HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Cabinet
Date:	26 March 2012
Title:	Public Health Transition
Reference:	3791
Report From:	Chief Executive

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1. Executive Summary

1.1. The Health & Social Care Bill gives local authorities new duties in relation to the responsibility for promoting and protecting the public's health which includes the transfer of the specialist public health staff to provide professional leadership from the NHS to local government with effect from April 2013 (subject to the passage of the Bill).

1.2. The purpose of this paper is to outline the extent of the public health responsibilities and functions that will transfer to Hampshire County Council in or by April 2013, outline how the function currently operates including its finance, people and performance and to understand what the opportunities, impact and issues are for the County Council.

2. Contextual information

2.1. As a key part of the overall NHS reform programme, the proposals for the transfer of public heath are intrinsically linked with the establishment of Clinical Commissioning Groups (CCGs), the role of the Health and Wellbeing (H&WB) Board as the one place where all partners will come together to address all aspects of the health and wellbeing of the local population, the development of a Joint Health & Wellbeing Strategy (JHWBS) informed by a Joint Strategic Needs Assessment and wider relationships with other partners in the health economy.

2.2. Local councils have worked closely with public health colleagues for many years and all tiers of local government deliver some services to address the wider determinants of health in their population. The wholesale transfer of responsibility for the management and delivery of public health will provide a

real opportunity for the County Council to significantly increase its influence on the health of Hampshire residents.

2.3. Despite the obvious opportunities that it brings, the shift in responsibilities also has some risks. The transfer will impact on the Council as a whole and will therefore require careful management. All departments will need to understand their role in and contribution to public health. Clearly it will be essential for Members to fully understand the new responsibilities that will transfer to the County Council and the scope of decision making.

2.4. Guidance on “Public Health in Local Authorities” was published in December 2011 setting out the expectations and requirements for the way in which public health services will be delivered including a list of specific, mandatory services which the local authority will be required to commission. A list of these services is attached at Appendix 1. This includes the Director of Public Health (DPH) having a specific responsibility, as well as oversight responsibilities, within the health protection domain for emergency health planning, co-chairing the Local Health Resilience Partnership in relation to health screening, immunisation and infection control.

2.5. The Public Health Outcomes Framework was published in January providing the Government’s overarching vision for improving the public’s health along with the key outcomes and proposed indicators to measure progress.

2.6. The new system is expected to be in place for the start of April 2013, subject to the passage of the legislation, although it is recognised that some local authorities may wish to make faster progress and effect some of the transfer earlier. Each upper tier local authority is required to produce a transition plan, jointly with the PCT cluster and Director of Public Health (DPH), setting out how it will take on the new duty to improve the health of its local population and detailed plans for the transfer of the current service from the NHS. Further guidance has been produced both by the Department of Health and the Local Government Association (LGA) to inform the transition planning process.

3. Public Health – the service

3.1. The Faculty of Public Health defines public health as ‘The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society’ (Sir Donald Acheson,1988). Despite some £60m of spend being attributed directly to the Public Health Department within Hampshire PCT, most of the work of the DPH and the team relates to working with and influencing the activity and spend of the PCT itself and a range of partners who have budgetary responsibility extending beyond £1bn per annum.

3.2. The main functions of Public Health relate to 4 domains:

- Health improvement (including peoples’ lifestyles as well as inequalities in health and the wider social influences on health)
- Health protection (including infectious diseases, environmental hazards, disease/injury prevention and emergency preparedness)

- Health and social care commissioning (including quality, service planning, efficiency, audit and evaluation)
- Public health intelligence and knowledge management, which underpin all these.

3.3. The current service includes 29 staff and is based at Hampshire PCT headquarters in Eastleigh. The structure has changed over the last year as discussions have continued as to which areas of the service will become the responsibility of CCG's, the NHS Commissioning Board (NHSCB) or Public Health England (PHE). However, there remains some lack of clarity about how these new bodies will operate in relation to public health and the structure therefore is still subject to some further change/fine-tuning.

3.4. The public health financial resource currently held in the PCT cluster, which includes the budgets for staff and commissioning, will transfer to three different bodies: the County Council, the NHSCB and PHE. In preparation for this transfer the Hampshire PCT public health budget has been held at the budget agreed for 2010-2011 for the current financial year. It should be noted that the DPH, as a statutory PCT Board member also has a responsibility for the main PCT budget and, per paragraph 3.1 is actively engaged in influencing other commissioning activity and spend.

3.5. In September 2011 a finance submission was jointly prepared by the County Council and the PCT for the Department of Health indicating a total of close to £60m across the three future "homes". Within this the amount likely to transfer to the local authority was identified as around £29m. Close to £2m of this is spent on the professional public health leadership and staff capacity. The remaining sum is almost entirely spent on commissioning with nearly 2/3rds of the direct spend covering Sexual Health and Alcohol and Drugs health care and preventative services. These services have a clear connectivity to the County Council including work to reduce teenage conceptions and cross-cutting community safety work and thus the transfer to the local authority and direct control over these budgets will reinforce the opportunities to make further improvements in these areas.

3.6. The projected transfer of around £30m to the NHSCB will require strong relationships to be maintained in order that spend and services continue to be influenced and the DPH will retain an oversight of services to ensure quality. This will be important, as this funding relates to the provision of key public health functions that affect Hampshire residents including public health services for children (0-5), screening programmes and immunisations services. The oversight role will be reinforced by the role of the Health and Wellbeing Board.

3.7. The Secretary of State for Health announced in January an overall ring-fenced budget for public health of £5.2bn from April 2013 with specific allocations to councils to be based on 2012/13 spend and totalling around £2.2bn. Further details of indicative allocations were announced for comment on 7 February and for Hampshire this shows a 2010/11 baseline of £26m and an uplifted 2012/13 allocation of £28m. While these figures remain indicative at this stage, discussions are continuing with the Strategic Health Authority and the PCT to understand and reconcile the final figures.

3.8. Recent performance reporting to the SHIP cluster Board shows overall performance and areas for improvement with specific action plans. See attached Appendix 2. Work is underway to better understand the current public health work programme, commitments and performance in the context of the specific responsibilities that are due to fall to local authorities from 2013/14.

3.9. Additionally, it will be important to ensure that the performance measures and targets used for public health are incorporated into the County Council's Open for Business framework and the Head of Performance & Partnerships has begun working with the Public Health team to gain a better understanding of the key measures and mechanisms. It should also be noted that the DPH will retain some joint reporting requirements, including to PHE, and will be required to produce an annual report on the health of the local population.

4. Public Health – the changes

4.1. The shift of responsibility to the County Council provides a real opportunity to improve health outcomes for Hampshire residents. This in turn can support a move towards a preventative agenda, helping to slow down cost pressures on adult social care and the wider NHS and maximise lifelong health outcomes for children and young people .

4.2. The changes will also increase the Council's ability to be influential at the local community level and the new set of responsibilities will ensure that we are best placed to take a strategic leadership role in:

- Tackling the causes of ill-health and reducing health inequalities;
- Promoting and protecting health;
- Promoting social justice and safer communities.

4.3. It will be important to also understand and manage the risks and potential reputational issues. A lot will depend on how well the function is integrated and how it relates to the role and support of other County Council directors and departments. In relation to the overall NHS reforms and changes, it will also be important to ensure effective relationships are maintained and/or further developed with a range of partners including CCGs, District Councils and the VCS.

4.4. An amendment to the Health and Social Care Bill has been put forward to establish the role of the DPH as a statutory Chief Officer role in local authorities in the same vein as Directors of Children's and Adult Services. The County Council will need to ensure that the leadership issues in relation to public health, and health issues more generally including the management of the H&WB Board, are robust especially as Government has signalled that it expects local authorities to put health at the heart of everything they do.

4.6. To make sense of existing Chief Officer responsibilities, the Chief Executive has agreed that an interim management group comprising the Director of Children's Services, the Director of Public Health and the Assistant Chief

Executive and chaired by the Director of Adult Services, will meet on a regular basis to:

- Help manage the transition and embed Public Health within the County Council
- Develop the management arrangements around the Health and Wellbeing Board.

This creates sufficient management capacity in relation to the current position and pace of change and opportunities that emerge.

4.7. There will be opportunities to do things differently as a result of the transfer and the associated issues of possible duplication or overlap, and improving efficiency will need to be considered alongside the potential risks to delivery and the need to retain specialist skills. Work is being undertaken through a desk top exercise to consider the extent to which the County Council's existing services relate to the outcomes in the published framework, and per paragraph 3.8 to better understand the content and the impact of the current public health work programme. Further work with Departments will help to develop this picture.

4.8. Public Health England (PHE) will be established nationally in order to protect and improve the health and wellbeing of the population and to reduce inequalities in health and wellbeing outcomes. PHE will consist of three main business functions:

a) Delivering services to national and local government, the NHS and the public;

b) Leading for public health; and

c) Supporting the development of the specialist and wider public health workforce.

4.9 PHE will have a central national office with four regional hubs and a number of local units (currently 26 which are described in legislation). The precise detail of the operational delivery will be developed over the coming months.

5. Planning for Transition

5.1. The proposals set out in the planning guidance cover many of the key issues for both the PCT cluster and local authorities in relation to the transfer. For 2012/13, as part of their overall integrated plan, each PCT cluster must have a set of comprehensive plans that support a robust transition to the new public health system. PCT clusters will be expected to work more closely with local authorities in delivering the transition plan with local government taking on an increasingly active and leading role in ensuring a robust transition.

5.2. Although the PCT cluster will be accountable for initiating planning for transition, the plans will need joint development and agreement with the respective local authorities and, for those elements that affect future NHS commissioning arrangements, should involve emerging CCGs. Specifically,

the CCGs will need to be involved in agreeing local arrangements with local authorities for the "core offer" of public health advice.

5.3. The planning guidance provides a checklist for the transition process setting out the responsibilities of the local authority, the PCT cluster and the DPH. In particular the guidance sets out the key milestones that the PCT cluster will need to achieve in partnership with the local authority including agreeing an approach to the development and delivery of the local public health vision, agreeing arrangements for local authorities to take on public health functions and developing a communication and engagement plan.

5.4. The NHS has identified six key workstreams for inclusion in the transition plan:

- Ensuring a robust transfer of functions, systems and services
- Delivering Public Health responsibilities during transition and preparing for 2013/14
- Workforce
- Governance
- Enabling Infrastructure
- Communications and engagement

5.5. There are two main categories of risk associated with transition that it will be important to manage. The first is related to the processes around actual transition i.e. of staff etc. The second relates to the need to maintain continuity of service delivery during the transition year and in preparing for 2013.

5.6. Key areas of focus during the transition year will be around information sharing/data transfer, IT compatibility and procurement and contracting issues. The DPH has recognised the importance of focussing on building on the relationships with CCGs and developing the "core offer" to ensure influence on spend and service delivery.

5.7. There is a significant amount of work to do in terms of the physical transfer of staff including understanding existing NHS terms and conditions and consulting and working with the DPH and the team on the timing and key milestones for the transfer.

5.8. In light of the concerns that have been raised nationally, a 'Concordat' has been published which provides the good practice against which contract transfers will need to be managed from the NHS to the local authority. Public Health specialists in the NHS are employed on standard NHS "agenda for change" and "Medical Consultant" contracts and how these terms and conditions are reflected into local government is the focus of discussion between the respective HR Directors. The DPH is also working with the HR Directors on refinements/a re-shaping of the existing public health structure in an attempt to ensure it is as fit for purpose as it can be prior to the transfer being initiated.

5.9. Good progress has been made to this point in terms of preparing for, and implementing the public health transfer to the County Council. A transition plan has been developed which identifies the key workstreams required to

achieve a seamless transfer. A summary of the plan including key milestones needed to take the work forward is attached at Appendix 3.

6. Conclusion

6.1. The Health and Social Care Bill provides for the transfer of the public health function from the NHS to local government within a raft of significant NHS reforms. The responsibility for public health offers a real opportunity for the County Council to reinforce the integration of health services for the benefit of the Hampshire community and to deliver tangible health and wellbeing outcomes in an era of reducing financial resource. It will be important that the public health changes, opportunities and issues are managed in the wider context of the NHS reforms.

6.2. The changes do present risks, especially reputational ones, which will require careful management. There are a number of issues to be addressed over the coming months in order to ensure a smooth transition of the overall public health resource whilst maintaining a continuity in the delivery for this key service. In particular there are still some elements of uncertainty where further clarification and confirmation is expected from the Government.

6.3. The relevant reporting relationships for all organisational arrangements will be reported to Cabinet through future updates of the Corporate Services Review.

7. Recommendation(s)

7.1. That Cabinet note the issues and timescales for the transfer of public health from the NHS to the County Council.

7.2. That Cabinet approves the transfer arrangements set out in Appendix III and that the Chief Executive report further on the integration of public health with other Council policies and services.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	Yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	Yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Other Significant Links

Links to previous Member decisions:		
Title	Reference	Date
Update on the NHS reforms and plans for the new Health and Wellbeing Board	2541	28 March 2011
HCC response to the ‘Equity and Excellence: Liberating the NHS’ White Paper consultation	1998	27 September 2010

Direct links to specific legislation or Government Directives	
Title	Date
Health & Social Care Bill 2011	

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

1.1. A full impact assessment will be considered when the legislative basis for the proposals is finalised later in 2012. The Government carried out a full impact assessment of the proposals (see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123583)

2. Impact on Crime and Disorder:

2.1. Aspects of the proposals in relation to the commissioning and delivery of NHS and other health and social care services will impact on crime and disorder issues including, for example, drug and alcohol services and domestic violence. This will be covered in the impact assessment.

3. Climate Change:

a) How does what is being proposed impact on our carbon footprint / energy consumption?

   None

b) How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

   None

Appendix 1: List of public health responsibilities

- tobacco control and smoking cessation services
- alcohol and drug misuse services
- public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)
- the National Child Measurement Programme
- interventions to tackle obesity such as community lifestyle and weight management services
- locally-led nutrition initiatives
- increasing levels of physical activity in the local population
- NHS Health Check assessments
- public mental health services
- dental public health services
- accidental injury prevention
- population level interventions to reduce and prevent birth defects
- behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- local initiatives on workplace health
- supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes
- comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)
- local initiatives to reduce excess deaths as a result of seasonal mortality
- the local authority role in dealing with health protection incidents, outbreaks and emergencies
- public health aspects of promotion of community safety, violence prevention and response
- public health aspects of local initiatives to tackle social exclusion
- local initiatives that reduce public health impacts of environmental risks.

Appendix 2: Public Health Indicators

New data

SHIP Focus - Public Health Indicators					
	Public Health Indicators	**Data Period**	**NHS H**		
			Target	**Actual**	
Lifestyle	Smoking Quitters	Q2 11/12	1834	1849	↓
	Alcohol-related hospital admissions per 100,000	Q1 11/12	1237	1383	↓
	Coverage NHS Health Checks (offered)	Q2 11/12	7.2%	6.4%	↓
	Coverage NHS Health Checks (received)	Q2 11/12	1.8%	2.1%	↑
Sexual Health	GUM Access	Oct-11	98%	100%	→
	Chlamydia Screening	Q2 11/12	35% year 12.25% Q2	12.0%	↑
	Teenage Conception Rate	2009	22.87	28.9	↑
Children & Young People	Breast-Feeding at 6-8 Weeks (prevalence)	Q2 11/12	50.82%	46.6%	↑
	Childhood Obesity - Reception Year	Academic Yr 2010/11	9.62%	7.1%	↑
	Childhood Obesity - Year 6	Academic Yr 2010/11	16.55%	15.6%	↑
	Maternity Access 12wk assessment	Q4 10/11	90%	93.5%	↓
	Number of Health Visitors	Dec-11	127.6	118.86	↓
Childhood Immunisations	DTaP/IPV/Hib (age 1)	Q2 11/12	95%	95.3%	↓
	PCV booster (age 2)	Q2 11/12	95%	91.1%	↓
	Hib & MenC booster (age 2)	Q2 11/12	95%	91.8%	↓
	MMR (age 2)	Q2 11/12	95%	91.7%	↓
	DTaP/IPV - 1st booster (age 5)	Q2 11/12	95%	89.8%	↓
	MMR - 2nd dose (age 5)	Q2 11/12	95%	87.6%	↓
	HPV Doses 1,2 & 3 (age 12-13)	Sep-11	90%	75.7%	↓
	School leaver boster (age 13-18)	Mar-11	90%	62.2%	↑
Screening Coverage	Breast cancer screening (ages 53-64 and 65-70) in last 3 yrs	Q4 10/11	70%	80.0%	→
	Cervical cancer screening 2 weeks test result	Dec-11	98%	99.0%	↓
	Bowel Cancer Screening extension	Q3 11/12	22%	77.4%	↑
	Breast Cancer Screening Age extension	Q2 11/12	8%	55.6%	↑
	Diabetic Retinopathy screening - % offered	Q2 11/12	95%	98.3%	↑

The arrow denotes peformance direction since the last reporting period

Improved	↑
Stayed the same	→
Declined	↓

Area	Indicator Description	Actions Being Taken to Improve Performance and By When	When Will These Actions Take Effect?	Reporting Period
Lifestyle	NHS Health Checks (offered)	A new risk to the delivery of the NHS Health Checks coverage target has been identified resulting in fewer offers being processed than expected. A plan has been put in place to mitigate this through a catch up to ensure delivery by year end.	Mar-12	Sep-11
Staying Healthy	Chlamydia Screening	PCT has commissioned providers in 2011/12 to deliver 22.4% (33,904 screens), plus approximately 4,000 non GUM/NCSP screens which can be counted towards the target. We expect to achieve an end of year total of 25% (national target is 35%)(12.25% achieved at Q2). Plans are being implemented to commission an integrated model of sexual health services from January 2012 which will release resource to commission the full 35% target. Once the 2012/13 target is known, we will review plans to commission and deliver this.	2012/13	Sep-11
Staying Healthy	Teenage Pregnancy	Performance continues to improve, current rate is the lowest since the strategy began in 1998 (20% reduction). Annual partnership action plans have been updated to continue to progress towards achieving further reductions in teenage conceptions. This is monitored quarterly. NHSH leads on: redesign of sexual health services (improve access to contraception including outreach services); development of more enhanced sexual health services in community pharmacy and general practice; work with termination of pregnancy and maternity providers to ensure under 18s are referred for fast-track contraception/outreach services as well as supporting the local healthy schools programme. 2010 data is expected imminently.	Ongoing	2009
Children & Young People	Numbers of Health Visitors	December 2011 position (118.9 actual vs 127.6 plan) represents slight deterioration against November 2011 position and plan. Recovery plan is in operation, and recruitment is on track. Currently there are 4.24 WTE due to start between Jan & Mar 2012. There is a 0.48 WTE at the short listing stage and this person should be in post before the end of March 12, but this will depend on CRB checks. 1.75 WTE are at the interview stage and these staff should be in post by March 12, again depending on CRB checks. Other vacancies are currently out to advert.	31-Mar-12	Dec-11
Public Health	Breastfeeding at 6-8 weeks	Recovery plan in place. Key Performance Indicators specified in the 2011-12 provider contracts, and performance management meetings are in place for providers with poor performance. Southern Health (Health Visiting Service) has agreed an action plan to improve performance based on full implementation of "Baby Friendly Initiative Standards". Plan reported and monitored at monthly contract meeting. Additional BF support services commissioned for low rate areas working with partners (Children's Centres and the voluntary sector). Development of multi-agency BF networks in localities to promote BF pathways and services. An action plan has been agreed with the provider (Southern Health) to provide assurance around data collection across Quarters 3 and 4. Quarter 3 collection is currently in progress - final position to be confirmed by 17 January 2012.	2011-2013	Q2 2011/12

Appendix 3: Public Health Transition Milestones

Ensuring a robust transfer of functions, systems and services
Agree transition milestones for 2012/13
Establish joint project group inc workstream leads to implement and oversee transition
Establish consistent criteria for workstreams to enable progress reporting
Understand correlation between current work programme and future County Council responsibilities
Agree that HCC will deliver public health responsibilities and establish a DPH to enable sign off of final transition plan by DH through SHA Cluster?
Develop draft prospectus and confirm PH core offer to CCGs & NHS CB
Agree overall vision and strategy for Public Health inc 3 year strategy
Implement IT support programme for transferred staff
Implement procurement support programme for transferred staff
Implement accommodation support programme for transferred staff
Implement HR support programme for transferred staff
Delivering Public Health responsibilities during transition and preparing for 2013-14
Produce 12/13 public health business plan including arrangements for HCC to take on more responsibilities
Agree process for recruitment to critical vacancies during transition
Finalise update of Joint Strategic Needs Assessment to inform Joint Health and Wellbeing Strategy
Produce Joint Health and Wellbeing Strategy (dependent on JSNA)
Develop work plans for ongoing delivery of critical and mandated public health services
Develop plan for transition of the commissioning of each public health programme to future national host, primarily: PHE; NHS CB (see Public Health in Local Government factsheet DH, commissioning responsibilities for full list)
Understand in detail all current contractual commitments of PCT
Develop plan for transition of the commissioning of each public health programme to HCC
Agree arrangements for handover of contracts (dependent on plan for transition of commissioning responsibilities and analysis of contractual committments)
Encourage close working between PCT and LA staff
Maintain PH relationship with districts and other local authorities during transition, seeking other sharing opportunities
Adapt NHS public health reporting systems to integrate with HCC performance monitoring to ensure all PH targets and trajectories to be delivered are maintained during transition (monthly reports)
Follow DH/LGA guidance and transfer DPH for April 2013

Workforce
Reassess current status of plans to physically relocate PH department to HCC and reschedule move
Provide information to HCC on staff due to transfer including terms and conditions
Establish workforce forum with union support
Undertake consultation prior to transfer
Confirm HCC has legal ability to employ medical staff
Use information from public health mapping to inform how new structure links to rest of the authority
Ensure clear statements on offer to PH staff are available (see 3.14 in HR guidance)
Review job profile data from PCT and amend existing/add new HCC role profiles
Agree date for physical transfer
Confirm how indemnity of PH clinical staff will be managed
Properly understand current status of PH staff including terms and conditions, pay and pension arrangements (dependent on data from PCT)
Carry out Equality Impact Assessment for staff transfer and ensure public sector equality duty is met
Manage the workforce contractual transfer process
Work with PCT to establish succession planning
Arrange for ongoing inductions for new staff post transfer
Ensure effective employee engagement and consultation (see 4.4 in HR guidance for detail) in line with legal responsibilities under TUPE and COSOP
Work with PCT to establish L&D programme for transferred staff to meet CPD requirements for specialist staff
Appointments made and staff transferred
Governance
Report on progress against transition plan to CMT/Cabinet/SHIP Board
HCC and SHIP formally agree transition plan
Ensure PH EPRR responsibilities which will become new and additional statutory LA responsibilities through the DPH are maintained and tested during transition
Agree MOU with CCGs, PHE & NHSCB
Agree clinical governance arrangements informed by work led by Regional DPH
Enabling infrastructure
Identify resources and shadow allocation to deliver public health functions and agree management of immediate risks
Legacy handover document folder developed by PH department
Facilities and assets assessed and issues resolved
Clinical and non-clinical risks addressed
Understand and agree available budget to deliver future functions and maintain business continuity

Communications and engagement
Agree key messages
Ensure robust and consistent approach for communicating
Agree key stakeholders (both internal and external) and build database
Prepare 'who's who' in public health
Design communications basics including webpage, email updates, newsletters, presentations
Identify opportunities and agree programme of presentations and newsletter releases
Develop briefings on key PH activities
Define roles and responsibilities