MUNICIPAL YEAR 2013/2014 REPORT NO. 11

Agenda - Part 1	**Item: 6**
Subject: Public Health 2013/14 **Wards:** All	
Cabinet Members consulted: Councillor Christine Hamilton Councillor Ayfer Orhan Councillor Chris Bond	

MEETING TITLE AND DATE:
Cabinet
19th June 2013

REPORT OF:
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1. EXECUTIVE SUMMARY

1.1. This report sets out the Public Health functions and objectives for Enfield from April 2013 in light of the legislative and organisational changes set out in the Health and Social Care Act 2012.

1.2. Supported by a ring-fenced grant of £12.961 million the local authority has a duty to provide mandatory services under the three domains of public health: health protection, health improvement and healthcare.

1.3. These new functions will be delivered under the guidance of the Director of Public Health and this report sets out the approach and capacity required to ensure that the Authority's legal responsibilities are met and locally agreed priorities, including Child Health and reducing health inequalities are addressed.

1.4. The report contains an initial Business Plan and budget allocation for Public Health which has been designed to meet the expectations of the Department of Health (DH) and to provide effective services to Enfield's residents.

2. RECOMMENDATIONS

Cabinet is asked to:

I. Note the contents of this report; and
II. Agree the key objectives for Public Health as set out in the Attached Public Health Business Plan (Appendix 1); and
III. Note the ring-fenced Public Health Budget as summarised in Appendix 2; and previously reported within the Budget Setting Report to Full Council on 27/2/2013
IV. Note the Public Health structure as detailed in Appendix 3.

3. BACKGROUND

3.1. The purpose of this report is to provide information relating to the Public Health objectives of LBE for 2013/14, provide details of the ring fenced allocation for public health and outline the establishment that is needed to accommodate the department's new responsibilities.

3.2. These functions are listed in Section 4 of this report and are explicitly stated as being to:

- Improve significantly the health and wellbeing of local populations
- Carry out health protection functions delegated from the Secretary of State
- Reduce health inequalities across the life course, including within hard to reach groups
- Ensure the provision of population healthcare advice.[1]

In addition to these new statutory functions, the public health function will have a key role to play in respect of existing Local Authority duties, including in respect of reducing inequality and the wellbeing of vulnerable children.

3.3. As of 1st April 2013 Local Authorities have taken over public health responsibility from the NHS, for improving the health of their local population under the legislative framework of the Health and Social Care Act 2012.

3.4. The Act states that local authorities should embed these new public health functions into all their activities, tailoring local solutions to local problems, and using all the levers at their disposal to improve health and reduce inequalities.

3.5. In order to meet it's responsibilities the DH advises that local authorities need a specialist, experienced public health professional (the Director of Public Health) supported by

[1] DH (2012) *The New Public Health Role of Local Authorities,* Public Health in Local Government Guidance Note: Gateway Ref 17876

specialist public health resources with access to adequate information and evidence functions.[2]

3.6. The transfer of Public Health staff from the NHS and the detail of the specialist capacity needed is set out in a separate DAR along with information regarding the transfer of contracts from the NHS to LBE.

3.7. Transition of the local public health function has taken place as part of large scale change within the NHS with the abolition of Primary Care Trusts (PCTs) and the setting up of:

- NHS England [National Commissioning Board] (NCB)
- Clinical Commissioning Groups (CCGs) – locally, the Enfield CCG
- Public Health England (PHE)

All of which took on their statutory areas of responsibility from 1st April 2013.

4. PUBLIC HEALTH RESPONSIBILITIES

4.1. Figure 1 – a diagram by Dahlgren and Whitehead illustrates the many factors that operate at a number of different levels to affect health and bring about health inequalities. It is important to note the broad definition of public health as encompassing general wellbeing, not just absence of illness

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4.2. The Dahlgren and Whitehead model was quoted in the first chapter of the Enfield 2012 Annual Public Health Report and underpins the Council's belief that most of the Council's work contributes to the health and wellbeing of the population and has the potential to tackle health inequalities.

4.3. Whilst the ring-fenced budget for public health is £12.961 million, many of the Council's and it's partners (including Enfield CCG) mainstream budgets have potential to help promote wellbeing and support work to tackle health inequalities.

4.4. The Health and Social Care Act rests on the premise that many of the wider determinants of health (for example, housing, economic development, transport) can be more easily impacted by local authorities, who have overall responsibility for improving the local area for their populations. [3]

4.5. Enfield is well-placed to take a very broad view of what services will impact positively on the public's health, and combine traditional "public health" activities with other activity locally to maximise benefits.

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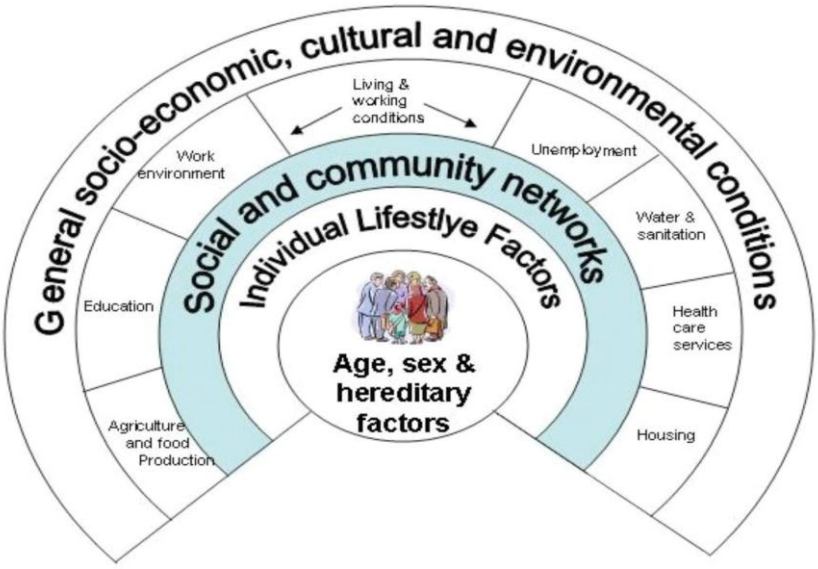
[2] DH (2012) *The New Public Health Role of Local Authorities,* Public Health in Local Government Guidance Note: Gateway Ref 17876

[3] DH (2012) *New Focus for Public Health – The Health and Social Care Act 2012*, Factsheet B4 available at www.dh.gov.uk/healthandsocialcarebill: Last accessed on 8th May 2013

Figure 1: The Wider Determinants of Public Health[4]



4.6. From April 2013 the legislation sets out both mandatory and discretionary services as part of the public health function of Local Authorities[5].

4.6.1. Listed below are the mandatory public health functions that must now be provided by LBE:

- Appropriate access to sexual health services.
- Ensuring there are plans in place to protect the health of the population, including immunisation and screening plans.
- Ensuring NHS commissioners receive the public health advice they need.
- The National Child Measurement Programme (NCMP).
- NHS Health Check assessment.

4.6.2. The following discretionary public health functions have also been passed on to LBE. This applies to people of all ages:

- Tobacco control and smoking cessation services.
- Alcohol and drug misuse services – Drug and Alcohol Misuse services (DAAT) – (it should be noted that the responsibility for the provision of DAAT services was already with the Authority, managed under a section 75 Agreement with the NHS. However with effect from the 1

[4] Dahlgren G & Whitehead M (1991) *Policies and Strategies to Promote Social Equity in Health*, Institute for Future Studies, Mimeo: Stockholm

[5] DH (2011) *New Public Health Functions for Local Authorities*, Public Health in Local Government Guidance Note: Gateway Ref 17876

April 2013, the funding formed part of the new Public Health Grant and any contracts not already in the name of LBE transferred across).

- 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 and lifestyle interventions.
- Locally-led nutrition initiatives.
- Increasing levels of physical activity in the local population.
- Oral health promotion.
- Accidental injury prevention.
- Population level interventions to reduce and prevent birth defects.
- Behavioural and lifestyle campaigns to prevent cancer and long-term illnesses.
- 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.
- Local initiatives to reduce excess deaths as a result of seasonal mortality.
- Public health aspects of community safety promotion, violence prevention and response.
- Public health aspects of local initiatives to tackle social exclusion.
- Local initiatives that reduce public health impacts of environmental risks.

The above list is drawn from statutory guidance. We are refreshing our Joint Strategic Needs Assessment and the priorities of Enfield's Health & Wellbeing Strategy to ensure resources are targeted in a way that both meets the statutory duties and addresses most pressing local needs..

4.7. The Public Health team will ensure the fulfilment of the aforementioned duties. Furthermore, they will champion health across the whole of the authority's business, promoting healthier lifestyles and scrutinising and challenging the NHS and other partners to promote better health and ensure threats to health are addressed.[6]

5. PUBLIC HEALTH OUTCOMES FRAMEWORK AND ENFIELD'S HEALTH NEEDS

5.1. The Public Health Outcomes Framework has a specifically defined vision, two outcomes and a range of indicators under four domains.

[6] DH (2011) *New Public Health Functions for Local Authorities*, Public Health in Local Government Guidance Note: Gateway Ref 17876

5.2. The vision is: to improve and protect the nation's health and wellbeing and improve the health of the poorest fastest.

5.3. The two outcomes are:

- Outcome 1: Increased healthy life expectancy
- Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in disadvantaged communities)

5.4 The four domains are:

- (1) Improving the wider determinants of health
- (2) Health Improvement
- (3) Health Protection
- (4) Healthcare Public Health and Preventing Premature Mortality

5.5 There are a range of indicators in the Public Health Outcomes Framework. An understanding of how Enfield performs on these indicators will be in the Joint Strategic Needs Assessment. This informs the Joint Health and Wellbeing Strategy which in turn shapes the Public Health Business Plan, the CCGs Commissioning Plans and local authority investments.

5.6 The Public Health Outcomes Framework will not give sub-borough data and therefore does not reflect the disparities in health within the Borough. These issues must and will be picked up in the JSNA e.g. low female life expectancy in Upper Edmonton.

5.7 The Health and Wellbeing Board have a responsibility to ensure that the council and CCG are commissioning against the Joint Health Wellbeing Strategy.

5.8 The utilisation of Enfield's Public Health ring fenced budget will be informed by Enfield's health needs, the JSNA and the Joint Health and Wellbeing Strategy.

6 PUBLIC HEALTH BUSINESS PLAN 2013/14

The initial Public Health Business Plan 2013/14 is built around the five objectives which have been agreed in Enfield's Health and Wellbeing Strategy.

6.1 The Business Plan will be updated on the production of the Joint Health and Wellbeing Strategy (JHWS)

6.2 It is anticipated that during the first six months an emphasis within Public Health will be on transition and training for staff on new systems, processes and ways of working within the local authority.

6.3 The Business Plan, attached as Appendix 1, is inclusive of the current activities undertaken by Public Health as well as the additional actions as detailed below which respond to local needs identified within Enfield.

A Healthy Start: Improving child health and wellbeing
▪ Development of a 7 year strategy to improve child health
▪ Focus on child healthy weight, including setting an agreed trajectory for improvements in healthy weight in reception and year 6. (Targets to include reducing numbers and improving performance compared to other Local Authority areas).
▪ Support NHS England in delivering immunisation programmes for Enfield
▪ Tackle infant mortality, including setting an agreed trajectory for improvements in infant mortality. (Targets to include improving absolute and comparative performance).
▪ Ensure the JSNA identifies the needs of vulnerable children
▪ Ensure good immunisation rates in looked after children
▪ Support child death overview panel and children's safeguarding board

Narrowing the Gap: Improve life expectancy across the Borough and narrow the life expectancy gap that currently exists
▪ Development of a 7 year health inequalities strategy
▪ Reduce smoking prevalence
▪ Better management of hypertension
▪ Earlier diagnosis of cancer

Healthy Lifestyles/Healthy Choices: Empower local populations to lead healthy lifestyles
▪ Develop 7 year strategy to improve life-styles. This should include best practice on measurement of changes in life-style
▪ Breast, bowel and cervical cancer screening
▪ HIV and sexual health
▪ Improve levels of physical activity
▪ Improve nutrition

Healthy Places: Improve the places in which people live and work for the betterment of their health
▪ Develop 7 year strategy; this should include health and well-being, physical activity, smoke-free areas, healthy high streets, open spaces and addressing the fear of crime
▪ Reduce smoking prevalence

▪ Improve the wider determinants of health
▪ Ensure regeneration improves health outcomes
▪ Violence reduction
▪ Establish Alcohol Alliance and reduce alcohol harm

Strengthening Partnerships: Strengthen partnerships with the wider Public Health workforce
▪ Ensuring that the needs of the Borough are known and understood and that Public Health informs commissioning decisions of the CCG and London Borough of Enfield.
▪ Develop Enfield's Public Health Network

7 ROLE OF THE DIRECTOR OF PUBLIC HEALTH

7.1 The DPH is a statutory chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health. [7]

7.2 Statutory Responsibility

7.2.1 In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority.

7.2.2 The exception is the annual report on the health of the local population – as the DPH has a duty to write a report, whereas the authority's duty is to publish it.

7.2.3 Aside from this the DPH's core responsibilities, as aligned with those of the Council are identified as being:

- All of their local authority's duties to take steps to improve public health.
- Any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations – these include services mandated by regulations made under section 6C of the 2006 Act, inserted by section 18 of the 2012 Act
- Exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health
- Their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders
- Such other public health functions as the Secretary of State specifies in regulations (more on this below).

[7] DH (2012) *Directors of Public Health in Local Government*, Public Health in Local Government Guidance Note: Gateway Ref 17876

7.2.4 As well as those core functions, the Acts and regulations give DsPH some more specific responsibilities from April 2013:

- Through regulations made under section 73A(1) of the 2006 Act, inserted by section 30 of the 2012 Act, the Department intends to confirm that DsPH will be accountable for their local authority's public health response as a 'Responsible Authority' under the Licensing Act 2003, such as making representations about licensing applications (a function given to local authorities by sections 5(3), 13(4), 69(4) and 172B(4) of the Licensing Act, as amended by Schedule 5 of the 2012 Act).
- If the local authority provides or commissions a maternity or child health clinic, then regulations made under section 73A(1) will also give the DPH responsibility for providing Healthy Start vitamins (a function conferred on local authorities by the Healthy Start and Welfare Food Regulations 2005 as amended)
- DsPH must have a place on their local health and wellbeing board (section 194(2)(d) of the 2012 Act).

7.3 Non legislative Responsibility

7.3.1 The DPH's most important functions are those laid out by law as detailed above but the role has a broader responsibility which the DH acknowledges is not always reflected in legislature.

7.3.2 The DPH must:

- Be the person who elected members and senior officers look to for leadership, expertise and advice on a range of issues, from outbreaks of disease and emergency preparedness through to improving local people's health and concerns around access to health services
- Know how to improve the population's health by understanding the factors that determine health and ill health, how to change behaviour and promote both health and wellbeing in ways that reduce inequalities in health
- Provide the public with expert, objective advice on health matters
- Be able to promote action across the life course, working together with local authority colleagues such as the Director of Children's Services and the Director of Adult Social Services, and with NHS colleagues
- Work through local resilience fora to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to public health
- Work with local criminal justice partners and police and crime commissioners to promote safer communities
- Work with wider civil society to engage local partners in fostering improved health and wellbeing.

7.3.3 Within their local authority, DsPH also need to be able to:

- Be an active member of the health and wellbeing board, advising on and contributing to the development of joint strategic needs assessments and joint health and wellbeing strategies, and commission appropriate services accordingly.
- Take responsibility for the management of their authority's public health services, with professional responsibility and accountability for their effectiveness, availability and value for money.
- Play a full part in their authority's action to meet the needs of vulnerable children, for example by linking effectively with the Local Safeguarding Children's Board, contribute to and influence the work of NHS commissioners, ensuring a whole system approach across the public sector. [8]

7.4 Subsequent guidance has also been issued by the DfE entitled 'Working Together to Safeguard Children' which states that the DPH should ensure that the needs of vulnerable children are a key part of the Joint Strategic Needs Assessment that is developed by the health and wellbeing board[9] and that public health professionals provide advice as needed to the LSCB and Child Death Overview Panel.

7.5 Details of the requirements of the JSNA can be found in Appendix 4 and a timescale for the completion of Enfield's is indicated in the initial Business Plan (Appendix 1).

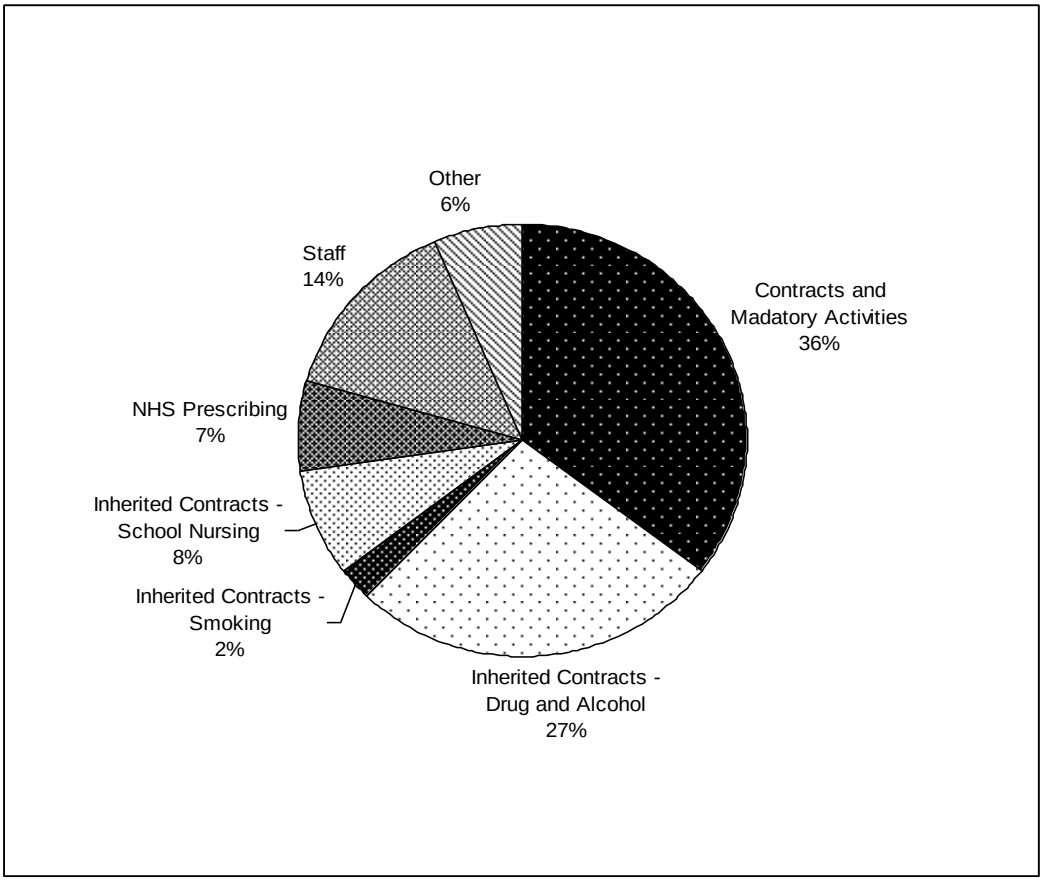
8 PUBLIC HEALTH BUDGET AND STRUCTURE

8.1 LBE's total ring fenced grant from the Department of Health is £12.961 million for Public Health functions and this will fund the provision of the mandatory and discretionary services detailed in section 4.

8.2 Figure 2 (overleaf) is a pie chart that illustrates expenditure on inherited contracts, mandatory functions, NHS prescribing costs, contracts for school nursing, Drug and Alcohol Treatment, smoking cessation services, staffing costs and other activities.

[8] DH (2012) *Directors of Public Health in Local Government*, Public Health in Local Government Guidance Note: Gateway Ref 17876
[9] DfE (2013) *Working Together to Safeguard Children*, Statutory Guidance: Reference DFE-00030-2013

Figure 2: Public Health Expenditure 2013/2014



8.3 The budgetary allocations for these functions are summarised in Appendix 2.

8.4 All public health contracts are recorded in the contracts register. The first contracts will come up for renewal on 1st April 2014, which means that notice will have to be given by 30th September 2013. The Joint Commissioning Board will make recommendations to the Health and Wellbeing Board of which ones to consider for potential change this year. Those contracts which were not previously commissioned either by the local authority or by the local public health team and where a potential

market exists for alternative suppliers will be prioritised for review.

8.5 Appendix 3 shows the structure of Public Health from April 2013, as detailed in the delegated authority report, which details the transfer of Public Health Consultants and Staff from NHS Enfield to the Council. This structure is intended to ensure that the Council is able to meet all its statutory responsibly for the Public Health functions transferred to the Council, maintaining professional standards and quality.

All posts in the structure could potentially undertake activities to improve the health of children and young people. We do envisage that there will be a Public Health Consultant on Children and Young People, one on Adults and interfacing with the CCG and one on health life styles and healthy places.

8.6 In addition to this, it is the intention to transfer LBEs Corporate Intelligence function to Public Health by 2014.

8.7 Vulnerable Children

In addition to current investments in vulnerable children, we will in 2013/14 Invest a further £20,000 to improve the health of vulnerable children. The exact plan will need to be developed further, but might include additional Healthchecks for vulnerable children or additional immunisation or anti smoking/drugs educational sessions. The Public Health Team will continue to work with colleagues in Childrens Services to ensure that future plans reflect the priorities for children and young people and link directly to the Children and Young Persons Plan and the Enfield Safeguarding Children's Board priorities and work plan.

9 REASONS FOR RECOMMENDATIONS

9.1 To ensure that the Local Authority has the appropriate capability and focus within the Public Health Directorate and ensure that Local Authority objectives are met in line with its new mandatory responsibilities and non mandatory responsibilities.

9.2 To enable dialogue to commence with our new providers and provide them with the knowledge of the criteria that is involved when working with the local authority, which is significantly different to the NHS.

9.3 To ensure continuity of joint working with the NHS.

9.4 To ensure that the current staff who have transferred to LBE are treated fairly in line with TUPE principles.

10 COMMENTS OF THE DIRECTOR OF FINANCE, RESOURCES AND CUSTOMER SERVICES AND OTHER DEPARTMENTS

10.1 Financial Implications

10.1.1 With effect from 1st April 2013, LBE will receive a single ring-fenced Public health grant that will cover three components:

- Mandated (statutory) services (sexual health services, NHS Health checks, National Child Measurement Programme, providing public health advice to NHS Commissioners and ensuring plans are in place to protect the health of the public);

- Non-mandated services (Tobacco control & Smoking Cessation services, increasing levels of physical activity and interventions to tackle obesity)

- The commissioning of drug and alcohol prevention and treatment services, which are currently commissioned by Drug and Alcohol Action Teams (DAAT's)

10.1.2 The Department of Health (DH) announced in early January 2013 that the grant allocation for 2013/14 will be £12.961 million rising by 10% to £14.257million in 2014/15. However it should be noted that Enfield has historically been underfunded in the area of Public Health. This was confirmed in the work carried out by the DH in determining the new Public Health grants. The baseline spend per head for 2013/14 is £36 per head (p.h). The actual target is £48 p.h. However even though Enfield was one of the Boroughs to receive the maximum increase of 10%, the grant allocation equates to £40 p.h, i.e. £8 below target (circa £2.6million). The position for 2014/15 is similar, with a target of £50 p.h, but actual grant equating to £43 p.h, i.e. £7 below target (circa £2.2million).

10.1.3 Appendix 2 provides an analysis of how the grant will be allocated to each category and the 2013/14 budget has been set on this basis.

10.1.4 Appendix 3 details the new Public Health structure, which consists of 27 permanent posts, which will be funded from the grant.

10.1.5 The grant is ring-fenced for promoting public health within the Council and cannot be used to support general Council expenditure. The associated grant conditions are specific to public health outcomes, with the requirement to submit both quarterly & annual expenditure returns, to the Department for Communities and Local Government & Public Health England. In addition the Public Health budgets will form part of the monthly budget monitoring cycle, which is reported through to Health and Adult Social Care DMT.

10.2 Legal Implications

10.2.1 The Health and Social Care Act 2012 gives local authorities new statutory responsibilities in respect of delivery of public health functions. One of its key proposals is the transfer of the existing public health functions from Primary Care Trusts to local authorities. The Act identifies the expected and mandated public health commissioning responsibilities from local authorities from April 2013. The Council's objectives set out in this report are in accordance with Health and Social Care Act 2012. Approving this report will enable the Council to implement its objectives.

10.2.2 The resultant contracts must be in a form approved by the Assistant Director of Legal Services.

10.3 Human Resources Implications

10.3.1 The transfer of Public Health Consultants and establishment of team within the Council has been detailed in a separate Delegated Authority Report.

11 KEY RISKS

A comprehensive analysis of the risks associated with the changes set out in this report has been undertaken and collated into a Public Health Transition Risk Register. The key areas of risk are summarised below:

<u>Contractual</u>

11.1.1 In keeping with the decision of Cabinet, the majority of contracts have been extended for one year to 31 March 2014 for continuity of service. These contracts will be reviewed during 2013/14.

<u>Financial</u>

11.1.2 2013/14 budget pressures arising from responsibility for contracts liabilities not identified during the transition year (particularly where the current provision is part of a large complex block contract).

11.1.3 Not all contracts have been transferred with historical performance data.

<u>Sexual Health</u>

11.1.4 Whilst it is anticipated that the majority of the sexual health spend will be commissioned and therefore manageable, the intent is that genitourinary medicine (GUM) services will continue to be provided through the national arrangement. Under this provision a resident of Enfield can access GUM services in any location of England and Wales and the provider

is to be reimbursed by the borough of residence. As this service is open access, the total spend is uncapped and could exceed the estimated budget.

11.1.5 Under the VD Act 1974, the resident seeking treatment is entitled to their privacy. This has been interpreted as the patient not having to give their full / proper name or address whilst the service provider still has the security of being paid. GUM services present a risk to the Council with an indicated spend of £2.5m.

Enhanced Services

11.1.6 Nationally Local authorities will not be able to commission Local Enhanced Services (LESs) for services that commence on or after 1 April 2013 as LESs are financial devices designed to transfer funding between NHS bodies and can only be commissioned by the NHS Commissioning Board. They are not available to Local Authorities. Therefore, Enfield will need to use its own commissioning powers and contracts to deliver public health services.

11.1.7 Enfield CCG (ECCG) has proposed to include the GP Enhanced Services in its overall commissioning budget and have the CSU manage the services. An agreement has to be made between ECCG and LBE.

12 IMPACT ON COUNCIL PRIORITIES

12.1 Fairness for All

12.1.1 The Council is committed to reducing health inequalities across the Borough and believes the Public Health Directorate to be a key contributor towards health reform.

12.1.2 Public Health is focussing on helping people to stay healthy and avoid becoming ill. This includes work on a range of policy areas such as immunisation, nutrition, tobacco control and alcohol, drugs recovery, increasing healthy lifestyles, sexual health, pregnancy and children's health. The transfer of public health into the Council supports the aim of making health everyone's business.

12.2 Growth and Sustainability

12.2.1 At the heart of the Council's priority of sustainable growth within our community is ensuring that public health is always considered during the decision making process – both by the Council itself and statutory and non-statutory partners.

12.3 Strong Communities

12.3.1 The mission of Public Health at LBE is to improve the health of people in Enfield by working in partnership with communities, families and individuals to do the following:

- Identify health needs and health inequalities;
- Support collective and individual action to prevent illness;
- Protect and promote good health and wellbeing;
- Tackle the causes of premature death, illness and reducing health inequalities in the borough.

13 EQUALITIES IMPACT IMPLICATIONS

13.1 The Council has an unwavering commitment to reducing health inequalities in the Borough and is confident that the proposed objectives, action and structure of Public Health will support this.

13.2 The transfer of public health to local government is being brought about under the Health and Social Care Act 2012. Although this is a national policy change, officers have reflected on the equalities implications, in order to understand whether there would be any negative impact which the Council would need to respond to.

13.3 The changes mean that public health professionals will be able to work closely with local people's elected representatives to influence all the factors that determine health, working in the places where people live their lives and use services.

13.4 Enfield Council has already identified the extent of inequalities in its population in its Joint Strategic Needs Assessment, carried out in partnership with the NHS, and are working to reduce the identified health inequalities.

13.5 Health equity audits are undertaken to understand the extent and nature of inequalities in relation to a particular public health issue or service area, and are used to inform future commissioning plans and work programmes.

13.6 Therefore, the transfer of public health is expected to have a positive impact on the ability of the Council to meet the needs of all groups within the community.

14 PERFORMANCE MANAGEMENT IMPLICATIONS

14.1 All performance management will be undertaken through the Health, Housing and Adult Social Care performance management processes already in place.

15 PUBLIC HEALTH IMPLICATIONS

Public Health is often described as having three key domains:

15.1 Health Improvement

15.1.1 Including contributing to increased life expectancy and healthier lifestyles as well as reducing inequalities in health and addressing the wider determinants of health.

15.2 Health Protection

15.2.1 Including protection from infectious diseases, environmental hazards and emergency preparedness.

15.3 Health Services

15.3.1 Including assisting those who plan health care to understand the health profile and health needs of the local population, and plan services to meet those needs, as well as evaluating how successful services are in meeting needs.

15.4 Guidance from the DH points to key means by which the local authority will deliver public health benefits:

- The new role of the Director of Public Health
- Health and Wellbeing Boards, Strategic planning and commissioning across local partnerships
- Commissioning services to meet local needs
- Public Health Outcomes Framework.

Appendix 1 **Public Health Business Plan 2013/14**

This will be part of the HHASC Business Plan but the children's element will also link into the Schools & Children's Services and the Children's Trust.

Departmental objectives for 2013/14	Key Milestones	Target Date
Strengthening Partnerships		
Provide evidence-based input into treatments outside Service Level Agreements	• Completion of up to 100 Individual Funding Requests (IFRs) • Work with CCG to reduce the number of IFRs • Input into the Commissioning Strategic Plan	On-going On-going Jan – March 2014
Ensuring that the needs of the Borough are known and understood and that Public Health informs commissioning decisions of the CCG and London Borough of Enfield	Producing a new Joint Strategic Needs Assessment (JSNA) by May 2013 by: • Analysis of Enfield demographics • Analysis of uptake and use of health services • Analysis of the health needs of the borough • Highlight of Mental Health issues in borough • Consultation and engagement with the LA, partnership agencies and residents to agree the priorities of the borough	Jan – May 2013

Departmental objectives for 2013/14	Key Milestones	Target Date
	• Production of a joint Health and Well-being Strategy following production of the JSNA	
Care pathway redesign	• Input into care pathway planning especially where this spans health and social care (community, primary & acute) to ensure cost effectiveness of services, more focus on early intervention / prevention & possibility of cost savings. Examples might include diabetes / maternity but would need agreement from the CCG	
Communications		
Production of:	PH report Social Marketing campaign on child healthy weight PH conference Health bus (if available) PH newsletters Establishment of locality groups Community Roadshow to promote Cancer awareness and diagnosis Development of community development and	December 2013 December 2013 December 2013 Depending on availability 1 a quarter December 2013 May 2013

Departmental objectives for 2013/14	Key Milestones	Target Date
	behaviour change programmes Reviews of evidence of best practice and community engagement Increased performance management, analysis and monitoring of community interventions, effectiveness etc.	
Narrowing the Gap		
Strategy development	Development of 7 year health inequalities strategy. This should include reduction of the Enfield life-expectancy gap to the London average.	October 2013
Community Healthchecks	• Continued roll-out of the community healthchecks programme • Agreement and implementation of healthchecks model and funding for 2013 onwards • Targeting of people who are not registered with GPs or who are unlikely to respond to GP invites	200 per month
Reducing Smoking Prevalence	• Dissemination of evidence base for smoking prevention • Conference on tobacco control for Enfield	On-going – initial document Sept 2013 December 2013

Departmental objectives for 2013/14	Key Milestones	Target Date
	stakeholders • Seek funding for prevention interventions e.g. Leicester smoking campaigns in schools focusing on young people signing up to not becoming smokers	Ongoing
Health Trainers	• Continue to promote health trainers • Target towards areas of high inequality, either deprivation and / or ethnicity.	150 contacts per month
A Healthy Start		
Strategy development	Development of 7 year strategy to improve child health. This should include reduction of infant mortality rates.	January 2014
Ensuring good uptake of Childhood Immunisation and vaccinations	Ensuring good uptake of childhood immunisation and vaccination programmes by holding the NCB / PHE to account.	TBC following guidance from NCB / PHE
Reducing Infant	• Promotion of 'Back To Sleep campaign'	On-going

Departmental objectives for 2013/14	Key Milestones	Target Date
mortality	through variety of media • Encouraging all pregnant women to have a maternity check before 12 weeks through variety of media and Health Equity Audit of early access (HEA – December, 2013) • Promotion and social marketing to communicate messages regarding the importance of early maternity booking and safer sleeping • Working with partners to implement the infant mortality action plan; performance monitoring via the Child Health Steering Group. Key actions: - stopping smoking in pregnancy - improving maternal / infant nutrition through Healthy Start - On-going data analysis	On-going On-going By December 2013 (next data release)
Breastfeeding	• Promote breastfeeding within the community through recruitment and support of 24 breastfeeding helpers • Promotion through variety of media	On-going On-going
Vulnerable children	Ensure needs of vulnerable children identified in Joint Strategic Needs Assessment and responded to appropriately. Ensure good vaccination rates in looked after	

Departmental objectives for 2013/14	Key Milestones	Target Date
	children Support Child Death Overview Panel and Local Children's Safeguarding Board	
Child Healthy Weight	• Delivery of the National Child Measurement Programme (NCMP) • Leadership of the child healthy weight board • Analysis of NCMP data to identify areas of greatest need (working with colleagues in the Children's Trust • Mapping of current prevention and intervention services to identify gaps in provision • Pilot projects, evaluate and disseminate findings • Monitor and implement action plan through delivery board	Annual, results to be submitted in August Ongoing On-going October 2013 December 2013 On-going
Healthy Lifestyles / Healthy Choices		
Strategy development	Develop 7 year strategy to improve life-styles. This should include best practice on	October 2013

Departmental objectives for 2013/14	Key Milestones	Target Date
	measurement of changes in life-styles	
Helping people to stop smoking	Achieving the smoking 4-week quitter target of 1,569 by: • Regular performance monitoring meetings with the smoking provider • Quarterly monitoring of achievement against the smoking target • Advertising of the service and ensuring that the service is as widely known as possible • Offer stop smoking to all smokers accessing LBE benefits systems • Implementation of automatic smoking referral system in North Middlesex • Roll-out of NRT prescribing and smoker referral project in Primary Care	On-going Quarterly On-going September 2013 Jan 2014 June 2013
Roll-out of the NHS Healthchecks programme	Ensure continued roll-out of the NHS Healthchecks programme by: • Continued offer and delivery of healthchecks by Primary Care through GP practices • Implementing new Healthchecks contract LES	Ongoing – 5500 delivered 2013-14 July 2013

Departmental objectives for 2013/14	Key Milestones	Target Date
Breast, Bowel & Cervical Screening	Assurance of uptake rates by holding NCB / PHE to account	TBC following guidance from NCB / PHE
HIV and sexual health	• Continued work with teenage pregnancy coordinator to reduce U18 conception rates • Promotion of access to emergency health contraception through expansion of service • Encourage early diagnosis of STIs and HIV through training and promotion to primary care staff • Reduction of rate of late diagnosis of HIV • Expand SHIP training and evaluate impact of training • Implement condom scheme across the borough Expand Sexual Health work in schools	On-going On-going On-going On-going March 2014 June 2013 March 2014
Winter flu	Ensuring uptake rates of winter flu vaccine in Primary Care including: • Residents aged 65+ • Pregnant women	Aug 2013 to March 2014

Departmental objectives for 2013/14	Key Milestones	Target Date
	• Vulnerable residents	
Infection control	Work with Primary Care, social care, PH England, health protection to reduce incidence of infectious diseases	On-going
Healthy Places		
Strategy development	Develop 7 year strategy, this should include health and well-being, physical activity, smoke-free areas, healthy high streets, open spaces and fear of crime.	October 2013
Reducing Smoking Prevalence	• Implementation of tobacco control strategy • Increase smoke-free areas in Enfield – including smoke-free children's play areas (e.g. all parks) • Reduce availability of illicit and illegal tobacco • Reduce acceptability of smoking in front of children – e.g. in front of school gates, in hospital grounds etc • Introduce prevention programmes in schools • Work with Youth Offending Programme,	On-going April 2013 and on-going On-going On-going December 2013 On-going

Departmental objectives for 2013/14	Key Milestones	Target Date
	Youth Engagement Panel to reduce smoking prevalence in young people	
Improving the wider determinants of health	• Develop evidence base of how physical activity in the borough can be increased • Develop evidence base of benefits of increasing physical activity • Promote concept of health parks and Green Flag scheme • Develop steering group • Develop action plan • Begin work to improve air quality • Input into transport plans, worklessness, households in temporary accommodation • Input into PH implications of CMB reports • Input into place-shaping agenda e.g. PH aspects of planning / building and input through HUDU model • Build on healthy schools, health promoting hospitals work	September 2013 May 2013 June 2013 July 2013 September 2013 Sept 2013 Sept 2013 On-going On-going On-going
Primary Care	Work with Primary Care to: • Increase the number of people referred to the Stop Smoking Service • Improve NRT prescribing – e.g. offered to	June 2013 On-going

Departmental objectives for 2013/14	Key Milestones	Target Date
	all smokers but for no longer than 2 weeks at a time • Improve prevalence and treatment of hypertension, hypercholesterolemia, diabetes, COPD. Production of registered / expected and work with Enfield practices / ECCG to close gaps • Promote early awareness of cancer and faster diagnosis and treatment	March 2014 On-going
Violence	Work with stakeholders to reduce violence and fear of violence – gang violence, violence against women Develop evidence base Dissemination of evidence base through workshop with safer / stronger.	September 2013 October 2013
Establish alcohol alliance	Production of alcohol strategy Production of alcohol action plan Alcohol campaign summer 2013	November 2013 December 2013 July 2013
Emergency Preparedness	Ensuring that robust health protection and emergency planning arrangements are in place.	On-going

Appendix 2: Public Health Budget Summary 2013/14

(As Per Appendix C_ LAC (DH) (2013) 1_ Ref: 18552) Categories for reporting local authority public health spend	£'000 2013/14 12,961	£'000 2014/15 14.257
Public health leadership Including Special Projects	1,615	To be determined following the Health & Wellbeing Strategy
Information & Intelligence Team	218	
Prescribed functions:		
1) Sexual health services - STI testing and treatment	2,656	
2) Sexual health services – Contraception	158	
3) NHS Health Check programme	454	
4) Local authority role in health protection	63	
5) Public health advice	189	
6) National Child Measurement Programme	80	
Non-prescribed functions:		
7) Sexual health services - Advice, prevention and promotion	1,109	
8) Obesity – adults	100	
9) Child Healthy Weight	75	
11) Physical activity - children	20	
12) Drug misuse - adults	3,291	
13) Alcohol misuse - adults	150	
14) Substance misuse (drugs and alcohol) - youth services	52	
15) Stop smoking services and interventions	528	
16) Wider tobacco control	30	
17) Children 5-19 public health programmes	1,041	
18) Additional Public Health Functions	854	
19) Obesity treatments	186	
Total Budget	**12,867**	
PH Contract Variation Contingency	94	
Total Budget Allocations	**12,961**	
	0	

Appendix 3: Public Health Structure 2013/14