri-borough councils is not risk free financially. Budget provision has been made for known commitments but further commitments may come to light once the service has transferred. This risk will need to be monitored carefully during the year.

15.3 The contracts transferring to the councils also bring their own risk. In particular, the sexual health contract is very volatile and difficult to control. Again, demand for this service and its associated cost will need to be monitored closely.

15.4 It is estimated that H&F has funds of approximately £600,000 available from within the current public health funding as a contingency against new commitments or increased demand materialising.

15.5 Implications verified/completed by: Jane West, Executive Director of Finance and Corporate Governance, 020 8753 1900

16. PROCUREMENT IMPLICATIONS

16.1 The Director of Procurement and IT Strategy concurs with the proposals in this report.

16.2 Implications verified/completed by: Jackie Hudson, Director of Procurement and IT Strategy, 020 8753 2946

LOCAL GOVERNMENT ACT 2000

LIST OF BACKGROUND PAPERS USED IN PREPARING THIS REPORT

No.	Description of Background Papers	Name/Ext of holder of file/copy	Department/ Location
	Health & Social Care Act 2012 (published)	Melanie Smith, Tri-borough Director of Public Health	

ANNEX A

PROPOSED OPERATING MODEL FOR PUBLIC HEALTH ON 1 APRIL

Statutory responsibilities

A1. The Triborough Councils will have public health duties in all three domains of public health:

- Health improvement. This involves creating opportunities and removing barriers so that individuals, families and communities take positive action to maintain and improve their health through physical activity and diet (etc) as well as action to address the social determinants of health such as the built environment and worklessness

- Health protection. The Council's current responsibilities in protecting the health of the local population from threats to health will be expanded and enhanced by their employment of public health specialists who can draw upon the expertise of Public Health England.

- Health care public health. The Councils' public health staff will work with CCGs to ensure that services are commissioned on the basis of good evidence to prevent as well as treat disease and address local need.

Overview of public health functions

A2. Activities undertaken or commissioned by the Public Health Team will fall into one or more of the following categories:

Mandated functions

- Sexual health services – STI testing and treatment
- Sexual health services – contraception
- NHS Health Check programme
- Local authority role in health protection
- Public health advice
- National Child Measurement programme

Non-Mandated Functions

- Sexual health services – advice, prevention and promotion

- Obesity – adults
- Obesity - children
- Physical activity – adults
- Physical activity – children
- Drug misuse – adults
- Alcohol misuse – adults
- Substance misuse (drugs and alcohol) – youth services
- Reducing smoking prevalence
- Children 5 – 19 public health programmes
- Non mandatory elements of the NHS Health Check programme
- Nutrition initiatives
- Health at Work
- Accident Prevention
- Mental health promotion and protection
- Other health improvement and disease prevention activities
- Violence prevention
- Dental public health
- Fluoridation
- Local authority role in surveillance and control of infectious diseases
- Information and Intelligence
- Public health spend on environmental hazards protection
- Local initiatives to reduce excess deaths from seasonal mortality
- Wider determinants and PH workforce development

How the Council will be held to account

A3. To date, the only information on performance management issued by the Department of Health is the set of grant conditions published on 10 January 2013. These cover how the grant may be spent and the activities on which it may be spent. The Councils will be required to report spend against the categories above.

Relationship of PH plan to Health and Well-Being Strategy

A4. The Health and Social Care Act (2012) requires local authorities to set up Health and Well-being Boards (HWBs). Although authorities may share HWBs, Tri-borough councils have determined to establish separate boards. These are well established in shadow form.

A5. The minimum membership of the HWB is defined in the Act and includes Adult Social Care, Family and Children's Services, the CCGs, HealthWatch as well as public health.

A6. The remit of a HWB is to produce a Joint Strategic Needs Assessment and a Health and Wellbeing Strategy as a framework for commissioning by members of the Board. In this way, the HWBs will oversee commissioning of health and social care (both adults and children) and public health services.

A7. Boards may choose to take a broader remit than this. But the Councils' public health responsibilities will only ever form a part of the Boards' remits. There may be public health activities (for example those which do not impact on partners) that will be outside the Boards' remits.

Resources

A8. The ring fenced grant for the public health service will be (for 13/14)

WCC (£k)	RBKC (£k)	LBHF (£k)
30,384	20,636	20,287

A9. In addition the transfer of substance misuse commissioning from ASC to public health will result in the following LA funding transferring

WCC (£k)	RBKC (£k)	LBHF (£k)
777	1182	676

A10. The public health team will comprise:

- 38 posts transferred from the NHS
- 10 SMS posts transferred from Adult Social Care

Team structures:

A11. The Public Health function will be led by the Director of Public Health, reporting to the Chief Executive of Westminster City Council (as a line manager), accountable to both CEOs for the delivery of the public health plan in each borough, and supported by three Deputy Directors, one for each borough. Each of the Deputy Directors is a consultant in public health and will sit on the Boards of the CCGs in his or her borough. Each of the three consultants will have a functional portfolio which will span all three boroughs and will manage a team to deliver it. These portfolios are:

Social determinants and public health intelligence

This team covers public health intelligence & knowledge management. It will also work across the councils providing public health advice in relation to work, housing, planning and regeneration, crime and violence. It will also work to develop public health skills in the non-specialist public health workforce.

Public Health Families and Children

As well as a focus on family and children, including the commissioning of school nursing and the healthy schools programme, this team will lead on early years nutrition, the promotion of healthy weight, third sector and community engagement and mental health protection and promotion.

Behaviour change and health protection

This team will commission a range of services to support behaviour change, including the health check programme, as well as delivering the Councils' responsbilites for sexual health and health protection, including assurance of infection prevention, screening, immunisation and health EPRR arrangements.

A12. Business support has been centralised and will manage the relationship with CCGs and Public Health England as well as managing the delivery of the public health work programme. The team will also act as the link with governance and member services.

External dependencies

A13. In order to fulfill the Council's duties the public health team will need to work closely with:

- Central London, West London and Hammersmith and Fulham CCGs
- Public Health England
- DH
- National Commissioning Board
- Service providers in the NHS, independent and third sector
- Faculty of Public Health
- Association of Directors of Public Health

ANNEX B

DRAFT DELEGATED AUTHORITY TO THE TRI-BOROUGH DIRECTOR OF PUBLIC HEALTH

B1. To be authorised to agree expenditure on relevant public health budgets subject to each Tri-Borough Council's constitution. Such authority can be delegated in writing to others.

B2. To lead on personnel decisions, including recruitment, appraisal and disciplinary decisions, subject to the City of Westminster's internal procedures only.

B3. To report to the Chief Executive and relevant Cabinet Councillors and relevant Scrutiny Committee. To provide policy advice, if requested, to any political party represented on any of the participating councils.

B4. To exercise the statutory functions of the Director of Public Health. These responsibilities may be delegated in writing to named public health consultants in each borough.

B5. To report to each Council's Chief Executive on the performance of the function and to support the accountability of the chief Executive for grant expenditure.

B6. To ensure that each participating authority has up-to-date plans, meeting statutory requirements and the demands of good practice.

B7. To be the officer responsible for leadership, expertise and formal advice on all aspects of the Public Health Service.

B8. To provide advice to the public in any period where local health protection advice is likely to be necessary or appropriate, in conjunction with each Council's communications team.

B9. To promote action across the life course, working together with local authority colleagues such as the Executive Director of Children's Services and the Executive Director of Adult Social Care and with NHS colleagues.

B10. To work through local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health.

B11. To work with local criminal justice partners and Police and Crime Commissioners to promote safer communities.

B12. To work with the wider civil society to engage local partners in fostering improved health and wellbeing.

B13. To be an active member of the Health and Wellbeing Board, advising on and contributing to the development of joint strategic needs assessments and joint health and wellbeing strategies and commission appropriate services accordingly.

B14. To take responsibility for the management of their authority's public health services with professional responsibility and accountability for their effectiveness, availability and value for money.

B15. To play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children Board.

B16. To contribute to and influence the work of NHS Commissioners, ensuring a whole system approach across the public sector.