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| | **Executive**<br>**15 October 2012**<br><br>**Report from the Director of Strategy, Partnerships and Improvement and the Director of Adult Social Care** |
| | Wards Affected:<br>ALL |

# Sharing a Director of Public Health and proposed structure for the Brent Public Health Service

## 1. Summary


1.1 The passing of the Health and Social Care Act has confirmed that from 1st April 2013 local government will take on responsibility for health improvement and with it many of the services currently delivered by public health teams based in PCTs. Already local government fulfils its new duty of health improvement in a number of ways, such as through the provision of leisure services, through the planning system, and in providing services such as housing. Ensuring the health needs of disadvantaged communities are addressed will be central to the new responsibilities.

1.2 Rather than a wholesale transfer of public health to local government, the public health system is to be split into four separate parts. Local government will be responsible for a range of new services including:

- The National Child Measurement Programme
- NHS Health Check assessments
- 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)
- The local authority role in dealing with health protection incidents, outbreaks and emergencies – council's will be mandated to ensure plans are in place to protect the local population. CCG will have a duty of cooperation with local government on health protection
- Provide population level healthcare advice to CCGs and the NHS
- 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)
- Interventions to tackle obesity such as community lifestyle and weight management services
- Local initiatives that reduce public health impacts of environmental risks.

1.3 Those services in bold will be mandatory – the council will have to provide them. It should also be noted that this is not a complete list of responsibilities.

1.4 There are three other elements of the new public health system. A number of public health services are to remain an NHS responsibility. The NHS Commissioning Board will be responsible for some public health services such as HIV treatment services, screening services and immunisation services. A new, national public health body, Public Health England, is to be established which will take on the responsibilities of a number of agencies that are to close, such as the Health Protection Agency and Drug Treatment Agency and will provide specialist health protection services including, coordination of outbreak control, and access to national expert infrastructure as and when necessary and provide national public health leadership. The Department of Health will also retain a budget for and manage national public health "campaigns".

1.5 The total budget for the public health system is likely to be around £5.2bn, but local government as a whole will receive £2.2bn, less than 50% of the total public health budget. Despite being publicised as a transfer to local government, the reality is that this is only a partial transfer of public health to councils.

1.6 That said the transfer of services that are coming to local government gives Brent an opportunity to mainstream health improvement work across the council and make health improvement the authority's core business. Brent intends to embrace this vision by integrating public health within existing council teams and not "lifting and shifting" the current public health team. This will help reinforce the message that health improvement is the responsibility of the whole council and its partners, not just public health staff.

1.7 As part of taking on health improvement duties and the responsibility for public health services, the legislation is clear that councils should appoint a Director of Public Health who will be added to the list of statutory chief officers in the Local Government and Housing Act 1989. The DPH has to be a trained specialist in public health (although not necessarily from a medical background) and will be appointed jointly with the Secretary of State for Health (in reality, with Public Health England acting on the SoS's behalf).

1.8 Whilst each council has to have a DPH, the post can be shared with other councils where it makes sense to do so. Brent Council has been open to sharing a DPH since the proposals in the NHS White Paper, *Healthy Lives, Healthy People* made it clear that local government would be taking on public health responsibilities. Brent is keen to share a DPH with a council that shares its vision for public health and intends to integrate public health services within its council. Initially the council was engaged in discussions with Harrow, Barnet and Hounslow Councils about the possibility of sharing a DPH, but it quickly became clear that Harrow and Barnet had very different ideas for public health and how they would implement the new functions in their borough. As a result, Harrow and Barnet have agreed to share a DPH and Brent and Hounslow have continued to work together on developing their plans for a shared DPH.

1.9 Guidance from the Department of Health and Local Government Association suggests that council's could share a DPH where they already have a shared management team or shared boundaries. Brent and Hounslow don't share a

boundary, but the two councils do share a vision for public health. This is far more important if a shared DPH is to be successful in helping to deliver health improvement in each borough than the need to share a boundary.

1.10 Brent and Hounslow think that it makes sense on a number of levels to share a DPH and take advantage of the opportunities that it will bring. A shared DPH will give the borough a greater outlook and interflow of ideas to tackle health inequalities, learning as they will from the best in Brent and Hounslow (and London) and applying those ideas in our borough. A shared DPH will have more influence across West London, working for two boroughs, to drive through opportunities for collaboration and integration with partners to improve services and outcomes for residents. They will also be able to foster a common response to the big issues affecting our boroughs, such as a population that's living longer, with multiple long term conditions that require better management, and working in two areas with sizable BME communities facing significant health related challenges.

1.11 This paper sets out the business case for Brent and Hounslow's proposal to share a DPH as well as the proposed structure for public health and how staff will be integrated into the current officer structure once it transfers to Brent Council from NHS Brent takes place.

## 2. Recommendations

2.1 The Executive is recommended to:

(i). Approve the proposal for Brent to share a Director of Public Health with Hounslow Council

(ii). Approve the proposed integrated structure for the public health service in Brent as set out in this report.

## 3. Report

### 3.1 A vision for Public Health services in Brent and Hounslow

3.2 Local authorities will take on a number of mandatory public health requirements from the 1st April 2013, which have been addressed in developing a model for public health in Brent and Hounslow. Local authorities will have statutory responsibilities for the following key domains of public health

- Health improvement
- Health protection
- Healthcare public health
- Improving the wider determinates of health

3.3 Council's will also have to commission (or provide) the following mandatory services:

- The National Child Measurement Programme
- NHS Health Check assessments
- Comprehensive sexual health services, including testing and treatment for sexually transmitted infections
- Plans to protect the local population in the case of a health related emergency

- Population level healthcare advice to CCGs and the NHS

3.4 A new National Public Health Outcomes Framework has been developed with the intention of refocusing the whole system around the achievement of positive health outcomes for the population and reducing health inequalities. The framework is focused on the following two overarching health outcomes to be achieved across the public health system:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities

3.5 The supporting public health indicators are grouped into four domains:

- Domain 1 – Improving the wider determinates of health
- Domain 2 – Health improvement
- Domain 3 – Health protection
- Domain 4 – Healthcare public health and preventing premature mortality

3.6 Brent and Hounslow Councils have developed a shared vision for public health and identified the areas where the two boroughs are closely aligned on their thinking concerning structures and expected outcomes from the public health service.

3.7 Both Brent and Hounslow Councils agree:

- There is logic in bringing the key elements of public health back into local government. The function can be reconnected with the core health improvement work carried out by local authorities and there will be greater co-ordination of health improvement activity once services are transferred to local government.
- That public health is not just the responsibility of a Public Health Team or the DPH, but that it is a council wide responsibility and that all service areas should contribute to improving the health and wellbeing of local people.
- That in order to mainstream public health, officers from the existing Public Health Teams should be integrated in existing council teams and departments to make best use of the additional resources and expertise available to local authorities.
- That public health spending should be realigned to focus more on the wider determinants of health, tackling health inequalities and preventing ill health rather than treating ill health. Resources will be re-orientated away from the treatment of ill health to preventative services.
- That every contact with customers should count, and that all frontline officers (not just those in public health) should be deliverers of health improvement services or advice, either directly or through sign posting to the right service.
- That both council's should work with communities to help them to make healthy choices to prevent the onset of ill health.

3.8 In order to deliver the vision for public health it is important that the structure and support around the DPH is in place. Brent and Hounslow's ideas around the role, the integrated public health service and the resources available to support the DPH are set out below.

**3.9 The Director of Public Health – A new role for new times**

3.10 Brent and Hounslow have the same ambition for the Director of Public Health role. The DPH's key function will be to understand and enhance the health of people in Brent and Hounslow. They will be clear on the link between economic success and good health and develop a clear, targeted, long term strategy that ensures health and social care, education, housing, employment and economic policies and infrastructure are shaped in ways which deliver maximum improvements in health and wellbeing.

3.11 The DPH will be central to the promotion of health improvement, tackling health inequalities and focussing council and health services on ill health prevention activities. The DPH will be the borough's advocate for health and wellbeing, using their influence to persuade service providers to contribute to the health improvement agenda. The public health budget in Brent will be around £16m, a significant amount of money. But this is dwarfed when compared to the council's overall budget and the NHS budget in Brent – combined this is close to £1bn. A successful Director of Public Health will work with decision makers in the health service and the council to use this resource on health improvement and ill health prevention activities. This will have a far greater impact than the use of public health resources alone. The DPHs ability to influence other organisations to deliver health improvement services will be central to the success of the person appointed to the role.

3.12 The Director of Public Health's role will be one of influence and strategic leadership rather than the traditional line management and budget responsibility. We want to ensure the DPH is freed up to work with key decision makers to push the council's health improvement agenda. The status that the DPH will have, as the borough's health improvement champion will mean that they are well placed to assert their professional views to a variety of organisations such as healthcare providers, voluntary sector groups and community groups to secure health improvement in Brent. The fact that the council is at the centre of local partnership working extends the remit and opportunity for the Director of Public Health.

3.13 There will be a number of ways in which they will be able to effectively carry out their influencing role:

3.14 ***Advice to Brent CCG and Brent Council*** - The Director of Public Health will provide advice and guidance to the Brent and Hounslow Clinical Commissioning Groups and the councils' service directors on health improvement and tackling health inequalities. They will be supported to do this work by the council's public health intelligence team – in Brent we plan to have two public health consultants and two public health analysts to support the DPH deliver their advice and guidance role. A memorandum of understanding has been developed between the council and CCG setting out how the relationship between the two will work and what each organisation can expect from the other. It has been proposed that:

3.15 Brent Council will:

- Provide specialist public health advice to the CCG
- Make public health intelligence resources available in support of clinical commissioning activities.

- Assess the health needs of the local population, and how they can best be met using evidence-based interventions (via the production and updating of the JSNA)
- Ensure the reduction of health inequalities are prioritised in the commissioning of services
- Provide specialist public health advice to the emerging Joint Health and Social Care Commissioning Vehicle.

3.16 Brent CCG will:

- Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.
- Utilise specialist public health skills to target services at greatest population need and towards a reduction of health inequalities
- Contribute intelligence and capacity to updating the JSNA

3.17 The Director of Public Health will be responsible for this element of the MOU and working with the CCG to embed public health advice and guidance in commissioning decisions. The council will require an individual who is able to bring their professional authority and influencing skills to the fore in order to work with the CCG effectively.

3.18 ***Statutory member of the Brent Health and Wellbeing Board*** - The NHS Operating Framework for 2012/13 says that Health and Wellbeing Boards should provide local system-wide leadership across health, social care and public health. The Director of Public Health will be a statutory member of the Health and Wellbeing Board, working with Executive councillors, council directors and Clinical Commissioning Group colleagues to set the strategic direction for health and wellbeing in Brent. As a public health specialist the DPH's advice will be particularly important as links are made between the council and NHS's efforts to tackle health inequalities. The DPH will have an overview of services in Brent and be well placed to advise on changes that can be made to improve the borough's health.

3.19 ***Voting Board Member of the Health and Social Care Commissioning Joint Venture*** – Brent Council with Brent Clinical Commissioning Group has ambitions to set up a joint commissioning vehicle, to lead the commissioning of health, adult social care, children's social care and public health commissioning in Brent. Whilst this organisation won't be established by the time public health transfers to the council, we are already preparing for this by realigning commissioning functions. Public health commissioning will transfer into adult social care, as commissioning activity is concentrated in one place within the council.

3.20 The Director of Public Health will be based in our Adult Social Care Department, reporting to Brent's Director of Adult Social Services. In time, as plans for the joint commissioning vehicle are realised, the DPH will become a voting board member of the joint venture board. It is possible that in time the head of the joint venture could be the statutory Director of Public Health. By putting the DPH at the heart of commissioning activity they will be well placed to ensure that public health aims and objectives are delivered across the range of health and social care services in Brent

and that every opportunity is taken to design in health improvement to service specifications.

3.21 ***Director of Public Health's Annual Report*** - The Health and Social Care Act makes it a statutory requirement for the Director of Public Health to produce an annual report on the health of the local population, and for the local authority to publish it. The DPH's annual report will give them an opportunity to promote the public health agenda and highlight issues of concern if they feel that the council, CCG or any other healthcare provider is not fulfilling their health improvement responsibilities. The annual report should become an important milestone, highlighting as it will areas where health improvement work is succeeding and areas where it is not. Brent wants this report to become required reading for members and officers working on the health improvement agenda. The independence of the DPH to be able to criticise or praise is crucial, and one of the reasons that the DPH will not be directly responsible for service management.

3.22 ***Influence beyond the council and Clinical Commissioning Group*** - The DPH, through the Health and Wellbeing Board and joint commissioning vehicle, will be well placed to influence the actions of the council and Clinical Commissioning Group to ensure that they are delivering the borough's health and wellbeing priorities and addressing identified health needs. However, it is just as important that the DPH is able to use their authority and professional skills to influence the work of health service providers (such as North West London Hospitals NHS Trust), voluntary sector organisations and community groups. The final membership of the Health and Wellbeing Board is not yet settled but it is likely that the voluntary sector and health service providers will be represented, which will open up channels for the DPH. But, again, the DPHs ability to network and influence others will be crucial.

3.23 The DPH will need to be able to build effective relationships with organisations, both formal and informal, in order to convince them of the need to deliver health improvement services. For example, greater integration of public health interventions such as referral to smoking cessation teams from North West London Hospitals would help to deliver health improvement benefits and lessen the burden on acute trusts in the longer term. Brent is aiming to deliver an integrated health and social care service – the DPH will be crucial in persuading other organisations to sign up to this and deliver services which contribute to tackling health inequalities.

3.24 Brent already has an officer level governance structure to implement the borough's health and wellbeing strategy - the Health and Wellbeing Steering Group, which has representation from acute service providers and the voluntary sector. Whilst officers will need to work to improve the added value of the group, relationships are already there. But, the onus will be on the DPH to build relationships to promote the benefits to organisations of tackling health inequalities, using their abilities to influence informally as well as ensure health improvement activity is part of the normal commissioning cycle so that services are tailored to help tackle Brent and Hounslow's health inequalities. The DPHs professional standing will help them "in" to organisations with the backing of the Health and Wellbeing Board, but the DPH will have to ensure organisations sign up to our ambitions for health improvement.

**3.25 Arguments in favour of retaining a Director of Public Health for Brent**

3.26 Whilst sharing a Director of Public Health is the preferred option, there are arguments in favour of appointing a DPH for Brent only and retaining the status quo. A DPH for Brent would be able to focus solely on matters concerning the borough and help consolidate public health services within the council following the transfer from NHS Brent. A single DPH would have the same responsibilities to the council, CCG and Health and Wellbeing Board and will be central to the promotion of health improvement and tackling health inequalities – the core roles and responsibilities will not change and it is understandable why other boroughs want to have a person in post focussed only on their area. But a single DPH is unlikely to have influence and reach of a joint appointment. A joint DPH will have influence across two boroughs and speak on behalf of two boroughs when working with others in North West London. Nor will a single DPH be able draw on the best practice and support of two public health functions as the DPH in Brent and Hounslow will be able to do.

3.27 A DPH covering one borough is going to appeal to seasoned public health professionals who will be used to focussing their efforts in one area. Sharing a DPH is becoming more common (Harrow and Barnet and Camden and Islington for example) but it is not the norm. However, it is also true to say that few Director of Public Health jobs will be like the one envisaged for Brent and Hounslow, where the focus is as much about relationship building, the ability to influence others and working in partnership as the technical and specialist public health requirements needed to carry out the role. By recruiting a shared DPH Brent and Hounslow are demonstrating their commitment to bringing a fresh approach to the disciple that will appeal to those ambitious to work in areas where there is huge potential to make real differences to peoples lives.

**3.28 Practical arrangements for a shared Director of Public Health**

3.29 The practical arrangements around the shared DPH post need to be agreed, but Brent and Hounslow have begun discussions on how they might work. The post will be shared, 50/50 between the two organisations, despite the differences in population size and budget. Both councils expect the DPH to be present in their borough for part of the working week, but won't be too ridged on the number of days that they have to be physically present in each borough. This is in line with Brent's approach to flexible working, where staff will be expected to manage their own time effectively, but also to take opportunities to work from home given the staff to desk ratio that will be in place in the new Civic Centre. Informally, Brent and Hounslow have agreed that Brent will be the employer of the shared DPH and Brent will also lead the recruitment process.

3.30 Of more importance is the work that the DPH will be doing, to make sure their time is balanced between working for Brent and working for Hounslow. Objectives will be set for the DPH by their line manager, based on priorities in the borough's Health and Wellbeing Strategy. They will take strategic leadership for health improvement in each borough, and like other senior officers, will be responsible for co-ordinating a portfolio of work to ensure the borough meets its health and wellbeing objectives. Brent and Hounslow will have to jointly manage the DPH's workload to ensure it is

balanced and that both boroughs have the public health leadership they require. It is likely that the DPH and their line managers will need to meet collectively to agree a work programme and to manage the DPH's performance.

3.31 By sharing a DPH, clearly there is a financial saving to Brent and Hounslow (although it should be noted that the current DPH in Hounslow works part time). Given that the funding allocation for public health is currently unknown, but that there is a real possibility that funding will reduce if the Government's proposed formula for public health funding is introduced, the council has to look at opportunities to reduce costs where it can.

**3.32 Future of Public Health Services – the new Public Health Structure**

3.33 Beyond sharing a DPH, Brent and Hounslow have considered the statutory requirements that will be placed on councils and feel that the best way to improve the public health offer is to integrate public health functions within existing teams in the local authorities – neither council intends to "lift and drop" the existing public health team and create a "Department of Public Health". In order to deliver improvements to health inequalities and deliver the Government's vision for health improvement, removing the silos between public health and local government are key. Integrating functions and activity in the most appropriate teams within the local authority should help to mainstream public health activity and deliver health improvement.

3.34 Brent's model for public health splits the service into three main areas – Health Intelligence, Public Health Commissioning and Health Improvement. The structure in the council is smaller than that which has been in place in NHS Brent. This is partly to do with concerns about future funding. But it is primarily a reflection of the fact that the council already has a number of staff in post working on health improvement activity. Integrating public health staff means that the council can take the opportunity to reduce duplication of roles and reduce management posts, as public health will be line managed within existing teams.

3.35 Services currently delivered by public health staff will be reviewed and possibly re-commissioned. The council is also taking the opportunity to look again at commissioning intentions, and redesign services. A report on contracts and commissioning will be presented to the Executive in November 2012.

3.36 The three public health areas will focus on the following activity –

- **Health intelligence** – A small team working on health intelligence will be integrated in the council's Corporate Policy Team. The main responsibilities of this team will be to support the DPH to provide population level healthcare advice to the CCG and council commissioners, lead on the council's JSNA and Health and Wellbeing Strategy and any other health needs assessments. The team will complement the council's existing data and intelligence functions.
- **Public Health Commissioning** – Public Health Commissioning will be integrated into the council's Adult Social Care Department. This will be a temporary measure, as the council in partnership with NHS Brent and the Brent CCG is working towards the establishment of a Brent Commissioning Joint Venture, which will be responsible for commissioning health, social care and children's

services in the borough. Public health commissioning will be included in the joint venture as commissioning expertise is pooled in one place to help secure integrated services where possible. Public health officers in the council's Adult Social Care Department will commission services such as drug and alcohol treatment services, sexual health and smoking cessation services The Director of Public Health will be included in this part of the structure, reporting to the Director of Adult Social Care. In time, as plans for the joint venture are realised the DPH will be a voting member of the JV board.

- **Health Improvement** – Health Improvement will be integrated into the council's Environment and Neighbourhood Services Department where staff will work with services such as our Sports Service, Trading Standards and Environmental Health on programmes to address health and wellbeing issues such as obesity, improving uptake of physical activity, and tobacco control. The public health staff will bring with them expertise that complements our existing service offer.

3.37 Hounslow's ambition to integrate public health staff within its departments mirrors Brent's and they are a taking a similar approach to integration within their teams. A shared DPH compliments the structure of the teams in the two organisations.

3.38 Line management of public health staff in Brent will be carried out by service managers in the departments where staff are located and not by the DPH. We want the DPH to focus on their influencing role and retain their independence from service management. However work plans and priorities will be set in collaboration with the DPH to ensure staff are working on priority areas as defined by the borough's Health and Wellbeing Strategy. By jointly setting public health staff objectives with service managers the DPH will be able to ensure health improvement is mainstreamed within council teams.

3.39 Neither Brent nor Hounslow Council is ruling out the possibility of sharing services and further posts in the future. This will be considered in more detail once both authorities have embedded their arrangements for public health. Brent and Hounslow will look to the joint DPH to lead this work, and bring forward ideas for further integration. We see the shared DPH as the start of a process of integration and closer working arrangements.

**3.40 Governance of public health**

3.41 It is important that public health activity within the council is joined up and co-ordinated, and that the public health outcomes framework and priorities in the Health and Wellbeing Strategy taken forward. The Director of Public Health will have a strategic leadership role and will be expected to ensure that the three arms of public health – Health Intelligence, Health Improvement and Public Health Commissioning – are working together effectively. They will also need to reinforce health messages across the council.

3.42 A governance structure will need to be set up so that the DPH is able to carry out this role properly, building on the existing Health and Wellbeing Steering Group and reporting to the Health and Wellbeing Board. Additional working groups maybe required, based around the priority areas in the Health and Wellbeing Strategy, or the

domain areas in the Public Health Outcomes Framework. Building an effective governance structure for public health is one of the activities in the public health transition plan. Arrangements will be put in place before the transfer on 1st April 2013 to enable the DPH to take forward the health improvement agenda.

**3.43 Conclusion**

3.44 Brent and Hounslow Councils are committed to sharing a Director of Public Health. Our shared vision for the post and the similarities between our structures for public health make this a viable proposition. Issues around borough boundaries should be ignored. What's more important is that both councils are determined to make this arrangement work and that it should be seen as the beginning of a fruitful partnership based around our health improvement responsibilities and tackling health inequalities in both boroughs.

3.45 This arrangement will give new focus to the role of Director of Public Health and moves it from a peripheral position in the machine of the NHS to front and centre of a partnership model which aims to fundamentally improve the health and wellbeing of Brent and Hounslow's communities. We strongly believe that sharing as DPH will give each borough opportunities that would not exist if we had a single DPH, such as a greater outlook and interflow of ideas to tackle health inequalities, more influence across west London to push for integrated services and joint commissioning and greater co-ordination in the commissioning of services between health and social care within Brent and Hounslow. If Brent and Hounslow get this right, the model of council's working in partnership and sharing posts and services, even where they don't share boundaries, could become a model that becomes common throughout local government.

## 4. Legal Implications

4.1 Pursuant to s30 of the Health and Social Care Act 2012 each Local Authority must appoint, jointly with Secretary of State, a Director of Public Health who will have responsibility for the exercise by the authority of its functions relating to public health. The Director of Public Health will be required to prepare an annual report on the health of the people in the area of the Local Authority and the Local Authority will be required to publish that report. Section 300 and Schedules 22 and 23 of the Health and Social Care Act 2012 make provision for rights and liabilities with regard to property and staff respectively to be transferred between the relevant bodies. Regulations as to the exercise by Local Authorities of certain Public Health functions are yet to be issued by the Government.

4.2 The current proposal is for the Council to directly employ the DPH to undertake work for both ourselves and Hounslow. The Council has the power to employ the DPH directly and then enter into an arrangement with Hounslow that provides for them to undertake to accept liability for half of the costs involved in the appointment and employment of the DPH as well accepting half of the liabilities that are inherently present when staff are employed directly. The Council's position as direct employer

would therefore be protected by indemnities that would be entered into to ensure an equitable risk share in the joint arrangements.

4.3 The staff who would form the main body of the function will be employed directly by Brent and Hounslow respectively. There is no proposal at this stage for any staff sharing arrangement to be entered into for anyone other than the DPH. The staff that will comprise the public health functions will become employees of the Council. Currently they are employees of the NHS and the mechanism for those staff to change employer will be through either a traditional TUPE transfer or a Transfer Order made by the Secretary of State which has a similar effect to a TUPE transfer.

4.4 In any event transferring staff would have the right to retain their contractual terms and conditions and the Council would also have to make appropriate pension provision, the precise nature of which has yet to be decided. The costs involved in the transfer will be met by the transfer of the public health budget from the NHS to the Council.

**5. Finance Implications**

5.1 The budget transfer as at 1st April 2013 remains uncertain but is projected to be in line with the PCT return to the Government in February 2012 suggesting spending of around £16m based on 2010/11 baseline estimates.

5.2 NHS Brent's public health allocation for 2012/13 is £17.3m, which leaves a gap of around £1.3m in funding. In planning for 2013/14, this degree of uncertainty and lack of clarity is unhelpful and will introduce ambiguity in the budgets.

5.3 To further complicate matters, the government has set up an advisory committee to look at the resource allocation (ACRA) and they have developed a formula for calculating allocations which, if implemented, could lead to a further reduction in funding for Brent of around 16% to around £13.5m

5.4 ACRA's formula for allocating public health resources is based on the standardised mortality ratio for those under 75 years of age. Analysis work has shown that the proposed formula is fundamentally flawed, as it will reduce spending in the country's most deprived areas and increase it in the least deprived areas.

5.5 Historic levels of spending on public health are higher in more deprived areas because the level of need is greater, a flaw that has been recognised by PCTs and which has been advised to Government. Authorities in those areas, which includes Brent, consider that they should not be penalised due to previous spending patterns in preventative services in the past.

5.6 The population figure used in calculating the ACRA formula is 252,105, where as the first results from the 2011 census have been published and they show that Brent's population has increased to 311,200, a difference of 59,000. This would suggest underfunding of approximately £3.2m.

5.7 Taking all the above into account, budgets are currently being developed, together with staffing structures based on the £16m allocation figure but mindful that should the ACRA view prevail, the service will need to be managed within the lower sum.

Confirmation of funding is due from Government in October 2012 and proposal will be presented to Executive in November 2012 for ratification.

5.8 It should also be noted that within this £16m total, two services (sexual health and health checks) are entirely demand-led and account for 41% of the total budget. This introduces a significant risk factor which is being managed through the establishment of a reserve of £500,000 per annum set aside from the £16m.

5.9 Negotiations are ongoing regarding the transfer of staff and any associated redundancy costs. Whilst Brent's position remains that these should be picked up by the NHS prior to the transfer of functions, a risk remains that some may need to be met be the Council post-transfer and a proposed reserve of £250,000 will be set aside by the Department to cover this eventuality.

5.10 There are not expected to be any capital requirements arising from this transfer

## 6. Diversity Implications

None

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