Committee: Children and Young People Overview and Scrutiny Panel

Date: 18 April 2012

Agenda item: 7
Wards: All Wards

Subject: **Public Health Transition and Performance in Merton**

Lead officer: Dr Val Day, Interim Director of Public Health

Lead members: Councillor Maxi Martin, Councillor Peter Walker.

Forward Plan reference number: N/A

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Recommendations:

A. Children and Young People's Overview and Scrutiny Panel note and discuss the contents of this report.

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1. Purpose of report and executive summary

The purpose of this report is twofold:

1.1 To update the Scrutiny Panel on the transition of Public Health functions from the NHS to the Local Authority and highlight the implications for children and young people.

1.2 To update the Scrutiny Panel on public health performance in Merton, highlighting findings published in the recent 'Child Health Profile 2012'. It also focuses on childhood immunisation, childhood obesity and dental registrations.

DETAILS

2 PUBLIC HEALTH TRANSITION

2.1 The Health and Social Care Act includes a transfer of responsibilities for public health from NHS Primary Care Trusts to local authorities from April 2013. The Council must appoint a Director of Public Health to take responsibility for its public health functions which include duties to improve the health of the people in the area of the borough, including information and advice, as well as services to promote healthy living and for the prevention, diagnosis and treatment of illness, and advice to the clinical commissioning group to enable it to discharge

its own functions in relation to prevention, diagnosis and treatment of illness and the protection and improvement of public health.

2.2 The clauses in the Act that relate to the public health provisions as applicable to local authorities are included as Background Paper 1 to this report. Further detail about the public health functions was published in December 2011, and is included in sections 2 and 3 of the London Borough of Merton Public Health Transition Plan, which is attached as Appendix 1. Although there has been substantial debate in Parliament since December, the amendments relating to the public health responsibilities of local authorities only apply to the need for the local authority to have regard to any document published by the Secretary of State for Health, including the exercise of the functions and the appointment of officers to discharge the functions, including the Director of Public Health. Parliamentary debate has not challenged the core proposals, which remain as published in the December guidance.

2.3 The new public health responsibilities are intended to clearly demonstrate the leadership role for local authorities in:

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

The vision for local government leadership of public health is that health and wellbeing is integral to everything the council does, and that health impact (what will this do for the health and wellbeing of the population? will this reduce health inequalities locally?) and maximising health benefit are systematically assessed during policy development.

2.4 Local authorities are required to agree plans for the transition of public health, including staff, programmes and contracts. A local transition plan is required by NHS London by 5 April 2012, although it is recognised that Council sign off may not have been achieved by this date.

2.5 In Sutton and Merton, where Public Health services are currently provided by NHS Sutton and Merton across both boroughs, transition has the added complexity of requiring decisions and possible consultation about the distribution of the public health arrangements between the two boroughs.

2.6 The Draft London Borough of Merton Public Health Transition Plan (Appendix 1) sets out a draft plan for the transition of public health functions from NHS Sutton and Merton to the London Borough of Merton in 2012/2013. The plan includes:

- The governance and assurance structures and processes that will be in place to support the transition
- The critical activities that need to be undertaken to ensure a smooth transition:
- The critical activities that must be delivered during the transition year to ensure that business as usual is not compromised as services and people transition
- The milestones that must be met during transition and the dependencies and interdependencies of supporting activities

- The key risks and issues that will need to be addressed during transition
- The control and reporting arrangements

The plan is supported by a number of appendices including the transition action plan which details the tasks that need to be carried out and will act as a tool to measure progress.

Implications for Children and Young People

2.7 The majority of Public Health functions currently commissioned by NHS Sutton and Merton are being transferred to local authorities but a few, significant services are being transferred to other organisations including:

- NHS Commissioning Board:
  - Child Health 0-4 years, including health visiting, immunisations and mental health
- Public Health England
  - Dental Health leadership

As a result, the responsibility for commissioning children's and young people's services will be split between the NHS Commissioning Board and the local authority who will have responsibility for children from 5-19. This separation of commissioning will continue until 2015 when it is proposed that local authorities will also become responsible for children 0-4.

2.8 While the commissioning responsibilities are changing, the providers of services are likely to remain the same in the short term, while new commissioning organisations review the contracts.

2.9 The Director of Public Health will have responsibility for providing public health advice to both the Council and to NHS commissioners and so will be in a good position to ensure co-ordination, consistency and quality of quality of services across all the children's and young people's services.

2.10 A new Public Health Outcomes Framework for Public Health 2013 - 2016 was published in January 2012, which sets the vision for public health and consists of two overarching outcomes, increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities. These will be delivered through a broad range of indicators grouped into four domains and include indicators specifically aimed at children as well as others covering all age groups. Those indicators that are most relevant to children and young people are shown below. A fuller summary is attached as Background Paper 2.

- Domain 1: Improving the wider determinants of health:
  - Children in poverty
  - School readiness
  - Pupil absence
  - First time entrants to the youth justice system
  - 6-18 year olds not in education, employment or training

- Domain 2: Health Improvement

- Low birth weight of term babies
- Breastfeeding
- Smoking status at the time of delivery
- Under 18 conceptions
- Child development at 2-2.5 years
- Excess weight in 4-5 and 10-11 year olds
- Hospital admission caused by unintentional and deliberate injuries in under 18s

- Domain 3: Health Protection
  - Air pollution
  - Chlamydia diagnosis (15-24 year olds)
  - Population vaccination coverage

- Domain 4: Healthcare public health and preventing premature mortality
  - Infant mortality
  - Tooth decay in children aged 5

2.11 There are other indicators relevant to children in the NHS Outcomes framework, including stillbirths and neonatal mortality and emergency admissions for children with lower respiratory tract infection.

2.12 During the transition year, contracts and performance will be measured against the Public Health indicators and will be monitored by the Public Health Transition Board for Merton.

3 PUBLIC HEALTH PROFILE AND PERFORMANCE

3.1 Borough level Child Health profiles have been published for the past three years by the national Child and Maternal Health Observatory. The most recent profile was published in March 2012 and provides a snapshot of performance against 32 selected public health indicators. It compares Merton with the England and London and with the boroughs' Children's Services 'statistical neighbours' (local authorities with similar characteristics: Barnet, Kingston upon Thames, Ealing and Redbridge). See Appendix 2 for full profile.

3.2 The profile highlights the following key findings:

- Around 22% of the population of Merton us under the age of 20. Around 61% of school children are from a black or minority ethnic group

- The health and wellbeing of children in Merton is generally better than the England average. Both the infant mortality rate and the child mortality rate are similar to the England average.

- The level of child poverty is better than the England average with 20% of children aged under 16 years living in poverty

- Children in Merton have average levels of obesity. 8% of children in Reception and 20% of children in Year 6 are obese. 58% of children participate in at least three hours of sport a week which is better than the England average.

- The MMR immunisation rate is lower than the England average. Immunisation rates for Diptheria, tetanus, polio and pertussis and Hib in children aged two are lower than the England average.

- The hospital admission rates for alcohol specific conditions is lower than the England average. The percentage of children who say they have been drunk recently is lower than the England average.

3.3 The Health profile provides a high level overview of public health issues in Merton. Further detail is available locally in the Joint Strategic Needs Assessment which is available on-line at www.jsna.suttonandmerton.nhs.uk.

3.4 Three public health issues are addressed in more detail below: childhood immunisations, obesity and dental registrations, together with an update on new data on teenage pregnancy.

Childhood Immunisation

3.5 After clean water, vaccination (immunisation) is the most effective public health intervention in the world for saving lives and promoting good health. The primary aim of vaccination is to protect the individual who receives the vaccine. Vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of unvaccinated individuals being exposed to infection. This means that individuals who cannot be vaccinated will still benefit from the routine vaccination programme. This concept is called population (or 'herd') immunity. The World Health Organization (WHO) recommends at least 95% of pre-school children to receive the recommended vaccinations to achieve 'herd' immunity.

3.6 All children starting the immunisation programme at 2 months of age will follow the schedule below:

When to immunise	What is given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (DTaP/IPV/Hib)
	Pneumococcal (PCV)

When to immunise	What is given
Three months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (DTaP/IPV/Hib)
	Meningitis C (MenC)
Four months old	Diphtheria, tetanus, pertussis (whooping cough) , polio and Haemophilus influenzae type b (DTaP/IPV/Hib)
	Pneumococcal (PCV)
	Meningitis C (MenC)
Between 12 and 13 months old - within a month of the first birthday	Haemophilus influenzae type b, Meningitis C (Hib/MenC)
	Measles, mumps and rubella (MMR)
	Pneumococcal (PCV)
Three years four months to five years old	Diphtheria, tetanus, pertussis and polio (dTaP/IPV or DTaP/IPV)
	Measles, mumps and rubella (MMR)
Girls aged 12-13 years	Human Papillomavirus Vaccine (HPV)
Thirteen to 18 years old	Tetanus, diphtheria and polio (Td/IPV)

3.7 The (Cover of Vaccination Evaluated Rapidly) COVER programme monitors immunisation coverage data for children in the United Kingdom (by PCTs) who reach their first, second or fifth birthday during each evaluation quarter. This information is promptly fed back to local level, creating the opportunity to improve coverage and to detect changes in vaccine coverage quickly.

3.8 In the table below are the selected immunisation performance indicators for 2010-11. (Source: The NHS Information Centre, September 2011). During the year quarterly data is published, but this is not significantly different to the full year data for 2010/11. Data is currently only published for the whole PCT and not by borough, although uptake at GP practice level is made available to practices.

	Age 1	Age 2			Age 5	
	DTaP/IPV/Hib	**Hib/MenC**	**PCV**	**MMR1**	**DTaP/IPV/Hib**	**MMR2**
England	94.2%	91.6%	89.3%	89.1%	85.9%	84.2%
London	90.7%	84.9%	82.4%	83.8%	74.7%	76.6%

NHS SM	89.4%	78.3%	76.9%	81.6%	72.7%	79.8%

3.9 Uptake locally is below the 95% level that would be ideal. Probable reasons for this are varied and include:

- Mobile population: A highly mobile population, which is a feature of London regions, gives rise to an inaccurate database of eligible population.
- Inaccurate, inconsistent and incomplete coding of immunisation history, complicated by change in vaccines, scheduling and revision of codes.
- Lack of regular updating of information between the GP practices and Child Health Records System, some of which is hampered by incompatible IT systems.
- Delayed immunisation of children which is not captured in performance figures, particularly in children moving in to the area.
- Lack of concerted effort in follow up of children defaulting on immunisation.
- Refusal of parents/ guardians to immunise children.
- Lack of information about, or knowledge of opportunities, to immunise children.
- Less than adequate performance management and clinical championing of immunisation.

3.10 Addressing underperformance in Sutton and Merton is a priority. The following measures have been planned to improve immunisation performance in Sutton and Merton for 2012-13. It is anticipated that they will have a significant impact on improving Merton's immunisation performance:

- An incentive related payment scheme for 2012-13 with GPs, who demonstrate proof of best-practices and processes to improve immunisation by second birthday of the child.
- Consistent and accurate coded (READ codes) information on immunisation history of the child.
- Upgrading of software for more timely and accurate information from the GPs to Child Health Records System and back.
- Verification of accuracy of registered children.
- Timely follow up of children defaulting on immunisation.
- Audit of unusually low rates for some of the vaccinations.
- Involvement of GPs/ nurses as clinical champions.

- Regular and intensive performance management.
- Immunisation promotion activities.

Childhood Obesity

3.11 Promoting healthy weight is a major public health challenge and there are rising trends in overweight and obesity for children and adults.

3.12 In Merton 19.5% of children in Reception are overweight or obese. Just over 36% of children in Year 6 are overweight or obese. There is an increase of nearly 12% in the number of children in Merton classified as obese in Reception and in Year 6. In reception the level is below the England average of 9.4%, but in Year 6 it is above the England average of 19%.

Table: Childhood Overweight and Obesity (by residence of child) 2010/11
(source: NHS Information Centre)

	Reception			Year 6		
	overweight	obese	Overweight and obese combined	overweight	obese	Overweight and obese combined
England	13.2	9.4	22.6	14.4	19.0	33.4
London	12.4	11.1	23.5	15.2	21.9	37.1
Merton	**10.9**	**8.4**	**19.5**	**16.5**	**19.6**	**36.1**

3.13 The causes of obesity are complex, having behavioural, genetic, environmental and social components, and it is a key health inequality issue. The health risks associated with being overweight and obese are many, including increasing risk of diabetes, cancer, heart and liver disease. Obesity costs the NHS in Merton over £50milion per year and there are wider costs to the local authority. Tackling obesity, including children and families, and adults is a priority, particularly in relation to raising life expectancy in East Merton.

3.14 A range of services and initiatives are in place to promote healthy weight including:

- school sports and healthy eating activities
- access to parks and open spaces
- Leisure centre services
- a targeted weight management service, ‘Alive n Kicking’, for children and their families
- a programme of physical activity, including targeted activities for girls, linked to the Olympics Legacy
- ‘LiveWell’ service providing personalised support for parents to improve their health

3.15 However, there is a need to have a better understanding of the scope and extent of overweight and obesity and to review the evidence about the effectiveness, and cost effectiveness, of interventions. It has been agreed that

an in-depth needs assessment will be undertake during 2012/13 in order to identify how best resources can be targeted across Merton to have the biggest impact on reducing obesity and provide recommendations for commissioners.

Dental Registrations

3.16 Dental care for children is free on the NHS, and children may be taken to the dentist for advice and care anytime from birth. Once their teeth have started to appear it is advisable for a dentist to check they are growing properly, and children should normally see the dentist at least once a year.

3.17 Dental registrations are not available at borough level. For NHS Sutton and Merton, the number of children (aged to 18 years, or 19 years if in full time education) is 53,387 for the 24 month period to February 2012. The number of children in aged 0-19 years in Sutton and Merton is around 95,000. Registrations have decreased slightly from 55,480 in 2006. The changes in the NHS consequent up on the Health and Social Care Act are likely to result in borough data becoming available form 2013.

3.18 Some general advertising has been undertaken to encourage people to see a dentist. For children, advice and encouragement should be given to families and carers by health visitors and in Children's Centres. We will explore with the borough Children's Services how best to address the need to increase dental access by children and young people.

Teenage Pregnancy

3.19 Since the publication of the Child Health Profile new data has been released on Teenage Pregnancy. In Merton teenage conceptions in girls age under 18 years has reduced to a rate of 30.4 per 1000 females aged 15-17 years (2010).

3.20 Merton has seen a 40.4% reduction in its under-18 conception rate since 1998, the time period of the Government's teenage pregnancy strategy. In 1998 the borough had a rate of 51.0 teenage conceptions per 1,000 females aged 15-17 year olds compared to the most recent figure of 30.4 in 2010. This reduction has been the second highest in outer London after Ealing, and has led to a lower rate than both London and England. This endorses Merton's long term commitment and support to this area of work throughout the last 10 years, particularly the fairly consistent membership of the partnership board which leads on this agenda.

3.21 The reasons behind teenage pregnancy have not changed. For a variety of reasons – lack of knowledge, lack of confidence to resist peer pressure, poor access to advice and support, low aspirations – around 100 young women in Merton become pregnant each year. Around three quarters are unplanned and over half end in abortion. Estimates from the Office for National Statistics on the prevalence of teenage mothers show 121 mothers aged under-20 in Merton at the end of 2009, all of which will require some level of support from the Local

Authority and PCT. Many of these are our most vulnerable young people such as Looked After Children and those who are Not in Education, Employment or Training. A comprehensive Teenage Pregnancy Action Plan is in place to address these issues.

4 ALTERNATIVE OPTIONS

Public Health Transition is not an option under the Health and Social Care Act 2012, although options for the service structure and design are currently being considered.

5 CONSULTATION UNDERTAKEN OR PROPOSED

Public Health Transition: There will be a consultation process before the transfer of staff, which may be under a transfer order, or under TUPE or TUPE like arrangements.

6 TIMETABLE

Public Health Transition: The timetable and key milestones for the transition of public health functions are covered in the Transition Plan and include:

- Public Health responsibilities will transfer to the Council on 1 April 2013.
- The Public Health ring-fenced Grant is expected to be announced in December 2012, for 2013/14.

7 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

Public Health Transition: Public health functions and staff will be funded by the Public Health Grant. There are concerns that this will be sufficient to fully fund the functions. There are also concerns that the proposed baseline funding allocation for Merton at £34 per head of population is below the average England spend of £40 per head. In addition, any decision to appoint a sole Director of Public Health will have costs implications, and an agreement to make 3% of the Public Health Grant available to the Mayor for London-wide public health delivery (£210,000 approximately), will need to be funded. Detailed analysis of the Public Health spend and the on-going commitments against the likely Public Health Grant is underway.

8 LEGAL AND STATUTORY IMPLICATIONS

Public Health Transition: In preparation for the transition year 2012/13, Primary Care Trusts are required to agree a Memorandum of Understanding (MoU) with their local authority covering working arrangements during the transition year. The MOU between NHS SW London and the London Borough of Merton has been agreed. The MoU makes clear that the continuing legal, professional and clinical accountability for public health functions and staff remain with NHS

SW London, Sutton and Merton, until 1 April 2013, unless any formal legal agreement to transfer any responsibilities to the London Borough of Merton is put in place. It also sets out the role of the Public Health Transition Programme Board for the oversight of the transition, as well as the monitoring of performance and outcomes of public health functions, including finance and activity to ensure transparency between the PCT and the Council during the transition year.

9 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

Public Health Transition: The statutory duty on the Council for public health will include the reduction of health inequalities

10 CRIME AND DISORDER IMPLICATIONS

None relating to this covering report

11 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

Public Health Transition: A risk log is attached to the Transition Plan as Appendix 6, identifying potential risks to transition. The Transition Project Board will agree mitigation plans and monitor the risks regularly.

APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

Appendix 1. London Borough of Merton Public Health Transition Plan and Transition Action Plan
Appendix 2. Child Health Profile for Merton, March 2012

BACKGROUND PAPERS

Health and Social Care Bill: Public Health provisions as applicable to local authorities

Improving outcomes and supporting transparency; A Public Health Outcomes Framework for England, 2013-2016
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf

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Appendix 1

South West London

LONDON BOROUGH OF MERTON

PUBLIC HEALTH TRANSITION PLAN

DOCUMENT CONTROL

Revision History

Document Number	Reason for Revision	Author	Issue Date
V2	Presented to the Public Health Transition Board	Anne Reeder	09.03.12
V3	V2 incomplete. Completed for submission to the Transition Board and LBM Executive	Anne Reeder	26.03.12
V3.1	Minor Amendments	Val Day	28.03.12
V3.2	Minor Amendments	Anne Reeder	30.03.12

CONTENTS

Executive Summary

The Health and Social Care Act (2012), includes a series of clauses that will transfer public health functions, currently the responsibility of NHS primary care trusts, to local authorities. The new system will give clear accountability for the improvement and protection of their population's health to local government. These new responsibilities will transfer on 1 April 2013.

Public Health services for the London Borough of Merton are currently provided by NHS Sutton and Merton, which also provides services to the London Borough of Sutton. It will be necessary to review and consider the redesign of the structure of the Public Health team before the services can transfer, in recognition of the potential for two separate teams, one for each borough.

PCTs and local authorities are required to produce and implement a transition plan providing assurance to the local authority and the NHS that robust arrangements are in place to support the transition of public health functions, including services, staff and resources.

This document sets out a draft plan for the transition of public health functions from NHS Sutton and Merton to the London Borough of Merton in 2012/2013. The plan sets out:

- The governance and assurance structures and processes that will be in place to support the transition
- The critical activities that need to be undertaken to ensure a smooth transition:
- The critical activities that must be delivered during the transition year to ensure that business as usual is not compromised as services and people transition
- The milestones that must be met during transition and the dependencies and interdependencies of supporting activities
- The key risks and issues that will need to be addressed during transition
- The control and reporting arrangements

The plan is supported by a number of appendices including the transition action plan which details the tasks that need to be carried out and will act as a tool to measure progress.

The situation in Merton is complex because public health services are currently provided by NHS Sutton and Merton across two local authorities, Merton and Sutton. Agreement needs to be reached on the best structure for both boroughs and the most appropriate way to disaggregate the functions.

Once this has been agreed, the London Borough of Merton will be in a good position to take on its new responsibilities for public health and benefit from the integrated service.

1. Introduction and background

The Health and Social Care Act (2012), includes a series of clauses that will transfer public health functions, currently the responsibility of NHS primary care trusts, to local authorities. The new system will give clear accountability for the improvement and protection of their population's health to local government. It will include new responsibilities and resources to improve the health and wellbeing of their local population, within a broad policy framework set by the Government. These new responsibilities will transfer on 1 April 2013. A list of relevant policy documents and guidance is attached as appendix 1.

Re-uniting public health responsibilities in the local authority offers new opportunities for innovative solutions in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and pollution, to support local communities to become healthy and stay healthy. It will take time for local authorities to realise the full potential and benefits of the shift of public health responsibilities, and for the NHS to reassess its continuing contribution to improving people's health.

As part of the new responsibilities for health, councils will need to consider:

- Health Impact: Local authorities will be expected to ensure health impact is considered and included in all policies, asking key questions such as "what will this do for the health and wellbeing of the population?" and "will this reduce health inequalities locally?" This will require the Council to adopt a new approach when developing policy, strategy and designing new services to consider health impact along with equality and environmental impact.

- Health Protection: there has been an increasing emphasis put on the role of local authorities in health protection, particularly through its response to emergency planning. Although Councils are already Category One responders in terms of the Civil Contingency Act, the new guidance means the response to emergency planning and business continuity needs to take into consideration the potential impact on health and the mitigation needed to protect health. In addition, the Director of Public Health will be the lead for health protection locally, supported by the local unit of Public Health England.

Public Health functions for the London Borough of Merton are currently provided by NHS Sutton and Merton, which also provides services to the London Borough of Sutton. It will be necessary to review and redesign the structure of the Public Health team to ensure it meet the future needs of the population served by the London Borough of Merton within the resources that are available.

This document sets out a draft plan for 2012/13 for the transition of public health functions from NHS Sutton and Merton to the London Borough of Merton. The plan sets out:

- The governance and assurance structures and processes that will be in place to support the transition

- The critical activities that need to be undertaken by each (provisional) work stream to ensure a smooth transition:
    - Future Operating Model (Vision, Strategy and Structures)
    - Finance, including arrangements for 2012/13 oversight
    - Workforce, including consultation
    - Governance and legal framework, including contracts
    - Arrangements for public health support to NHS commissioners
    - Commissioning and performance
    - Transition of services and programmes
    - Communications and Engagement
    - Infrastructure and IT
    - Project Management

- The critical activities that must be delivered during the transition year to ensure that business as usual is not compromised as services and people transition

- The milestones that must be met during transition and the dependencies and interdependencies of supporting activities

- The key risks and issues that will need to be addressed during transition

The draft plan will be subject to refinement and agreement with:

- London Borough of Merton
- The shadow Health and Wellbeing Board for Merton
- NHS South West London
- Clinical Commissioning Group for Merton
- Public Health England
- Staff and trade union representatives

2. Local government's new public health responsibilities

The Government is returning responsibility for improving public health to local government because of their unique potential to transform outcomes through their population focus; ability to shape place based on local need; ability to influence the wider social determinants of health; ability to tackle health inequalities. Local Authorities will have key responsibilities across the three domains of public health: health improvement; health protection and healthcare public health. In particular new responsibilities are focussed on:

- Tackling the causes of ill-health and reducing health inequalities
- Promoting and protecting health (including a greater focus on Emergency preparedness)

- Promoting social justice and safer communities

Local Government will be expected to:

- ensure **health impact** is considered in all policies asking key questions, “what will this do for the health and wellbeing of the population?” and “will this reduce health inequalities locally?”
- invest the new ring-fenced grant in high-quality public health services
- encourage health promoting environments, for example, access to green spaces and transport and reducing exposure to environmental pollutants
- support local communities by promoting community renewal and engagement, development of social networks (in particular for young families and children, and isolated elderly people)
- tailor services to individual needs based on a holistic approach, focusing on services that address multiple needs, rather than commissioning a plethora of single issue services, and using new technologies to develop services that are easier and more convenient for users
- make effective and sustainable use of all resources, based on evidence to help ensure these are appropriately directed to areas and groups of greatest need and represent the best possible value for money for local citizens
- work with a wide range of partners to achieve these goals through health and Wellbeing boards (H&WBBs) and supported by HealthWatch. The H&WBBs will also drive the agenda of working with clinical commissioning groups to provide integration across clinical pathways, which will maximise the scope for upstream interventions

and to:

- Produce the joint strategic need assessment (JSNA) jointly with clinical commissioning groups to ensure coherent and co-ordinated commissioning strategies and enable Health and Wellbeing Boards to develop joint health and wellbeing strategies.
- Support local voice and patient choice
- Promote joined up commissioning of local NHS services, social care, children’s services and health improvement
- Lead on local health improvement, health protection and prevention activity
- Provide public health support to clinical commissioning groups
- Have clear roles, responsibilities and accountabilities for emergency preparedness, resilience and the response.

3. Public health commissioning

From April 2013, Local Government will be expected to commission services for the following areas of responsibility

Commissioning responsibilities (mandated services*)		
▪ Tobacco control and smoking cessation initiatives ▪ Alcohol and drug misuse services ▪ Interventions to tackle obesity ▪ Community nutrition initiatives ▪ Increasing physical activity levels in the local population ▪ **NHS Health Check Programme*** ▪ Public mental health services ▪ Dental public health services ▪ Accidental injury prevention ▪ Population level interventions to reduce and prevent birth defects ▪ Behavioural and life style campaigns to prevent cancer and long term conditions	▪ Local initiatives on workplace health ▪ Local initiatives to reduce excess deaths as a result of seasonal mortality ▪ Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation programmes ▪ **Comprehensive sexual health services)*** (excluding HIV treatment services and terminations) ▪ **Ensuring NHS commissioners receive the public health advice they need ('core public health offer')*** ▪ Children's public health services including Healthy Child Programme 5-19 years (pregnancy to age 5 including health visiting services from 2015) ▪ **The National Child Measurement Programme***	▪ **Role in dealing with health protection incidents and emergencies including duty to ensure there are plans in place to protect the health of the population*** ▪ Public health aspects of promotion of community safety, violence prevention and response ▪ Public health aspects of local initiatives to tackle social exclusion ▪ **The local authority role in dealing with health protection incidents, outbreaks and emergencies*** ▪ **Local initiatives that reduce public health impacts of environmental risks***

The decision to commission non-mandatory services will be based on the PH Outcomes Framework, the local Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

Current position in Merton

The Public Health Team of NHS Sutton and Merton currently provides public health functions to both the London Boroughs of Merton and of Sutton. A public health programme analysis has been carried out to detail all the programmes currently commissioned and /or provided by the team. There are already robust arrangements in place to commission the mandatory services but the majority of services are commissioned and delivered across both the boroughs and further work is being undertaken to assess how the services can be split between the two boroughs.

The shared delivery of public health through NHS Sutton and Merton means that there is a key interdependency with the London Borough of Sutton, and that agreement by both councils on the distribution and any sharing of the public health resource (including staff) will be critical to transition.

The functions are provided by a public health team of twenty, which includes the Director of Public Health (DPH), two Consultants in Public Health medicine, two joint Consultants in Public Health (one of whom is a joint appointment with the London Borough of Merton and the other a joint appointment with the London Borough of Sutton) and service and programme managers. Some of the staff are part time and the DPH is an interim appointment. In addition, there is a small team delivering Stop Smoking Services.

The public health team, apart from the joint Consultants in Public health who have bases in the Council offices as well as the NHS, is based together in NHS accommodation.

Once the issue of separating the public health resources and agreeing the structure has been settled, Merton Council will be well placed to take on its new public health responsibilities. As well as already having the joint appointment, it has well-established strategic partnerships and an established process for producing the Joint Strategic needs Assessment (JSNA).

4. Governance arrangements and structure for public health transition

Public Health Governance

NHS Sutton and Merton is currently responsible for the discharge of public health functions and will remain so until the end of March 2012 when responsibility transfers to the local authorities.

The Director of Public Health (Interim) is the Executive Director accountable to the PCT Chief Executive, who is also the NHS S W London cluster Chief Executive, for the effective delivery of the services.

A Memorandum of Understanding has been agreed which sets out the arrangements that will be in place for the governance and direction of the public health system during the shadow working period of April 1st 2012 to March 31st 2013.

Project Governance

To support effective governance during the transition, a Public Health Transition Board for Merton has been established to ensure that the Public Health services are transferred to the London Borough of Merton by April 2013. An equivalent Board has been established for Sutton. The Transition Boards for each council meet together or separately depending on issues to be addressed. The Terms of Reference for the Transition Board are shown in Appendix 2.

The Transition Board has decided to establish a formal transition project and has appointed a project manager to manage the process, jointly for Sutton and Merton.

PCTs and local authorities are required to produce a Transition Plan, which describes how the PCT and local authority will work together to transfer the public health services to the local authority on April 1st 2013. The plan will give assurance to the local authority and NHS that there are robust transition arrangements for the public health system.

Public Health Transition Project Board

The Transition Board for Merton is chaired by the Director for Public Health and includes:

Director of Community and Housing, London Borough of Merton
Interim Director of Public Health, NHS SW London, Sutton and Merton
Borough Managing Director, NHS SW London, Sutton and Merton
Joint Consultant in Public Health (Merton)
Representative of the Director of Transition, NHS SW London
Project Manager, Public Health Transition

Additional members will join the group as the work continues, including finance and human resources colleagues.

Transition Project Team

The Transition Plan includes ten work steams and work stream leads will be identified from both the council and the PCT. The work stream leads will meet as a Project Team and attend Transition Board meetings as required.

The Public Health Transition project structure is shown in Appendix 3.

Key Stakeholders

A list of key stakeholders is shown in Appendix 4. Stakeholders will be involved in the project at appropriate levels and times in line with the Public Health Transition Communications Plan.

Roles

Roles of each party to the transition plans for Public Health have been identified as follows:

Director of Public Health (Interim): is the Project Director and ensures plans are robust and services/programmes are transferred appropriately, considers/identifies with other DPH and Local Authorities, services and functions that could be delivered more effectively on a larger geographical footprint; public health risks and mitigating action are in place and communicated to partners and a legacy handover process in agreed.

The Project Board: is the project sponsor and is be responsible for:

- Agreeing the Project's aims, scope, outputs, structure and resources
- Providing the resources
- Agreeing the Public Health Transition Plan and agreeing any major changes to the plan
- Ensuring that the expected outcomes are achieved and determining any corrective action if required
- Monitoring progress and resources
- Deciding on key issues
- Co-ordinating formal approval processes
- Briefing the Council and the PCT Board
- Ensuring that the plan is delivered on time and within the resources

The Project Team
The work stream leads form the project team and will agree and complete the tasks and actions in the Transition Action Plan and will be responsible for planning, tracking and delivering the tasks. They will delegate tasks as required and decide whether to meet in person or remotely to progress the tasks. They will identify risks and issues and agree plans to mitigate these. They will report progress to the Project Manager. The Project Manager will support the work stream leads and will collate the plans and reports.

The Project Manager: will manage the project, coordinate the work stream tasks and implement any changes with advice from the Public Health Consultants

NHS Sutton & Merton: will ensure the engagement of staff; input from Clinical Commissioning Groups (CCG) and the shadow Health and Wellbeing Boards (sHWBBs); regard for Public Sector equality duty; clear specification for the destination of all public health functions, services and programmes; identify

transitional risks including impact on workforce; demonstrate clear accountability for delivery during transition year; explicit on resources available for delivery and supporting transition

The London Borough of Merton will ensure involvement with the PCT and PCT Cluster, development of transition plans; agreement of delegated responsibility for delivery of public health services; sign off final plans as demonstration of involvement and agreement to plan

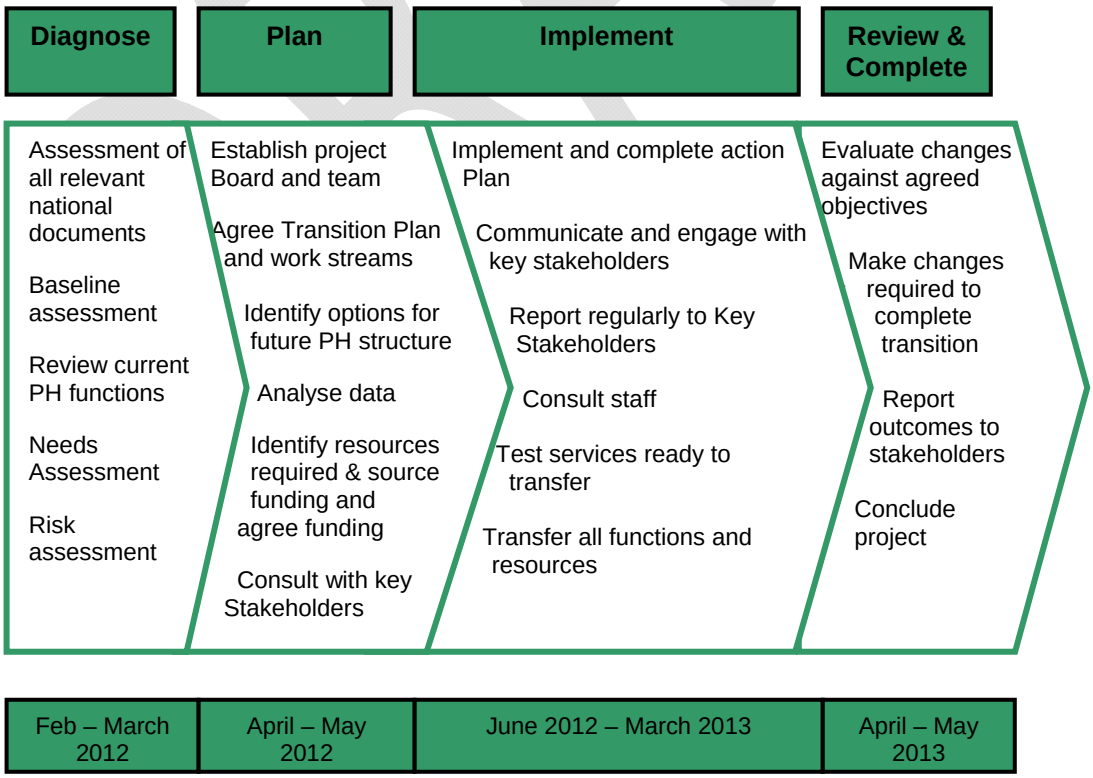
Merton shadow Health and Wellbeing Board
The shadow Health and Well being Board will approve the transition plan and receive regular progress reports, ensuring that plans are in line with the vision and health and well being strategy for Merton.

NHS SW London will assure that the transition plans and processes are in accordance with guidance and legal duties.

NHS Commissioning Board will ensure full participation in development of plans; governance and accountability for public health services it has responsibility for.

5. Approach

The project will be based on PRINCE 2 methodology. There will be four stages to the project:



6. Aims, objectives and outcomes of the public health transition project

The aims, objectives and outcomes of the transition project are:

Aims

1. To ensure the smooth transition of the public health function to the London Borough of Merton by April 2013 in line with government policy and guidance.

2. To ensure current public health performance and delivery is maintained during the transition.

3. To ensure the future function and form is fit for purpose (keeps the population safe, improves its general health and reduces health inequalities within allocated resources)

Objectives

1. To advise the Council on the local implications of national guidance on the role of Public Health in Local Authorities

2. To provide a detailed assessment of the current services and expenditure on the public health services due to be transferred. This includes identifying current contracts, service specifications; spend, performance and quality, in order that future commissioners can make a risk assessment of the transition of the responsibilities

3. To ensure that current staff are properly consulted and kept informed of the changes as it affects their current roles

4. To develop a number of options for the Council Executive and Officers to consider for how Public Health might function following the transfer

5. To ensure that all key stakeholders are aware of and engaged in the process at an appropriate level.

Outcomes

At midnight, on 31 March 2013, a robust public health function will transfer to the London Borough of Merton, funded and staffed to commission and deliver the mandatory and locally agreed public health services which are designed to improve the health and wellbeing of the local community and fully comply with public health legislation.

7. Project scope and exclusions

Scope

The project covers all the public health functions currently provided by NHS Sutton and Merton. The project will focus on functions transferring to the London Boroughs of Merton and Sutton but will also include services and staff transfer to other organisations such as local provider services, National Commissioning Board or Public Health England. The transition includes public health services, staff and resources.

While the project, by necessity, focuses on the successful transition of the public health functions to the local authority, opportunities will also be taken to review, improve and develop and transform the services, integrating more closely with the council's existing services and building on existing relationships to provide expert public health advice and support to the Clinical Commissioning Groups and other organisations.

Exclusions

The following are not within the scope of the transition project but are related to it. They have their own separate work groups, projects and project plans.

- Health and Wellbeing development programme and strategy
- JSNA development project.

8. Constraints and Assumptions

The project is subject to the following constraints:

- Delays in the release of further national policy and guidance
- Delay in or failure to agree the structure and operating model for the new public health system for Merton
- Failure to secure an acceptable level of funding to be deliver the public health functions and operating model when transferred

The project will, therefore, proceed with the following assumptions

- A timely decision will be reached on the future operating model for the London Borough of Merton's Public Health Services
- The operating model can be delivered within resources available.
- Sufficient resources will be available to carry out the tasks required to deliver the project

9. Reporting and control arrangements

PCT clusters are required to provide monthly progress reports to NHS London who will carry out a formal assessment of progress in October 2012.

The Merton Public Health Transition Project will be required to provide progress reports to the NHS SW London cluster for inclusion in their reports to NHS London. It is anticipated that NHS London and NHS SW London will expect progress to be reported based on the local public health transition plan check list (attached as Appendix 5) which was included with the Public health transition planning support for Primary care trust and local authorities (details of this and other relevant publications are attached in Appendix 1).

The project will also report progress to the Council, the PCT Board, The shadow Health and Wellbeing Board and the Health Scrutiny Panel.

Progress within the project will be measured against the Transition Action Plan (appendix 10). This has been developed to cover all the tasks required to transfer the public health functions successfully by April 2013. It has taken into account the Transition Plan check list.

A risk log and an issues register will be maintained by the work stream leads (see section 11 below and Appendix 6 &7).

The leads for each work stream in the action plan will produce a monthly highlight / exception report for the project team which will be summarised for the Project Board. The reports will confirm that the work stream is progressing in line with the action plan or identify any areas where they are failing to make adequate progress or there are changes or issues for discussion or decision by the Project Board.

Example of the reporting form is attached in Appendix 8

10. Timetable and key milestones

National timetable

The Department of Health has set out the following timetable and milestones for public health transition. It is anticipated that further dates and milestones will be published during the year.

Action	By when
Agree a local transition plan for public health as part of the overall integrated plan, taking account of the checklist	End March 2012
Develop a communication and engagement plan	first draft by March 2012
Agree an approach to the development and delivery of the local public health vision	June 2012
Agree arrangements on public health information requirements and information governance	September 2012
Test arrangements for the delivery of specific public health services, in particular screening and immunisation	October 2012

Test arrangements for the role of public health in emergency planning, in particular the role of the Director of Public Health and local authority based public health	October 2012
Ensure an early draft of legacy and handover documents is produced	October 2012
Ensure final legacy and handover documents are produced	January 2013
Agree arrangements for local authorities to take on public health functions	Local determination

Merton Timeline

A high level timetable has been drafted for Merton. A more detailed timeline, showing dependencies, is attached as appendix 9.

Action	By when
Options Paper on future public health structure and position of DPH to Merton Council CMT	March 12
Agree Memorandum of Understanding for shadow year	March 12
Draft Transition Plan	March 12
Agree Transition Plan and submit to NHS SW London	April 12
Agree work streams and work stream leads	April 12
Draft Communications and Engagement Plan	April 12
Agree model for PH structure & DPH	April 12
Start shadow financial and performance reporting	May 12
Agree approach to developing & delivery of local PH vision and strategy	June 12
Agreed vision, strategy and operating model	June 12
Agree staff transfer process	June 12
Identify staff to transfer	July 12
Staff consultation document produced	Aug 12
Staff consultation starts	Sept 12
Draft legacy and handover documents	Oct 12
Test arrangements for delivering PH Services (screening & immunisation)	Oct 12
Agree PH role in emergency planning	Oct12
Formal assessment of progress against plan	Oct 12
Test arrangements for emergency planning	Nov 12
Staff consultation ends	Dec 12
Consultation response document	Jan 12
Final legacy and handover documents	Jan 12
PH Functions transfer to successor organisations	April 13

11. Risks and issues

While it is hoped that the majority of risks will be eliminated through careful planning, good communication and a joint approach to the transition, a

number of risks to the success of the project have been identified and need to be managed:

The risks fall into two categories:

- Transition risks: immediate risks which affect the delivery of the public health functions arising during the transition period
- Legacy risks: longer term risks to the future delivery of public health functions as a consequence of the transfer.

The risks have been aligned to the appropriate work stream. The impact and probability of each risk will be assessed and rated and a plan for managing the risk will be agreed on a risk log, which is shown in appendix 6.

The issue register template has been drafted and is attached as appendix 7. It will be maintained and updated throughout the duration of the project by the work stream leads and reviewed by the project board.

12. Communications Plan

The communications Plan describes how stakeholders will be kept informed of the project and its progress. An outline plan is shown below. This will be developed more fully by the communications and Engagement work stream lead.

Information	Recipient	Distribution	Responsibility
Transition Plan	Project Board Project Team	Following Project Board approval to Council, Cluster, sHWB.	Project manager
Action Plans	As above	Following Board approval, as above when required	Project Manager
Project highlight/exception reports	As above	Monthly	Project manager
Project News	As above	tba	Communications Lead
Project Closure report	As above	At the end of the project, as required	Project Manager

13. The Work streams

The successful transition of the public health functions will be achieved through ten work streams, each with an identified lead from the PCT and the London Borough of Merton. They will be responsible for delivering a number of key tasks, which are described in detail in the Transition Action Plan, attached as Appendix 10.

<u>Future Operating Model work stream will:</u>

Ensure that the future function and form of Merton Public Health is fit for purpose (keeps the population safe, improves its general health and reduces health inequalities within allocated resources). It has three main objectives;

i. To develop a number of options for the Council Executive and Officers to consider on how Public Health might operate following the transfer, including the role of the DPH and the wider public health team.
ii. To agree a vision and an appropriate organisational structure for Public Health including the role of the DPH and the wider public health team
iii. Design a future operating model ensuring that all mandatory services continue to be delivered and specific services are developed and delivered to meet local need (based on the JSNA and Merton Health and Wellbeing Strategy).

<u>The finance work stream has three overall objectives:</u>

i. To provide a detailed financial assessment of the current services, income and expenditure on the public health services, the proposed future structure and the financial allocation due to be transferred so that the London Borough of Merton can make an informed assessment of the financial implications of the transition of the responsibilities.
ii. To ensure that financial systems and support functions are in place and funded to support the transition of PH functions from the PCT to the LB of Merton
iii. To manage the handover of day to day financial management

Key issues for the finance group include:

- Concerns that the baseline spending estimates calculated by the Department of Health are inadequate and inequitable. Merton has a public health spend of £34 per head of population which is below the average England spend of £40 per head.
- Concerns about the way the funding will e split between Merton and Sutton
- Concerns that the funding will not support the preferred operating model and structure

<u>The Workforce work stream has three overall objectives:</u>

i. To produce a workforce plan and manage the transfer of staff to their new organisation(s) in line with national guidance
ii. To ensure that current staff are properly consulted and kept informed of the changes as it affects their current roles
iii. Take reasonable steps to avoid redundancies and ensure that arrangements are in place to support the redeployment as necessary of any displaced staff. Engage the local unions in the process

<u>The Governance and Legal work stream has six overall objectives</u>:

i. To ensure that all legal and governance issues have been identified and are in place to support the safe transfer of Public health function to the London Borough of Merton by April 20013
ii. Ensure clinical governance systems are in place for all relevant services to be commissioned by the Borough
iii. Test new arrangements for specific public health functions, including emergency planning, resilience and response
iv. Test new arrangements for specific public health functions – screening and immunisation
v. Agree PH information requirements and Information governance
vi. Ensure a comprehensive legacy handover document is produced

<u>The Public Health Support to Commissioners work stream has two objectives:</u>

i. To ensure that appropriate systems are in place for Public health officers to advice and support all commissioners of public health functions and that commissioners have systems in place to respond to PH advice and guidance
ii. To establish systems to ensure support is available to healthcare commissioners to both in put and take account of the JSNA and provide public health skills to interpret and analyse population data to support commissioning decisions.

<u>The Commissioning and Performance work stream has three objectives:</u>

i. In liaison with the financial group, to provide a detailed assessment of the current services and expenditure on the public health services due to be transferred. This includes identifying current contracts, service specifications; spend, performance and quality, in order that future commissioners can make a risk assessment of the transition of the responsibilities.
ii. To ensure robust internal accountability and performance monitoring arrangements are in place to cover the transition year and beyond, including schemes of delegation, providing monthly reports to the Transition Board.
iii. To review the contracts and performance reports in line with the Public Health Outcomes Framework

<u>The transition of Services and programmes work stream has four objectives:</u>

i. To ensure current public health performance and delivery is maintained during transition
ii. Undertake a public health programme analysis of functions currently commissioned and delivered by NHS Sutton and Merton, identifying the service provided to each of the boroughs
iii. Plan a phased separation and transfer of services as appropriate
iv. To test the arrangements for the services that have been transferred

<u>The Communications and Engagement work stream has five objectives:</u>

i. To produce a Communications and Engagement Plan
ii. To Identify all key stakeholders and level of interest / involvement
iii. To ensure that all key stakeholders are aware of and engaged in the process and implications of the transfer of responsibility of the Public Health function to the Council, at an appropriate level.
iv. To consider events to increase awareness and engagement

The Infrastructure and IT work stream has one overall objective:

i. To ensure that the appropriate infrastructure is in place for public health to transfer to the LB Merton by April 2013 including:
    a. Accommodation
    b. IT systems and hardware
    c. Support services

The Project Management work stream has three overall objectives:

i. To produce a Public Health Transition Plan for Merton setting out clear plans for ensure the smooth transition of the public health function to the London Borough of Merton by April 2013 in line with government policy and guidance.
ii. To manage the implementation of the plan and report progress regularly to the Transition Board
iii. To advise the Council on the local implications of national guidance on the role of Public Health in LA

14. Resources

The project will require a substantial amount of time from staff both within and outside the public health team. In addition, £30,000 has been allocated from the NHS SW London Transition Team and this has been supplemented (up to £20,000) by the Sutton and Merton Public Health budget. This resource will support project management until July 2012, and further resource will be sought to continue this capacity.

Staff from NHS SW London and the council will also need to free up time to take on specific pieces of work and attend project meetings. It is anticipated that support will be needed from the council, PCT and cluster to support the work stream tasks.

Additional costs will be identified as the project progresses. It is anticipated that there will be costs associated with the IT and infrastructure required to move public health staff to the council offices, with communication, and possibly redundancies, if this cannot be avoided.

Publications Appendix 1

Policy Documents

Nov 2010	Healthy lives, healthy people, our strategy for public health in England, HM Government
Dec 2011	Local Government leading for Public Health
Dec 2011	Public Health England (PHE) Operating Model
Jan 2012	Public Health Outcomes Framework

National Guidance and Support

July 2011	Healthy lives, healthy people: Update and way forward, HM Government
Nov 2011	Public Health Human Resources (HR) Concordat, DOH
Jan 2012	Public health transition planning support for primary care trusts and local authorities, DOH and Local Government Association
Jan 2012	Public Health Workforce Issues, Local Government Transition Guidance, Local Government Association
Feb 2012	Building a People Transition Policy for Public Health England, DOH
Feb 2012	Baseline Spending estimates for the new NHS and Public Health Commissioning Architecture

Terms of Reference for the Public Health Transition Board - Merton **Appendix 2**

Constitution	The London Borough of Merton Corporate Management Team and NHS SW London resolve to establish a Working Group to be known as the Public Health Transition Board - Merton
Membership	The members shall be appointed by Chair of the Board. Membership of the Board is below.
Quorum	A quorum shall be four members, with at least one representative from both the London Borough of Merton and NHS SW, London Sutton and Merton.
Attendance	Members or their deputies shall normally attend meetings.
Frequency	Meetings shall be held monthly.
Authority	The Transition Group is authorised by the London Borough of Merton Corporate Management Team and NHS SW London Sutton and Merton to investigate any activity within its terms of reference.
Aim/Purpose	The aim of the Board is to ensure a smooth transfer of the Public Health Responsibilities from NHS Sutton and Merton to the London Borough of Merton by April 2013 in line with government policy and guidance.
Principles	The principles of the Transition Board are:

1. The health and social care reforms propose the transfer of public health functions currently provided by PCTs to local authorities, a new integrated public health service called Public Health England, and the NHS commissioning Board. All three domains of public health; health improvement, health protection and health services planning and effectiveness are covered by these new arrangements from April 2013 and in turn, by the Public Health Transition Board – Merton

2. The objective of transition planning is to ensure current public health performance and delivery is maintained during the transition and that future function and form is fit for purpose (keeps the population safe, improves its general health and reduces health inequalities within allocated resources).

3. This means the transition planning can be divided into three phases:
   - September – December 2011 for development of mutual understanding of baselines of public health activities, commissioning, finance, provider contracts; exploring design principles;
   - January – March 2012 for detailed design and planning/negotiation leading to agreement of formal transition plan;
   - April 2012 – March 2013 for shadow arrangements and implementation of transfer.

4. Two Transition Boards have been established for Sutton and Merton to oversee the transition of the current public health functions and resources (including staff) to the two Councils. The two groups will work together or separately as appropriate to maximise resources, minimise duplication and ensure that both groups are in agreement with actions and decisions taken.

Statement of Task for the Transition Board

1. To ensure the smooth transition of the public health function to the London Borough of Merton by April 2013.

2. To ensure current public health performance and delivery is maintained during the transition.

3. To ensure the future function and form is fit for purpose (keeps the population safe, improves its general health and reduces health inequalities within allocated resources)

Objectives/duties The objective / duties of the Transition Board is:

1. To advise the Council on the local implications of national guidance on the role of Public Health in Local Authorities

2. To provide a detailed assessment of the current services and expenditure on the public health services due to be transferred. This includes identifying current contracts, service specifications; spend, performance and quality, in order that future commissioners can make a risk assessment of the transition of the responsibilities

3. To ensure that current staff are properly consulted and kept informed of the changes as it affects their current roles

4. To develop a number of options for the Council Executive and Officers to consider for how Public Health might function following the transfer

5. To ensure that all key stakeholders are aware of and engaged in the process at an appropriate level.

6. To establish a formal project management process to deliver the aims and objectives of the group on time and within the available resources, ensuring handover and closure is planned and timed to minimise service and staff disruption.

Reporting

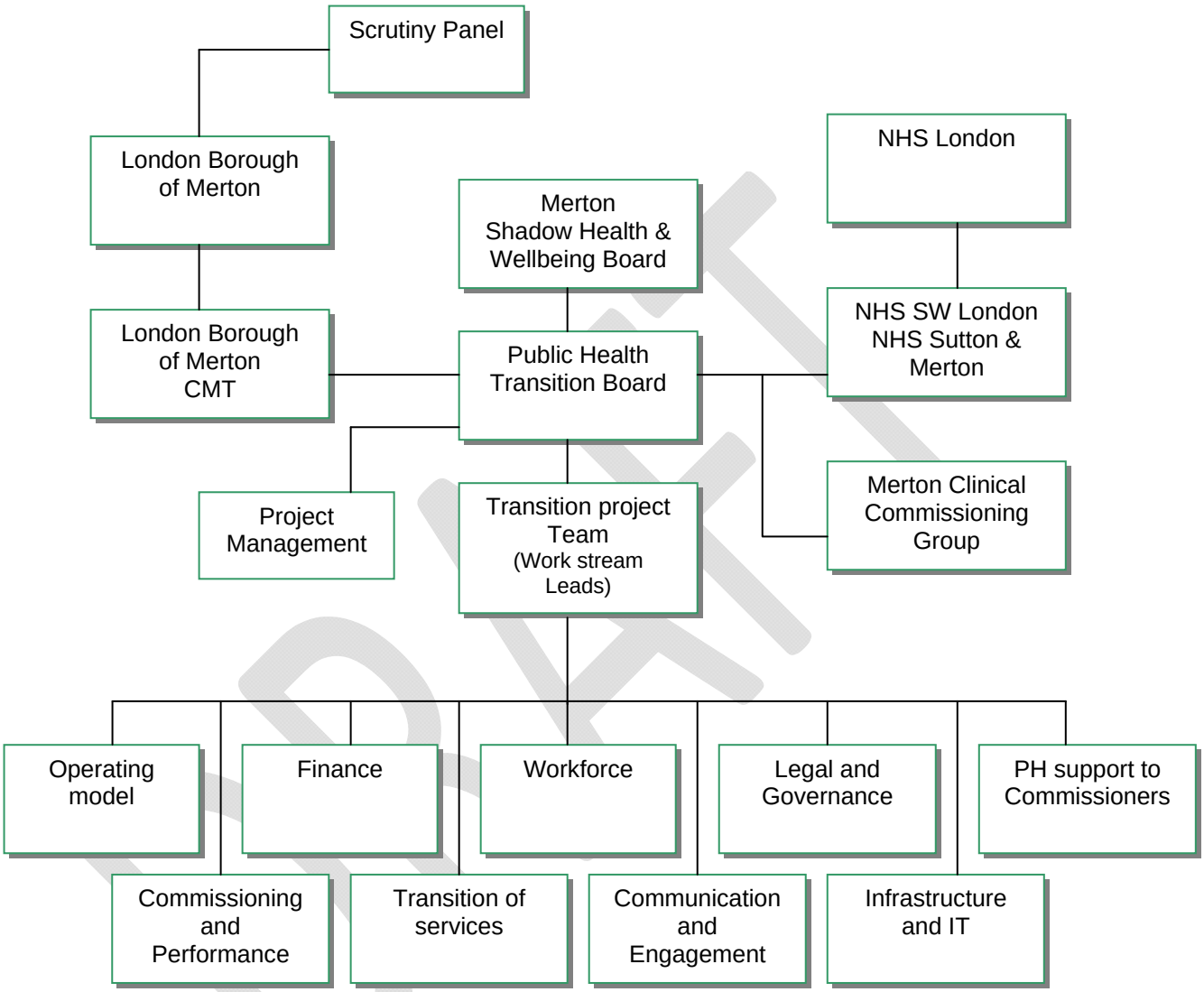
The minutes of Public Health Transition Board – Merton meetings shall be formally recorded and submitted to the Council's Corporate Management Team, the shadow Health and Wellbeing Board, Health Scrutiny Panel, the Leaders Strategy Group, the LSCB and the Children's Trust and the PCT Management Team.

Membership

Dr Val Day (Chair)	Director of Public Health (Interim), NHS SW London, Sutton and Merton
Simon Williams	Director of Communities and Housing, London Borough of Merton
Yvette Stanley	Director of Children's , Schools and Families Services, London Borough of Merton
Adam Wickings	Borough Managing Director, NHS SW London, Sutton and Merton
Julia Groom	Joint Consultant in Public Health, London Borough of Merton and NHS SW London, Sutton and Merton
Anne Reeder	Project Manager, Public Health Transition

Contact Name: Anne Reeder
Designation: Project Manager
Date: 12.03.12
Date for Review of ToR:

Transition Plan Project Structure Appendix 3



Key Stakeholders Appendix 4

Sutton and Merton Public Health Team
Consultants, managers, advisors, coordinators

NHS Sutton and Merton
NHS Sutton and Merton Board
NHS Sutton and Merton managers and staff

NHS London
NHS London Public Health Transition Board

NHS SW London
NHS SW London Joint Board
Clinical commissioning groups
South London Commissioning Support Service

London Borough of Merton
Cabinet
Chief officers, members, Senior Management Team, staff
Health and Wellbeing Scrutiny Panel
Council Departments, members and staff:
- Adult Services
- Children's Services
- Environment and Regeneration

Public, Patients and Service Users
PALs Managers
PPI Forums

Partnership Organisations
Local Strategic Partnership Groups
Shadow Health and Wellbeing Board
Public Health England
Health Watch
Children's Trust
Local criminal justice services
Providers of health services
Local voluntary organisations
Local businesses

Trade Unions

Check List for Transition Appendix 5

Key Elements for Transition are:

- contributing to the development of the vision and strategy for the new public health role in local authorities
- developing robust transition plans for functions systems and services
- preparing local systems for new commissioning and contracting
- ensuring robust governance arrangements are in place during the transition year
- ensuring delivery of the public health delivery plan for 2012/13
- ensuring new clinical governance systems are in place for all relevant services to be commissioned by the local authority
- preparing for and undertaking formal transfer of staff, including appropriate mechanisms for consulting with staff and trade unions
- testing the new arrangements for specific public health functions, including emergency planning, resilience and response
- effective communications and engagement to give confidence to the public, providers and other stakeholders

Key Element	Checklist
Ensuring a robust transfer of systems and services	Is there an understood and agreed (PCT/local authority) set of arrangements as to how the local public health system will operate during 2012/13 in readiness for the statutory transfer in 2013? Is there a clear local plan that sets out the main elements of transfer including functions, staff TUPE and commissioning contracts for 2013/14 and beyond? Are there locally agreed transition milestones for the transition year, 2012/13? Is there a clear local plan for developing the Joint Strategic Needs Assessment in order to support the Health and Wellbeing Board strategy? Is there a clearly developed plan for ensuring a smooth transfer of commissioning arrangements for the services described in *Healthy Lives, Healthy People* that local authorities will be responsible for commissioning? Is there a clearly developed plan for ensuring a smooth transfer of those public health functions and commissioning arrangements migrating to the NHS Commissioning Board and Public Health England? Is there local agreement on the delivery of a core offer providing local authority based public health advice to Clinical Commissioning Groups?
Meeting public health delivery plan and targets during transition year	Is it clear how mandated services and steps are to be delivered during 2012/13 and during 2013/14 as part of the new local public health services, ensuring: • Appropriate access to sexual health services? • Plans in place to protect the health of the population? • Public health advice to NHS commissioners? • National Child Measurement Programme? • NHS Health Check assessment? Is there clarity around the delivery of critical public health services/programmes locally, specifically, screening programmes; immunisation programmes, drugs and alcohol services, and infection prevention and control?

Key Element	Checklist
Workforce	Have the workforce elements of the plan been developed in accordance with the principles encapsulated within the *Public Health Human Resources Concordat*?
Governance	Does the PCT with local authority have in place robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation agreed as appropriate? Are there robust arrangements in place for key public health functions during transition and have they been tested, e.g. new emergency planning response to include: • Accountability and governance? • Details of how the Director of Public Health, on behalf of the local authority, assures themselves about the arrangements in place? • Lead Director of Public Health arrangements for emergency preparedness, resilience and response, and how it works across the Local Resilience Forum area? Are there robust plans for clinical governance arrangements during transition including for example arrangements for the reporting of serious untoward incidents/incident reporting and Patient Group Directions? Has the PCT with the local authority agreed a risk sharing based approach to transition? Is there an agreed approach to sector-led improvement? Is the local authority engaged with the planning and supportive of the PCT approach to public health transition?
Enabling infrastructure	Has the PCT with the local authority identified sufficient capability and capacity to ensure delivery of their plan? Has the PCT with the local authority identified and resolved significant financial issues? Has the PCT with the local authority agreed novation/other arrangements for the handover of all agreed public health contracts? Are all clinical and non-clinical risk and indemnity issues identified for contracts? Are there plans in place to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer? Have all issues in relation to facilities, estates and asset registers been resolved? Is there a plan in place for the development of a legacy handover document during 2012/13?
Communication and engagement	Is there a robust communications plan? Does it consider relationships with the Health and Wellbeing Board, Clinical Commissioning Groups and the NHS Commissioning Board, HealthWatch and local professional networks? Is there a robust engagement plan involving stakeholders, patients, the public, providers of public health services, contractors and Public Health England?

Risk Log

Appendix 6

Risk ID	Work Stream	Risk Definition	Date Identified	Consequence	Likelihood	Risk Rating	Risk Management Plan	Lead	Open	Closed
1.	Operating model	Lack of clarity and common vision for public health								
2.	Operating Model	Lack of agreement on future structure for PH								
3.	Operating model	Structure agreed, including position of DPH but out of line with other LAs resulting in recruitment problems								
4.	Operating model	Lack of clarity and delay in agreeing PH strategy affecting service delivery								
5.	Finance	Insufficient financial allocation								
6.	Finance	Inability to split resources between the 2 boroughs								
7	Finance	Unavoidable redundancy costs								
8.	Workforce	Future change/ anticipation of change may destabilise staff who may leave or become distracted								
9.	Workforce	Change may not be supported by staff or trade unions – potentially leading to industrial action								
10.	Workforce	Loss of specialist PH skills								

11.	Legal & Governance	Delay in agreeing MOU								
11.	Legal & Governance	Loss of PH corporate memory, knowledge								
12.	Commissioning	Lack of clarity and /or agreement on position of PH commissioning in new structure								
13	Communication and Engagement	Insufficient understanding and buy in from key stakeholders to implement changes								
14.	Infrastructure	Insufficient resources to accommodate PH in borough accommodation								
	Infrastructure	Inability to access both council and NHS systems								
	Project Management	Changes in national policy leading to major rescoping of project								
	Project management	Existing projects not aligned with transition project								

To be completed, agreed by Transition group

Issues Register

Appendix 7

Issue ID	Work Stream	Issue Detail	Date Identified	Issue Rating	Current position	Lead	Last reviewed	Open	Closed

Risk scoring table

		Frequency				
		Rare - 1	Unlikely - 2	Moderate - 3	Likely - 4	Certain - 5
Severity	Minor – 1	1	2	3	4	5
	Moderate - 2	2	4	6	8	10
	Serious – 3	3	6	9	12	15
	Major - 4	4	8	12	16	20
	Critical - 5	5	10	15	20	25

Work Stream Report Template

Appendix 8

Date:	Work stream:	Work stream lead:	Report Author:

Milestones due this month

Task no.	Task / Milestone	Achieved Y/N	Revised date	Comments / corrective action

Changes in Risks

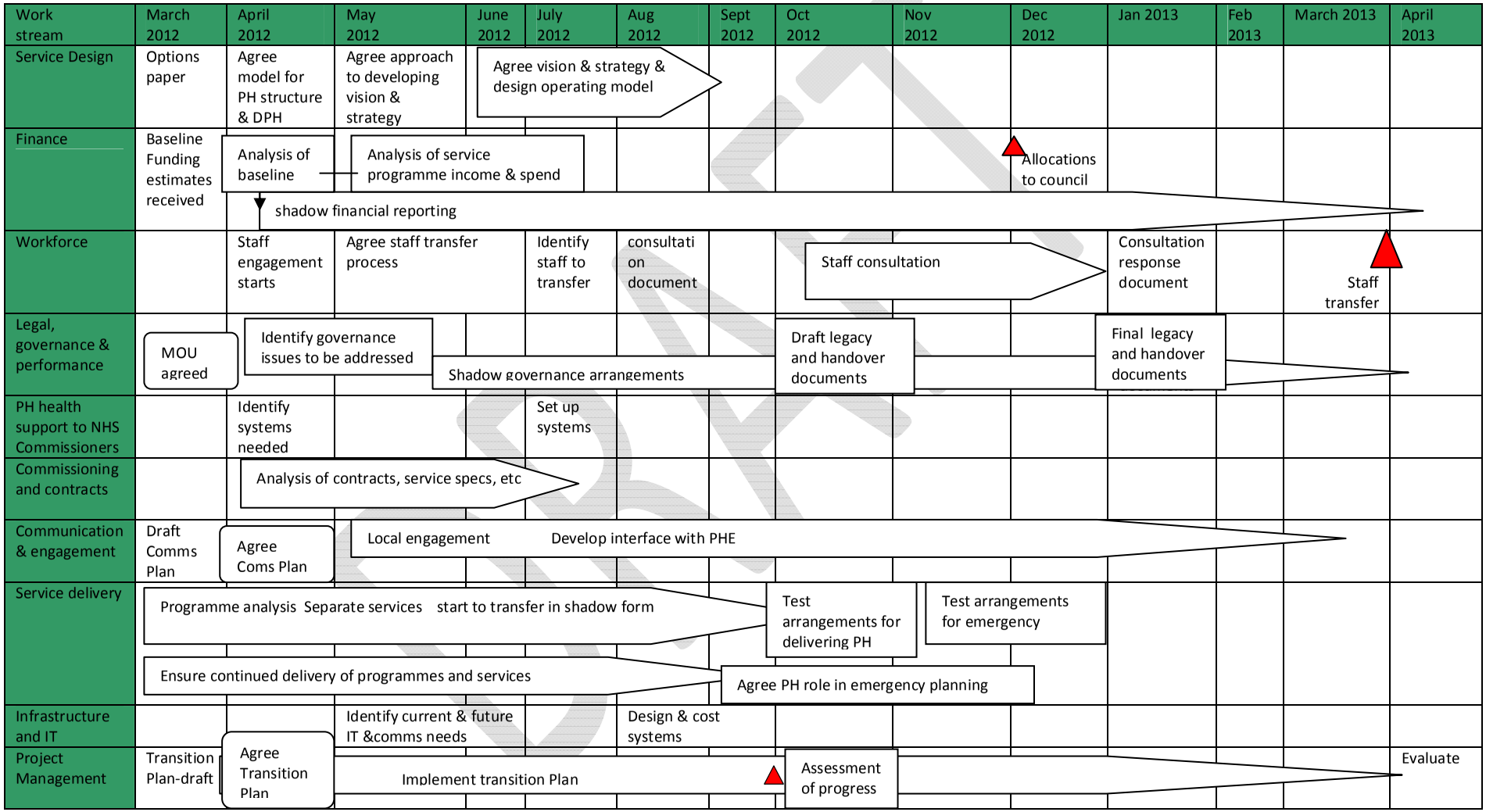
Risk ID	Risk Definition	Comments / Changes / risk resolved/ new risk	Risk rating

Changes in Issues

Issue ID	Risk Description	Comments / Changes / issue resolved/ new issue	Issue rating

Outline Transition Plan

Appendix 9



Transition Action Plan **Appendix 10**

Attached as a separate paper

Public Health Transition Action Plan

Work in progress: V 3

For the London Borough of Merton

Summary of Work-streams and Key Objectives with responsibilities and timelines.

Overall aim: To ensure a smooth transfer of the Public Health Responsibilities from NHS Sutton and Merton to the London Borough of Merton by April 2013

CONTENTS

Key to lead responsibility in Work-streams.

Transition Plan

A. Future Operating Model (Vision, Strategy and Structures), including critical decisions about a dedicated or shared Director of Public Health and public health team lead (LBM) and (NHS)

No.	Key Tasks	Actions	Comments / Progress	Lead	Complete by	Start	Finish	RAG /Risk
A1	Agree Organisational structure including position of DPH	Identify options		VD				
		Cost options		VD				
		Produce paper on options for discussion and agreement of preferred option		VD				
		Agree preferred option						
A.2	Develop vision and strategy for Public Health in Merton	Link with Health and Well being Strategy						
		Engage with key stakeholders						
A.3	Design future operating model							

Transition Plan								
B. Finance, including arrangements for 2012/13 oversight: lead (LBM) and (NHS)								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
B.1	**Financial assessment of the current services, income and expenditure and compare with proposed financial baseline allocation**	Identify 2011/12 spend						
		Agree 2012/13 Public Health budget and resolve any significant finance issues						
		Divide funding between the two boroughs of Merton and Sutton						
		Compare with proposed base line allocations and identify future financial implications						
B.2	**General Ledger & Respective Feeder systems: Payroll, Debtors, Creditors, Procurement**	Agree new hierarchy in Council ledger						
		Transfer historic/previous years information and ensure it is accessible						
		Get new licences for and all other associated software and systems for PH services						
		Transfer debtor and creditor balances as at 31.03.13 to Merton Council systems						
		Set up new payroll run for PH staff						

		Cancel all existing PH call off orders						
		Set up new call off orders as required at LBM						
		Resolve all outstanding disputed invoice queries						
		Agree which organisation will chase bad debts existing						
		Transfer PH computers and other small items of equipment from NHS SW London Sutton and Merton Public Health asset register by writing value down to nil, or minimal value to be covered by non-recurrent funding transfer						
B.3	**Financial governance including: Financial Controls, Financial Reporting, Final Accounts & Board Approval for New Budgets and Financial Plans**	Complete full year accounts NHS SWL SM						
		Keep open access to PCT and associated financial systems post year end in order to complete final accounts						
		Amend LBMs SO's, SFI's and Scheme of Delegation to take account of PH						
		Agree new year Internal Audit plan for PH as part of LBM internal audit process						

		List of signatory at LBM to be updated to include PH staff						
		Notify all stakeholders, both internally and externally, of transfer						
		Set up a process for inclusion of PH financial position to be included with LBM reports						
B.4	**Cash, Reserves, Capital and Financial Plans**	Amend cash flow forecasts at LBM to take account of the additional requirements from PH						
		Identify any reserves within NHS Sutton and Merton budgets being transferred						
		Upgrades and backlog maintenance issues should be in the Facilities scope of the adequacy of premises, equipment and any associated indemnities						
B.5	**Non-Pay Expenditure**	A list of all goods and services provided, product codes, quantities and prices paid (including unit of issues) by provider						
		A comprehensive list of all repetitive items required by provider and department including the role of NHS Supply Chain						

		A list of all areas, transfer points, and their geographic Site Locations						
		Users and delivery point details						
		Flowchart of existing supply chain processes used, e.g. from request of requirements to payment of invoice						
		Any existing details related to requisition books currently deployed						
B. 6	**Support Functions**	Ensure all support functions and facilities needed by the team are in place and funded						
B.7	**Handover**	Establish links between PCT and LA finance teams						
		Provide monthly financial reports to the Transition Project Board during the transition year						
		Handover day to day financial functions to the LA						

Transition Plan								
C. Workforce, including consultation: lead (LBM) and (NHS)								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
C.1	**Develop a workforce plan**	Map current functions and responsibilities						
C.2	**Achieve the successful transfer of PH staff and ensure full staff engagement, communication and partnership working** **SUBJECT TO EVOLVING NATIONAL GUIDANCE / AGREEMENTS**	Agree NHS and LA staff in scope for transfer / deployment to new operating model based on guidance re roles of PHE and LA						
		Identify all potential NHS employees that should transfer to LA including impact on corporate (business support) functions						
		Confirm TUPE or COSOP. Identify implication of this						
		Establish pension arrangements for transferring staff						
		Formal notification to Trade Unions re proposed transfer						
		Agree process for populating posts in new operating model./ structures						
		Submit first round the workforce employee liability information / HR Due Diligence						
		Formal letter to transferee regarding measures						

		Staff Briefing sessions to continue including consultation on measures,/ re-structuring process if appropriate						
		Letter to assigned staff confirming transfer & employee liability information						
		Offer 1-1's with line managers supported by HR & trade union rep where individual concerns over TUPE are raised.						
		Panel for appeals to consider any objection to transfer						
		Final submission of workforce employee liability information and staff lists to be produced (with names) and identifying ongoing CPD requirements						
		Ensure workforce liabilities and warranties are agreed as part of contractual documentation – Business Transfer Agreements						
		Transferor collate all employment policies, procedures and agreements relevant under TUPE and submit to transferee						
		Transferor complete payroll information template for all transferring staff and submit to transferee						

		Close consultation & confirm TUPE transfer letter Clarification on regional holding position to be sought from SHA & Regional holding position to be included in consultation if appropriate						
C.3	**Review the current employment policies / HR processes across the 2 organisations and determine what fit for new organisation (i.e. PDR / Management Of Absence / Training)**	review position and establish what contractual, what will be continued with / integrated						
C.4	**Organisational development / Learning & Development**	Prepare induction plans for all transferring staff						
		Training / awareness for both council and PH team of culture, skills, etc						
		Agree CPD arrangements with relevant staff in order to ensure continuity						
		Annual training needs analysis to be undertaken as normal						
C.5	**Corporate Services**	Consider other Corporate functions. Link with other areas on Work on post integration Structure.						
		PCT current SLAs HR and OH review. SLAs to ensure transferred organisations have provision.						

C.6	**Staff Contracts**	New contracts issued						
C.7	**Confirm accommodation provision post April 2013**	Identify current accommodation occupied and cost. Identify proposed accommodation						
		Identify any individual workplace adjustments that may be required including IT						

Transition Plan

D. Governance and legal framework, including contracts: lead (LBM) and (NHS)

No.	Key Tasks	Actions	Comments / Progress	Lead	Complete by	Start	Finish	RAG /Risk
D.1	**Governance Plans**	LA and PCT leads to work together to ensure that all governance arrangements are adhered to during the transition year.						
		Ensure the PH team has appropriate governance support during transition and beyond						
D.2	**Performance**	Ensure that there are integrated arrangements in place to ensure contract continuity and monitor new public health outcomes framework - key performance indicators						

D.3	**Risk**	Ensure risk registers updated in NHSSM prior to transfer Ensure arrangements, systems and procedures are agreed for safe effective transfer in all areas pertaining to risk including: • SUIs • Emergency plan • Health and Safety						
D.4	**Information Governance**	With the Infrastructure / IT work stream, identify existing information governance arrangements and implement in shadow form new systems and processes to ensure a smooth transition:						
		Records Management • Archiving Information Asset register						
		Documentation • Policies • Procedures • Patient Literature						

		Freedom of Information - Need to ensure that FOI records relevant to the transferred PH services are passed over to LBM - If there are any outstanding complaints to the Information Commissioner/Information Tribunal relating to FOI compliance – who will be held liable - Who will be responsible for handling any requests for internal review relating to PCT FOI requests? Who will be responsible for handling any complaints relating to the PCT's FOI compliance including any that are taken on to the Information Commissioner?						
		Information policies Policies provided covering info sharing Guidance for personal identifiable information policy Responding to subject access request Code of Practice Information security policy						

D.5	**Infection control**	Establish existing arrangements for Infection Prevention and Control and develop future safe efficient arrangements						
D.6	**Clinical Effectiveness**	Establish existing arrangements for clinical effectiveness and develop and propose safe and efficient arrangements for future service delivery Identify role of LBM in research and development and clinical audit						
D.7	**Litigation**	Ensure all areas of litigation are flagged (if any)						
D.8	**Insurance**	Ensure LBM insurance covers work to be transferred, including clinical activity						
D.9	**Review all outstanding SUIs and complaints**	Create a database of outstanding / on-going services issues						
D.10	**Business Continuity Plans**	Develop BCP for new public health team						
D.11	**Legal and democratic**	Develop scheme of delegation						
		Clarify statutory officer functions						
		Define / agree role for Cabinet member for public health						
		Define 'public health outcomes framework' as a statutory plan						

Transition Plan								
E. Arrangements for public health support to NHS commissioners: lead (LBM) and (NHS)								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
E.1	**Ensure arrangements are in place to support NHS Commissioners**	Provision of objective support in following areas: • PH analysis • Clinical effectiveness • Resource allocation • Engagement with public and patients To improve quality in primary care To support strategic planning						

Transition Plan								
F. Commissioning and performance: lead (LBM) and (NHS)								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
F.1	**Review and renew Contracts Signed within the**	Agree draft new contract format, ensuring it is appropriate for clinical care.						

	agreed timescale	To collate a list of all contracts and service specifications requiring transfer with public health to The Council						
		Review and revise in line with 2013-2014 Operating Framework and Public Health outcomes framework and commissioning intentions						
		Identify service specifications to be transferred						
		Service specifications agreed by The Council						
		Data quality and improvement plans agreed to ensure access to data by the contracting team						
		Provide assurance that all services are covered by an SLA						
		Contract and values agreed using LBM format						
		Contract sign off						
		Establish a contract payment schedule which finance and providers are aware of						

		To provide and share finance / activity schedules for the main PH contracts						
		Are all clinical and non clinical risk and indemnity issues identified for contracts?						
		Notice served where appropriate on current contracts						
		Provide assurance that all services are covered by an SLA or contract						
		Where services are provided by NHS SM or successor organisation under an SLA/contract, there is a supporting finance schedule and the SLA/contract is accounted for correctly						
		Further review of the relevant detail on Contract Register. Ensure all services have formal documentation in place						
F.2	**Non-Clinical Contracts**	Expenditure by supplier exclusive of VAT						
		Budget Vs Actuals						
F.3	Ensure an early draft of legacy and handover documents is produced							

F.4	Ensure final legacy and handover documents are produced							
F.5	Agree robust internal accountability and performance monitoring arrangements to cover the whole of the transition year, including schemes of delegation							

Transition Plan								
G. **Transition of services and programmes: lead (LBM) and (NHS)**								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
G.1	Identify and agree all services to be transferred	Carry out programme analysis						
		Rank services according to ease of separating between Merton and Sutton						
		Monitor performance, etc and separate where possible and appropriate						
G.2	Agree the delivery of critical public health	Ensure services continue to be delivered during 2012/13						

	services/programmes locally, specifically, screening programmes; immunisation programmes, drugs and alcohol services, and infection prevention and control	Plan transfer of services to LBM and where appropriate transfer in using shadow arrangements						
G.3	Agree how mandated services are to be delivered during 2012/13 and during 2013/14 as part of the new local public health services	• Sexual health • Protection of public health • Public Health advice • National child measurement programme • NHS Health Check Assessment						
	Testing	With the Governance work stream leads, plan and test arrangements for PH in emergency planning						

Transition Plan								
H. Communication and Engagement: lead (LBM) and (NHS)								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
H.1	**Develop Communication & Engagement Strategy**	Development of staff communications and engagement strategy [with internal and external communications]						
		Identify all stakeholders and agree appropriate level of communication and engagement						
		Agree appropriate ways to communicate with stakeholders						
H.2	**Links with Public Health England**	Clarity about mutual responsibilities						
		Articulate mutual working arrangements						
		Articulate mutual working arrangements						
H.3	**Relationships with CCG (s)**	Engagement, if any, by PHO in CCC governance						
		Agreement of resource in LA PH to provide 'core offer'						
		Agreed means of delivering 'core offer'						

H.4	**Links with CSS(S)**	Mutual confirmation of no functional overlaps						
		Articulate mutual working arrangements (if any)						

Transition Plan								
I: Infrastructure and IT (LBM) and Lead (NHS)								
No.	**Key Tasks**	**Actions**	**Comments / Progress**	**Lead**	**Complete by**	**Start**	**Finish**	**RAG /Risk**
I.1	**IT support to PH team**	Obtain info regarding current IT systems including IT support staff						
I.2	**IT systems**	Agree access to NHS data – for public health intelligence / N3 connection						
I .3	**Identify Technology licenses and implications**	Identify all licenses including consents which need to transfer from existing organisations into new organisation						
I.4	**Information Governance**	Work with the Legal and Governance work stream leads to ensure access to IT systems, sharing of data and access to health intelligence in line with information governance and business requirements during transition and beyond transfer.						

I.5	**Electronic Records**	Migrate e-mail and electronic records to LBM systems ensuring forwarding of e-mails to new account						
I.6	**Mobile Phones**	Identify mobile phones and budget.						
I.7	**Intranet**	Ensure current access to Intranet, to include sensitive health search terms						
I.8	**ID Badges and Swipe Cards**	Produce LBM ID badges and swipe cards for access to premises						
I.9	**Car Park Passes**	Establish entitlement to car park passes and issue accordingly						
I.10	**Accommodation**	Assess accommodation (office/ desk/ meeting room) requirements of the team and what will be available on transfer to council accommodation						
		Ensure accommodation is suitable and ready for use on April 1st						

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www.chimat.org.uk

Child Health Profile

ChiMat
Child and Maternal Health Observatory

Merton

March 2012

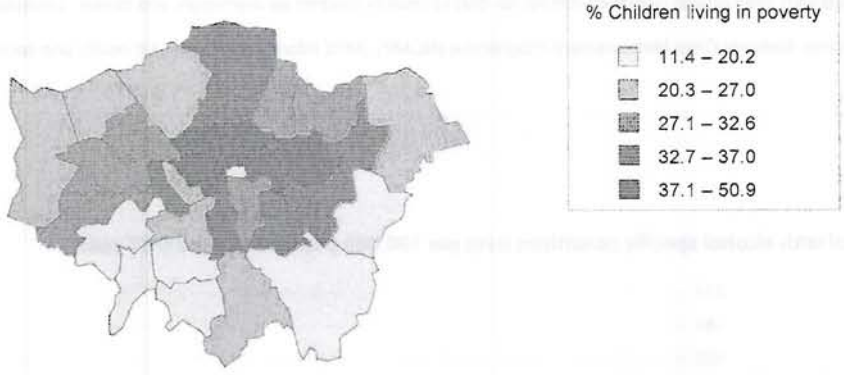
This profile provides a snapshot of child health in this area. It is designed to help the local authority and primary care trust improve the health and well-being of children and tackle health inequalities.
This profile is produced by the Child and Maternal Health Observatory (ChiMat) working with London Health Observatory (LHO).

The child population in this area

	Local	London	England
Live births in 2010	3,523	133,111	687,007
Children (age 0-4 years), 2010	15,400	586,400	3,267,100
% of total population	7.4%	7.5%	6.3%
Children (age 0-19 years), 2010	46,700	1,868,600	12,417,500
% of total population	22.4%	23.9%	23.8%
Children (age 0-19 years) predicted in 2020	51,800	2,012,100	12,898,400
% of total population	22.3%	23.8%	23.0%
School age children from black/ethnic minority group	12,380	631,170	1,586,340
% of school age population (age 5-16 years)	61.4%	66.9%	24.6%
% of children living in poverty (age under 16 years)	19.7%	29.7%	21.9%
Life expectancy at birth			
Boys	80.7	79.0	78.6
Girls	84.6	83.3	82.6

Children living in poverty

Map of the London area showing the relative levels of children living in poverty.



Data sources: Live births, Office for National Statistics (ONS) 2010; population estimates, ONS midyear estimates 2010; population projections, ONS (based on 2008 mid year estimates); black/ethnic minority maintained school population, Department for Education 2011; children living in poverty, Her Majesty's Revenue and Customs (HMRC) 2009; life expectancy, ONS 2008-10

Key findings

- Around 22% of the population of Merton is under the age of 20. Around 61% of school children are from a black or minority ethnic group.
- The health and well-being of children in Merton is generally better than the England average.The infant mortality rate is similar to the England average and the child mortality rate is similar to the England average.
- The level of child poverty is better than the England average with 20% of children aged under 16 years living in poverty.
- Children in Merton have average levels of obesity. 8% of children in Reception and 20% of children in Year 6 are classified as obese. 58% of children participate in at least three hours of sport a week which is better than the England average.
- The MMR immunisation rate is lower than the England average. Immunisation rates for diphtheria, tetanus, polio, pertussis and Hib in children aged two are lower than the England average.
- The hospital admission rate for alcohol specific conditions is lower than the England average. The percentage of children who say they have been drunk recently is lower than the England average.

YHPHO
YORKSHIRE & HUMBER PUBLIC HEALTH OBSERVATORY

London Health Observatory

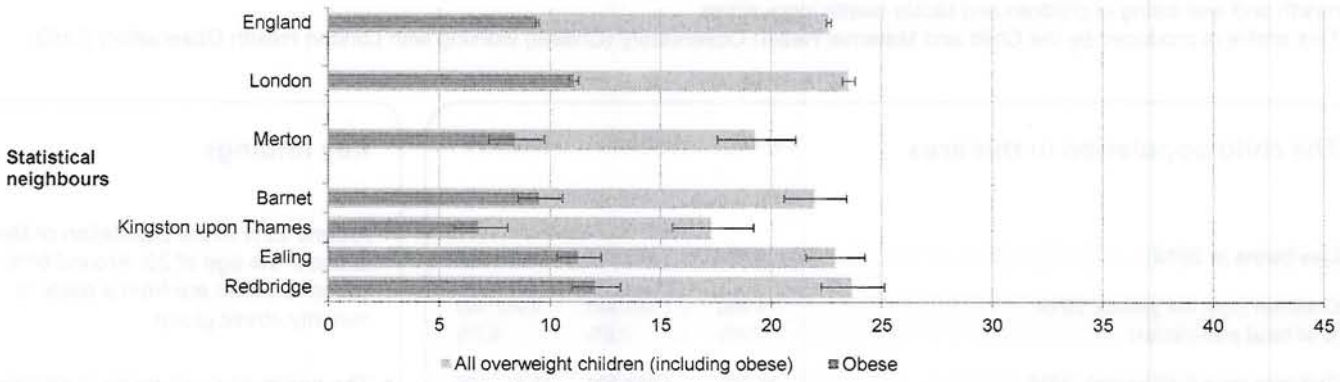
NHS

ChiMat is funded by the Department of Health and is part of YHPHO.
This profile is produced by ChiMat working with LHO on behalf of the Public Health Observatories in England.

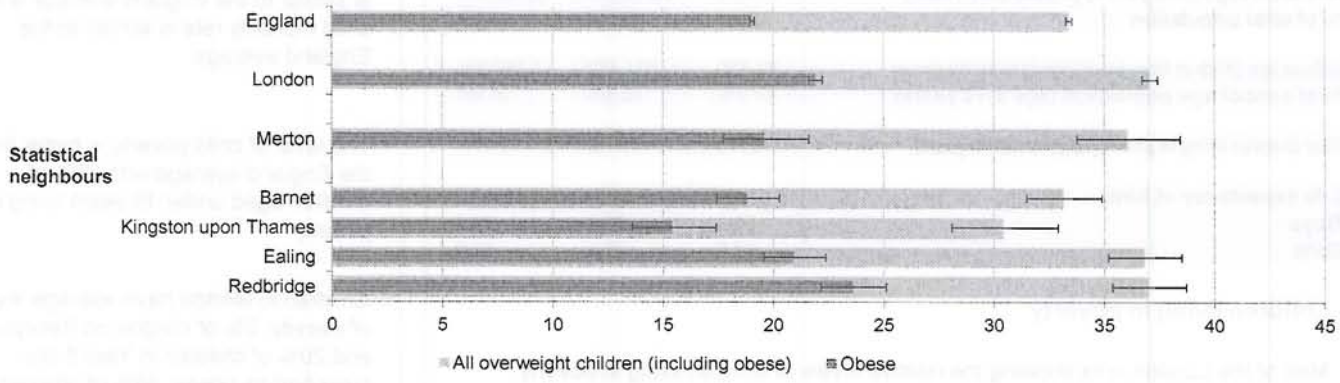
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared to their statistical neighbours. This area has a lower percentage in Reception and a higher percentage in Year 6 classified as obese or overweight compared to the England average.

Children aged 4-5 years classified as obese or overweight, 2010/11 (percentage)



Children aged 10-11 years classified as obese or overweight, 2010/11 (percentage)



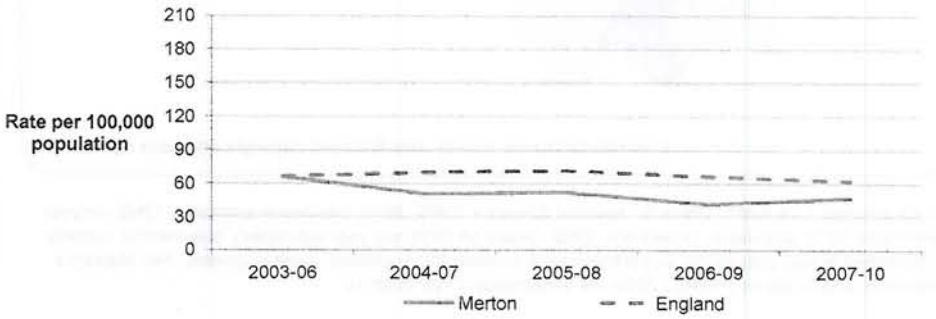
Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese. I indicates 95% confidence interval.

Data source: National Child Measurement Programme (NCMP), NHS Information Centre for health and social care.

Young people and alcohol

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

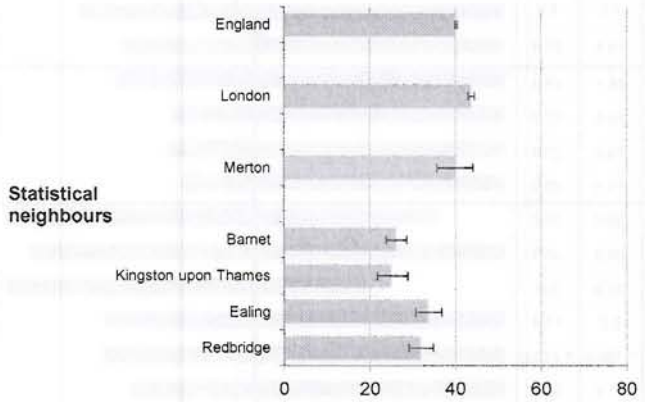
In comparison with the 2003-06 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose has decreased in the 2007-10 period. Overall rates of admission in the 2007-10 period are lower than the England average.



Data source: Hospital Episode Statistics (HES), The NHS Information Centre for health and social care.

These charts compare Merton with statistically similar areas (its 'statistical neighbours'), the England and regional average and, where available, the European average.

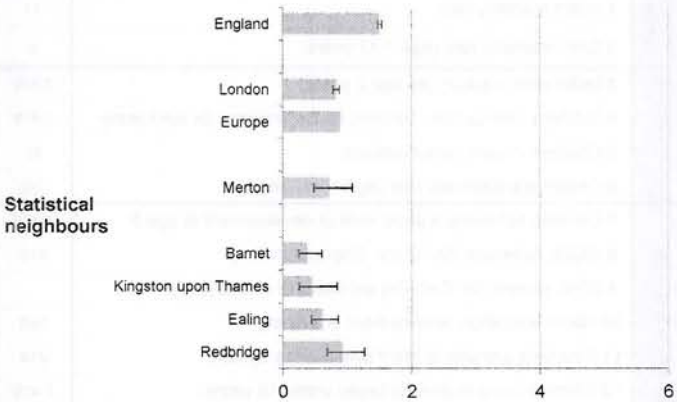
Teenage conceptions in girls aged under 18 years, 2007-09 (rate per 1,000 female population aged 15-17 years)



During the 2007-09 period, approximately 40 girls aged under 18 conceived for every 1,000 of the female population aged 15-17 years in this area. This is similar to the regional average. The area has a similar teenage conception rate compared to the England average.

Data source: Office of National Statistics (ONS)/ Teenage Pregnancy Unit

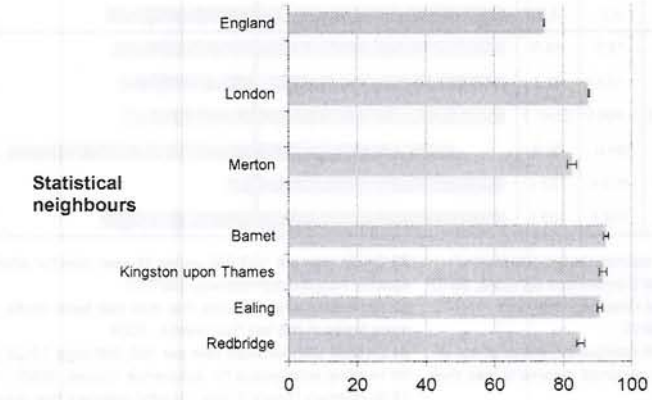
Teenage mothers aged under 18 years, 2010/11 (percentage of all deliveries)



In 2010/11, 0.7% of women giving birth in this area were aged under 18 years. This is similar to the regional average. This area has a lower percentage of births to teenage girls compared to the England average and a similar percentage compared to the European* median.

Data source: Hospital Episode Statistics, NHS Information Centre
* European data are from 2004

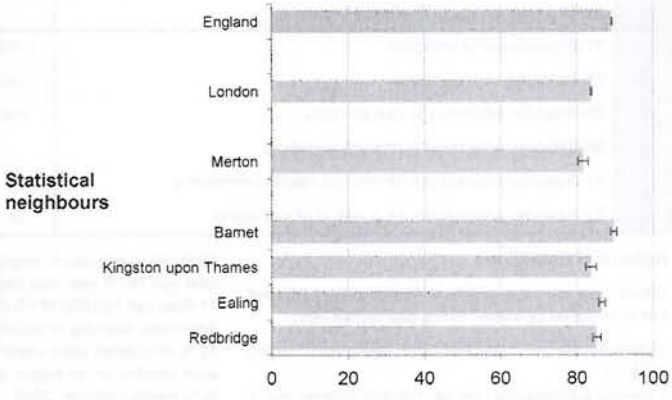
Breastfeeding initiation - 2010/11 (percentage of maternities where status is known)



In this area, 82.5% of mothers initiate breastfeeding when their baby is born. This is higher than the England average. By six to eight weeks after birth 64.3% of mothers are still breastfeeding.

Data source: Vital Signs Monitoring Report, Department of Health

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2010/11 (percentage of children age 2 years)



A lower percentage of children (81.6%) have received their first dose of immunisation by the age of two in this area when compared to the England average. By the age of five, the percentage of children who have received their second dose of MMR immunisation is lower with 79.8% of children being immunised. This is lower than the England average.

Data source: NHS Information Centre for health and social care

Note: Where no data are available or have been suppressed, no bar will appear in the chart for that area.

Merton Child Health Profile

March 2012

Summary of child health and well-being in Merton

The chart below shows how children's health and well-being in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

Significantly worse than England average | Not significantly different | Significance not tested
Significantly better than England average | Regional average

England average: 25th percentile – 75th percentile

	Indicator	Local no. per year	Local value	Eng. ave.	Eng. worst	Eng. best
Preventable mortality	1 Infant mortality rate	13	3.8	4.6	8.0	2.2
	2 Child mortality rate (age 1-17 years)	6	16.1	16.5	27.6	10.5
Health protection	3 MMR immunisation (by age 2 years)	2,558	81.6	89.1	75.4	96.8
	4 Diphtheria, Tetanus, Polio, Pertussis, Hib immunisations (by age 2 years)	2,876	91.8	96.0	87.3	98.9
	5 Children in care immunisations	80	94.1	79.0	20.4	100.0
	6 Chlamydia diagnosis rate (age 15-24 years)	142	6.2	13.4	43.5	4.4
Wider determinants of ill health	7 Children achieving a good level of development at age 5	1,448	61.0	59.0	48.0	74.0
	8 GCSE achieved (5A*-C inc. Eng and maths)	910	59.5	58.3	40.5	74.4
	9 GCSE achieved (5A*-C inc. Eng and maths) for children in care	-	0	12.8	0.0	40.0
	10 Not in education, employment or training	160	5.5	6.0	11.4	2.7
	11 First time entrants to the Youth Justice System	214	1,320.0	1,160.0	2,410.0	390.0
	12 Children living in poverty (aged under 16 years)	7,410	19.7	21.9	50.9	7.4
	13 Rate of family homelessness	60	0.7	1.9	7.3	0.1
	14 Children in care	130	31.0	59.0	142.0	20.0
	15 Children killed/seriously injured in road traffic accidents	2	5.0	23.6	64.2	2.1
Health improvement	16 Obese children (age 4-5 years)	160	8.4	9.4	14.6	5.5
	17 Obese children (age 10-11 years)	315	19.6	19.0	26.3	10.3
	18 Participation in at least 3 hours of sport/PE	11,749	58.4	55.1	40.9	79.5
	19 Teenage conception rate (age under 18 years)	117	39.7	40.2	69.4	15.3
	20 Teenage mothers (age under 18 years)	23	0.7	1.5	3.5	0.3
	21 Children's tooth decay (at age 12)	-	0.5	0.7	1.5	0.2
	22 Hospital admissions due to alcohol specific conditions	19	46.8	61.8	154.9	18.6
	23 Children and young people using alcohol	-	7.0	15.0	23.0	3.0
	24 Hospital admissions due to substance misuse (age 15-24 years)	6	25.1	63.5	163.6	19.8
	25 Children and young people using drugs	-	3.0	4.0	13.0	0.0
	26 Children and young people smoking	-	2.0	4.0	9.0	1.0
Prevention of ill health	27 Breastfeeding initiation	2,562	82.5	74.5	39.0	94.7
	28 Smoking in pregnancy	196	6.3	13.6	32.7	3.1
	29 Hospital admissions due to injury	498	1,159.6	1,466.0	2,547.7	890.7
	30 Children who have someone to talk to	-	62.0	64.0	56.0	74.0
	31 Hospital admissions for mental health conditions	44	102.5	109.4	722.1	36.8
	32 Hospital admissions as a result of self-harm	24	55.9	158.8	359.5	34.3

Notes and definitions

Where data are not available or have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2008-10
2 Directly standardised rate per 100,000 children age 1-17 years, 2002-10
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2010/11
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2010/11
5 % children in care with up-to-date immunisations, 2011
6 Positive chlamydia tests reported per 1,000 population aged 15-24 years, 2010/11
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2011
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2010/11 (provisional)
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2010/11 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local Connexions services, 2010
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2009/10
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2009
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2007/08
14 Rate of children looked after at 31 March 2011 per 10,000 population aged under 18, 2011
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2008-10
16 % school children in Reception year classified as obese, 2010/11
17 % school children in Year 6 classified as obese, 2010/11
18 % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009/10
19 Under 18 conception rate per 1,000 females age 15-17 years, 2007-09 (provisional)
20 % of delivery episodes where the mother is aged less than 18 years, 2010/11
21 Weighted mean number of decayed, missing or filled teeth in 12 year olds, 2008/09
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2007-10
23 % children who reported that they had been drunk one or more times in the last four weeks, 2009
24 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2008-11
25 % children (Years 8 and 10) who reported that they have taken cannabis or skunk one or more times in the last four weeks, 2009
26 % of children who reported that they had smoked at least one cigarette in the last 4 weeks, 2009
27 % of mothers initiating breastfeeding where status is known, 2010/11
28 % of mothers smoking at time of delivery where smoking status is known, 2010/11
29 Crude rate per 100,000 (age 0-17 years) for hospital admissions following all injury, 2010/11
30 % children who reported that they can talk to their mum or dad when they are worried, 2009
31 Inpatient admission rate per 100,000 population age 0-17 years for mental health disorders, 2010/11
32 Crude rate of inpatient admissions for self-harm per 100,000 population (aged 0 - 17 years), 2010/11

Background paper 1: Health and Social Care Bill: Public Health provisions as applicable to local authorities

12 Duties as to improvement of public health

- Each local authority must take such steps as it considers appropriate for improving the health of the people in its area
- The steps that may be taken include:
    - Providing information and advice
    - Providing services or facilities designed to promote healthy living (whether by helping individuals to address behaviour that is detrimental to health or in any other way)
    - Providing services or facilities for the prevention, diagnosis or treatment of illness
    - Providing financial incentives to encourage individuals to adopt healthier lifestyles
    - Providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment
    - Providing or participating in the provision of training for persons working or seeking to work in the field of health improvement
    - Making available the services of any person or facilities

14 Clinical Commissioning Groups

- Each clinical commissioning group must obtain advice appropriate for enabling it effectively to discharge its functions from people who have a broad range of professional expertise in-
    - the prevention, diagnosis and treatment of illness, and
    - the protection or improvement of public health

30 Appointment of Directors of Public Health

- Each local authority must, acting jointly with the Secretary of State, appoint an individual to have responsibility for the exercise of its public health functions, including those that relate to planning for, or responding to, emergencies involving a risk to health and the functions of the authority under section 325 of the Criminal Justice Act 2003.
- The individual so appointed is to be an officer of the local authority and is to be known as its Director of Public Health.
- A local authority may terminate the appointment of its Director of Public Health.
- Before terminating the appointment of its Director of Public Health, a local authority must consult the Secretary of State.
- A local authority must have regard to any guidance given by the Secretary of State in relation to its Director of Public Health, including guidance as to appointment, terms and conditions and management.

31 Exercise of public health functions of local authorities

- A local authority must, in the exercise of any of its public health functions, have regard to any document published by the Secretary of State for the purposes of exercises these functions.

- A document and guidance published under this section may include guidance as to the appointment of officers of the local authority to discharge any of the public health functions, including their terms and conditions, management and dismissal.
- The Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority.
- The local authority must publish the report.

32 Complaints about exercise of public health functions by local authorities

- Regulations may make provision about the handling and consideration of complaints about the exercise by a local authority of any of its public health functions, and any of its other functions which relate to public health and for which its Director of Public Health has responsibility.

212 Establishment of Health and Wellbeing Boards

- A local authority must establish a Health and Wellbeing Board for its area, which must include the Director of Public Health as a member.

Reference: Health and Social Care Bill as published for House of Lords Report Stage 14 March 2012
http://www.publications.parliament.uk/pa/bills/lbill/2010-2012/0132/2012132.pdf

Background Paper 2: Improving outcomes and supporting transparency
A Public Health Outcomes Framework for England, 2013-2016

A new Public Health Outcomes Framework is intended to set the vision for the public health system. It consists of two overarching outcomes and four domains.

The overarching outcomes are:

- **Increasing healthy life expectancy** – this indicator takes account of the health quality as well as the length of life, and will use a self reported health assessment applied to life expectancy

- **Reduced differences in life expectancy and healthy life expectancy between communities** – through greater improvements in more disadvantaged communities

The four domains are:

Domain 1: Improving the wider determinants of health
Objective: Improvements against wider factors that affect health and wellbeing and health inequalities
Indicators:

- Children in poverty
- School readiness
- Pupil absence
- First-time entrant to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness and disability in settled accommodation (2 indicators)
- People in prison who have a mental illness or a significant mental illness
- Employment for those with a long-term health condition including those with a learning disability or mental illness
- Sickness absence rate
- Killed and seriously injured casualties on England's roads
- Domestic abuse
- Violent crime
- Re-offending
- The percentage of the population affected by noise
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- Social connectedness
- Older people's perception of community safety

Domain 2: Health Improvement
Objective: People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
Indicators:

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery

- Under 18 conceptions
- Child development at 2-2.5 years
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- Emotional wellbeing of looked after children
- Smoking prevalence – 15 year olds
- Hospital admissions as a result of self-harm
- Diet
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adults
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol related admissions to hospital
- Cancer diagnosed at stage 1 and 2
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check programme by those eligible
- Self-reported wellbeing
- Falls and fall injuries in the over 65s

Domain 3: Health Protection
Objective: The population's health is protected from major incidents and other threats, while reducing health inequalities
Indicators:

- Air pollution
- Chlamydia diagnoses
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development managements plan
- Comprehensive, agreed inter-agency plans for responding to public health incidents

Domain 4: Healthcare public health and preventing premature mortality
Objective: Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities
Indicators:

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- Mortality from communicable disease
- Excess under 75 mortality in adults with serious mental illness

- Suicide
- Emergency readmissions within 30 days of discharge from hospital
- Preventable sight loss
- Health-related quality of life for older people
- Hip fractures in over 65s
- Excess winter deaths
- Dementia and its impacts

Detailed technical analysis is underway to populate those indicators for which data is currently available, which will support priority setting for the public health performance priorities and the Joint Health and Wellbeing Strategy.

Reference:
Improving outcomes and supporting transparency
A Public Health Outcomes Framework for England, 2013-2016
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_132559.pdf

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