	Executive **12 November 2012** **Report from the Director of Strategy, Partnerships and Improvement and the Director of Adult Social Care**
	Wards Affected: ALL

The structure of Public Health Services in Brent

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 This paper sets out the proposed structure for public health in Brent and how staff will be integrated into the current officer structure once the transfer to Brent Council from NHS Brent takes place.

2. Recommendations

2.1 The Executive is recommended to 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

3.2 Local authorities will take on a number of public health requirements from the 1st April 2013, which have been addressed in developing a model for public health in Brent. 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 has developed a vision for public health which has informed the proposed structures and expected outcomes from the public health service.

3.7 Brent Council believes:

- 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 Director of Public Health, 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 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 the council 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 Director of Public Health is in place. Brent'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 intends to develop a new role for the DPH that fits local government's requirements. The transfer of public health should not be viewed as a continuation of the existing public health service within the council, but as a chance to take a fresh look at the service and its staff. Brent shouldn't look to recreate the NHS model. The DPH's key function will be to understand and work with the council and partners to enhance the health of people in Brent. 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 the 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. Although the Director of Public Health won't be line manage public health staff, they will have an important role to play in the management and performance of public health activity. The Director of Public Health will be responsible for the professional development and management of the public health staff. They will have strong ties to those staff and important working relationships. The council has no desire to have a remote DPH who has little interaction with the rest of the public health team. But, most importantly, Brent wants the DPH to have a crucial influence over council policy, ensuring that it fully reflects the health challenges the borough faces and that the council as a whole is taking steps to address these.

3.13 There will be a number of ways in which the DPH 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 Clinical Commissioning Group and the council's 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 a public health analyst 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. This is one of the central aims that the council was looking to achieve when designing the structure for public health.

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' 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 Future of Public Health Services – the new Public Health Structure

3.26 Brent has 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 authority – the council does not intend 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.

3.27 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.

3.28 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 December 2012.

3.29 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 and sexual health 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 team will also support GPs and pharmacists to deliver smoking cessation services and GPs to deliver Health Checks. The public health staff will bring with them expertise that complements our existing service offer.

3.30 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. As mentioned above, the DPH will also be responsible for the professional development and management of the public health staff. The DPH will have strong ties to those staff and important working relationships. The council has no desire to have a remote DPH who has little interaction with the rest of the public health team and through jointly setting public health staff objectives with service managers the DPH will be able to ensure health improvement is mainstreamed within council teams.

3.31 Governance of public health

3.32 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.

3.33 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.

3.34 Conclusion

3.35 The transfer of public health from the NHS to local government gives councils a once in a generation opportunity to think about how it wants to deliver health improvement services. Brent Council is committed developing a new model for Public Health and a new role for the Director of Public Health. We want to take advantage of the benefits that are to be gained from integrating public health objectives into mainstream service provision within the council. The council also believes that the new role, as proposed, for the Director of Public Health can help to harness the support of our partners to make a real difference to the health of people in the borough. Most importantly, the DPH should be able to take a radical approach to public health, to reinvigorate the function, transforming it from a "Cinderella" service in the NHS to one that is front and centre of the council's activity

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 In any event transferring staff from NHS to the council 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 include 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 December 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 There are not expected to be any capital requirements arising from this transfer.

Contact Officers

Phil Newby, Director of Strategy, Partnerships and Improvement
Tel – 020 8937 1032
Email – phil.newby@brent.gov.uk

Alison Elliott, Director of Adult Social Care
Tel – 020 8937
Email – Alison.elliott@brent.gov.uk

Andrew Davies, Policy and Performance Officer
Tel – 020 8937 1609
Email – Andrew.davies@brent.gov.uk

ALISON ELLIOTT
Director of Adult Social Care

PHIL NEWBY
Director of Strategy, Partnerships and Improvement