Nottinghamshire County Council

Public Health Committee

Wednesday, 26 November 2014 at 10:30

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

(3) Reports in colour can be viewed on and downloaded from the County Council's website (www.nottinghamshire.gov.uk), and may be displayed at the meeting.

(4) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

(5) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

Nottinghamshire County Council

minutes

Meeting	PUBLIC HEALTH COMMITTEE
Date	11 September 2014 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

Joyce Bosnjak (Chair)
Glynn Gilfoyle (Vice-Chair)

Steve Carr
Steve Carroll
Kay Cutts MBE
Alice Grice
Martin Suthers OBE
Stuart Wallace
Muriel Weisz

A Ex Officio: Alan Rhodes

OFFICERS IN ATTENDANCE

Rachel Adams, Public Health Manager
Barbara Brady, Public Health Consultant
Paul Davies, Democratic Services
Chris Kenny, Director of Public Health
Lindsay Price, Senior Public Health Manager
Lynn Robinson, Senior Public Health Manager
Helen Ross, Public Health Manager, Nottingham City Council
Helen Scott, Senior Public Health Manager
Robin Smith, Communications and Marketing
John Tomlinson, Deputy Director of Public Health

ALSO IN ATTENDANCE

Chris Cutland, Deputy Police and Crime Commissioner

MINUTES

The minutes of the meeting held on 11 September 2014 were confirmed and signed by the Chair.

MEMBERSHIP

Councillor Wallace had been appointed in place of Councillor Adair, for this meeting only.

DECLARATIONS OF INTEREST

There were no declarations of interest.

NHS HEALTH CHECK PROGRAMME

RESOLVED: 2014/026

(1) That the procurement of NHS Health Checks provision for GPs to deliver a core service, via direct award, from April 2016 be approved.

(2) That an outreach service to engage high risk groups that are unlikely to take up the core offer from their GP, via open tender, from April 2016 be approved.

(3) That the procurement of an associated information technology system to support delivery and enable the required data flow in fulfilment of the local authority mandate, from April 2016 be approved.

(4) That the above contracts be for a three year period for April 2016 with an option to extend on an annual basis for a further three years (ie 3+1+1+1) to a maximum of six years in total.

(5) That the outreach and IT procurement be conducted jointly with Nottingham City Council.

(6) That the funding of a social marketing campaign this year (2014/15) be approved, to increase uptake in fulfilment of the local authority mandate.

(7) That an update on the NHS Health Check Commissioning Plan be presented following the outcomes of the County Council budget consultation.

DOMESTIC ABUSE SERVICES

Chris Cutland and Rachel Adams gave a presentation on the Domestic Violence Review and the proposals for joint commissioning domestic abuse services by the County Council and Police and Crime Commissioner.

RESOLVED: 2014/027

That approval be given to option one in the report, and a joint open procurement process on behalf of the County Council and the Police and Crime and Commissioner (with the County Council as lead partner) be undertaken, recognising that at this stage the financial envelope is yet to be determined.

OBESITY PREVENTION AND WEIGHT MANAGEMENT SERVICES COMMISSIONING UPDATE

RESOLVED: 2014/028

(1) That the current position regarding the commissioning of obesity prevention and weight management services be noted.

(2) That the plans to extend the current service arrangements be noted.

(3) That an increase in the financial envelope up to £1.9 million per annum be agreed to allow for the successful retendering of obesity prevention and weight management services from within the Public Health Grant.

(4) That a report be brought to the Public Health Committee on 11 December 2014 to recommend the award of contract.

PUBLIC HEALTH OUTCOMES PROGRAMME – PLANS AND PROGRESS

RESOLVED: 2014/029

That the progress of on the Public Health Outcomes Programme be noted, and the plan of action be endorsed to identify further efficiencies by January 2015 for implementation during 2016/17.

PUBLIC HEALTH SERVICES PERFORMANCE AND QUALITY REPORT FOR HEALTH CONTRACTS

RESOLVED: 2014/030

That the report be received and the performance and quality information be noted.

LOWLAND DERBYSHIRE AND NOTTINGHAMSHIRE LOCAL NATURE PARTNERSHIP

RESOLVED: 2014/031

(1) That the development of joint working between the Local Nature Partnership, Public Health and the Health and Wellbeing Board be supported.

(2) That the mapping of existing health and wellbeing work with the natural environment and best practice and gaps be supported.

(3) That ways of complementing and enhancing outcomes by working together be developed.

(4) That project proposals be developed based on key areas of priority where resources allow.

WORK PROGRAMME

RESOLVED: 2014/032

That the work programme be noted.

The meeting closed at 3.55 pm.

CHAIR

Nottinghamshire County Council

Report to Public Health Committee

26 November 2014

Agenda Item: 4

REPORT OF DIRECTOR OF PUBLIC HEALTH

COMMISSIONING COMPREHENSIVE SEXUAL HEALTH SERVICES IN NOTTINGHAMSHIRE FROM APRIL 2016

Purpose of the Report

1. The purpose of this report is to:

   a. Advise the Committee of the health needs and contractual arrangements related to the Council's responsibility for commissioning mandatory comprehensive sexual health services, and the implications and consequential costs of potential reductions in funding.

   b. Secure approval to consult with stakeholders about how to address these sexual health needs in advance of a Committee decision in March 2015 about the budget to be allocated to sexual health.

Information and Advice

Public health significance of good sexual health

2. Good sexual health is an important part of physical, mental and social well-being, requiring a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences which are free of coercion, discrimination and violence[i].

3. The burden of poor sexual health falls most heavily on disadvantaged groups and there is a clear link between sexual ill health, poverty and social exclusion in Nottinghamshire County. The consequential costs of poor sexual health are borne by society at large as well as the individuals.

4. The public health significance of the overall sexual health agenda is underlined by the inclusion of several indicators in the Public Health Outcomes Framework:

   a. **Under 18 conceptions** (Domain 2, Health Improvement): children born to teenage mothers are much more likely to experience a range of negative outcomes in later life, such as developmental disabilities, behavioural issues and poor academic performance.

   b. **Chlamydia diagnoses in people aged 15-24 years** (Domain 3, Health Protection): if untreated, between 10-20% of chlamydia cases result in infertility due to pelvic inflammatory disease.

c. **People presenting with HIV at a late stage of diagnosis** (Domain 3, Health Protection): the proportion of late diagnoses remained high in Nottinghamshire County in 2012 (63%) compared to England (50%)[ii]. These individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed early. In addition to the significant, dismal and unnecessary health outcomes for the individuals concerned, late diagnosis also yields significant treatment, clinical and social care costs.

5. In recognition of the extent to which good sexual health contributes to health and wellbeing, the Nottinghamshire County Health and Wellbeing Strategy includes the priority to reduce the rates of STIs and unplanned pregnancy.

Commissioning responsibilities & interdependencies

6. Since April 2013 responsibilities for commissioning comprehensive sexual health, reproductive health and HIV services have been divided across local government, Clinical Commissioning Groups (CCGs) and NHS England (NHSE).

7. Local Authorities Regulations[iii] mandate that unitary and upper tier local authorities commission confidential, open access services for STIs and contraception, as well as reasonable access to all methods of contraception. Appendix 1 provides a summary of the system wide commissioning responsibilities for sexual health, reproductive health and HIV services.

8. The delegation of commissioning responsibilities for a single patient "pathway" to a number of organisations means that the delivery of an effective overall commissioning system depends on close collaboration between CCGs, NHSE, and other local authorities. This is important both in terms of ensuring satisfactory outcomes at each stage of the patient pathway and to mitigate the unintended consequential costs of changes made to services earlier in the same pathway.

9. The consequential costs of poor access to timely testing for STIs, prompt treatment and a full range of contraception are borne by CCGs, NHSE, Nottinghamshire County Council, neighbouring local authorities and other public service budgets. Some of these costs are considerable. For example, the cost of completing treatment and clinical care of the 30 people in Nottinghamshire County who were diagnosed with HIV in 2010-11 is estimated to be £8,400,000[iv].

10. Appendix 2 provides insight into three service users' sexual health "journey" and demonstrates the interdependencies and collaborative commissioning arrangements required to ensure seamless access across and between a range of services.

11. There are also close dependencies between sexual health and other local authority agendas. For example, the availability and accessibility of effective sexual health and reproductive health services makes a critical contribution to Nottinghamshire's ambition to continue to lower teenage conceptions across the whole of Nottinghamshire and to a greater degree in more deprived areas[v]. Similarly there are close dependencies with Sex and Relationships Education (SRE) and the Child Sexual Exploitation (CSE) agenda.

12. Nottinghamshire County's Joint Strategic Needs Assessment (JSNA) highlighted significant variation across the county in both the prevalence of STIs and the number of teenage conceptions and identified that addressing sexual ill health and promoting sexual wellbeing is a key step to reducing overall health inequalities.

13. Further needs assessment is under way. Amongst other things, this is likely to confirm the need to commission an integrated sexual health service, so that residents (as service users) are able to attend for STI testing and at the same appointment be able to access relevant contraceptive advice and provision.

14. We know that there is a gap in what is commissioned to deliver Sexual Health promotion, particularly targeting sexual health promotion to young people in teenage hot spot areas across the county and to people who have higher sexual health risks (MSM - Men who have sex with men and sex workers). Along with the need to address the late diagnosis of HIV across the county.

Current contracts and pressures

15. The Council's current sexual health contracts are summarised in Appendix 3.

16. The total annual cost of these sexual health contracts is in excess of £6.8 million.

17. In regard to management of contracts which cover the south of the County, it is critical to work in close collaboration with Nottingham City Council who are also associate commissioners of Nottingham University Hospitals for Genito-urinary Medicine (GUM) and Contraception and Sexual Health (CaSH) services. Dependencies in Bassetlaw are with Doncaster Council whose services are currently provided by Doncaster & Bassetlaw Hospital. Account needs to be taken of any implications for services in Bassetlaw of what Doncaster Council chooses to do with services provided by Doncaster & Bassetlaw Hospital in their neighbouring locality.

18. In common with other commissioners of acute healthcare services, the council is obliged to pay for its GUM services using a simple per-patient tariff which is determined nationally. Therefore there is little scope for reducing the unit price of each treatment. Indeed, looking ahead it is more likely that the tariff will be increased. Furthermore, since the Council must provide equity of access to an open universally available service there is limited scope in the short term for reducing the volume of activity.

19. Payment for Contraception and Sexual Health (CaSH) services are currently transacted through "block" contracts, in which a fixed overall amount is paid to the provider irrespective of the total number of treatments. Exceptions to this arise in respect of residents who are at liberty to access CaSH services in other areas, for which we are liable to make payment. Changes to the way pathology costs are recharged to providers may present as a cost pressure.

20. The Council also commissions Long Acting Reversible Contraception (LARC) from general practice, for which there is evidence of gaps in coverage. Treatments provided are paid according to a pricing schedule which varies across the County. Discussions with primary care to rationalise payment stalled last year due to limited freedom of movement on either side.

21. Service accessibility is important to increase outcomes, Emergency Hormonal Contraception (EHC) is commissioned from 144 Community Pharmacies; the service includes signposting to contraceptive and sexual health services and C-Card for young people.

22. Within our current and future commissioning arrangements, there is a need to be mindful that NHS providers (within specialist areas such as sexual health) are key contributors to medical and clinical workforce development and training, which is essential to support future Sexual Health Service sustainability and delivery.

23. The key implications arising from these considerations is that short term scope for reducing costs to the Council is limited and that financial pressures on the current budget are growing.

Future commissioning & prospects

24. All current CaSH and GUM contracts expire on 31/3/2016 and have no further permissible extension periods. This means that some form of procurement will have to be undertaken to commission services for the period from 01/04/2016. This will be a key opportunity to address the recommendations from the needs assessment (e.g. to implement an integrated service across the county) and the goals agreed by the Health and Wellbeing Board (to reduce rates of STIs and unplanned pregnancy).

25. In considering the reprocurement of these services, current and potential providers are unlikely to agree to new arrangements based on block contracts which expose them to risk of cost pressures if treatment activity increases. Work is under way to quantify the additional financial pressures for the Council of “unblocking” these contracts.

26. Introduction of a new national integrated tariff will provide a payment structure which enables a faster implementation of integrated working. The rate for the per-patient tariff has yet to be determined, but is likely to represent a net additional financial pressure compared to our current pricing arrangements.

Likely consequences of reductions in funding for sexual health services

27. The portion of the Public Health Grant to be allocated to sexual health will not be determined by the Public Health Committee until March 2015. Until that time, it is not possible to quantify the impact of changes to the budget. Nevertheless, there is some evidence which indicates that the nature of the impact would be adverse, significant and felt by a range of stakeholders (refer to Appendix 4). The reasons are as follows.

28. Firstly, it is likely that any reduction in budget is likely to result in some kind of restriction in access to mandatory open services and/or curtailment of discretionary services targeted to address underlying causes in areas with the worst sexual health outcomes. This is because there is limited scope within our mandated sexual health services for containing all of the existing cost pressures. Taken together with the requirement to move from block contracts to a per-patient tariff, it is unlikely that current levels of provision can be maintained within the existing budget. A reduction in budget would increase the likelihood and scale of the impact on services.

29. Secondly, reductions in access to mandatory open sexual health services and/or curtailment of discretionary services targeted to address underlying causes are likely to impact outcomes at individual and population levels. For example, reductions in the proximity of services or opening hours will impact on their accessibility to some people in need of contraceptive services or STI testing. Evidence for this rests on local intelligence from providers, feedback emerging from engagement with service users and is consistent with assumptions underlying modelling undertaken at a national level.

30. Thirdly, the scale of impact at an individual level is potentially very serious including, for example, unplanned pregnancies in teenagers and adults, onward transmission of untreated STIs, infertility arising from delay in or lack of treatment for Chlamydia infection, and additional complications or early death associated with delayed diagnosis of HIV. At a population level, these outcomes are likely to be reflected in terms of increased health and social inequalities with their long term implications (Refer to Appendix 5 emerging early themes from the SH JSNA refresh).

31. Fourthly, in addition to the potentially serious impact for individuals and their communities, these impacts also entail adverse financial consequences for public service budgets in Nottinghamshire County. For example, a recent study based on national-level modelling found that modest restrictions to sexual health services would negatively impact outcomes and that the consequential costs of this to public service budgets across the whole UK would be in the order of £100 billion over an 8 year period[vi]. Accurately quantifying what the scale or timing of these impacts would be in Nottinghamshire is problematic and sensitive to underlying assumptions and local conditions. Nevertheless, it indicates the general scale and adverse nature of the likely impact.

32. An earlier study provides crude support for the significant positive economic impact of investment in contraceptive services, which was found to deliver £11 of benefit to public service budgets for every £1 invested[vii]. NICE guidance relating to sexual health interventions also provides summaries demonstrating their cost effectiveness. None of these studies provides a refined basis for estimating the impact on outcomes from a reduction in sexual health services in Nottinghamshire, but it is clear that the impact would be negative for individuals, population outcomes, and for commissioners of public services responsible for managing the associated consequences.

33. The implication of this is that it is very likely that any net saving the Council finds it possible to realise from its sexual health budget will be paid for by CCGs who will have to divert funds to meet the costs associated with additional demand for termination of pregnancy, ante- and perinatal services, treatment for infertility and other complications arising from delayed diagnosis and treatment. NHS England and other parties will bear additional costs associated with failure to secure early diagnosis of HIV.

34. Fifthly, notional savings in the Council's sexual health budget will be offset by increased demand and consequential costs for other interventions. Some of these will represent additional pressures on other Council budgets (e.g. increased demand for Early Years interventions such as Sure Start). In other instances, the impact will be felt in Council commissioned services funded by some form of capitated grant (e.g. nursery provision), for which it is already very challenging to identify sufficient adequate capacity in the market.

35. Appendix 4 outlines the benefits of investment in effective SH services.

Immediate next steps

36. The immediate next steps are to complete the needs assessment, continue with work to develop a proposed future service model and a recommendation about the preferred procurement approach for securing this.

37. Work on the future service model will explore the value of delivering contraceptive and sexual health services in a more integrated way, and other recommendations which emerge from the needs assessment work which will be completed by December. Appendix 5 identifies early emerging themes identified so far.

38. Work on the future service model will be undertaken in collaboration with Nottingham City Council in particular, because of our shared interest in the availability of services which are accessible to people who live or work near to Nottingham.

39. Engagement with CCGs on this agenda is through their participation in the Sexual Health Procurement Group, and the Public Health directorate's CCG Engagement Group. It is proposed to bring a version of this paper to the Health and Wellbeing Board in January.

40. As our recommendations develop, Public Health will undertake consultation with relevant stakeholders. It is likely that this will take place in early 2015.

41. It is proposed that a paper is brought to the Public Health Committee in March to recommend a procurement approach and to secure approval for a budget to support this.

Reason for Recommendations

42. Contract expiry and the timescales involved in procurement mean that it is necessary to undertake preparatory work and stakeholder consultation about future sexual health services during the next few months, and prior to seeking Committee approval in March 2015 for a budget.

Statutory and Policy Implications

43. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

44. None

RECOMMENDATIONS

1. The Committee is asked to note the information shared in the paper to inform future decision making
2. The Committee is asked to approve the consultation with stakeholders about the future model of sexual health services in advance of a Committee decision in March 2015 about the budget to be allocated to sexual health

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Dr Jonathan Gribbin Consultant in Public Health (jonathan.gribbin@nottscc.gov.uk)

Constitutional Comments (LMC 31/10/14)

45. The Public Health Committee has delegated authority within the Constitution to approve the recommendations in the report.

Financial Comments (KAS 04/11/14)

46. There are no financial implications contained within the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Divisions and Members Affected

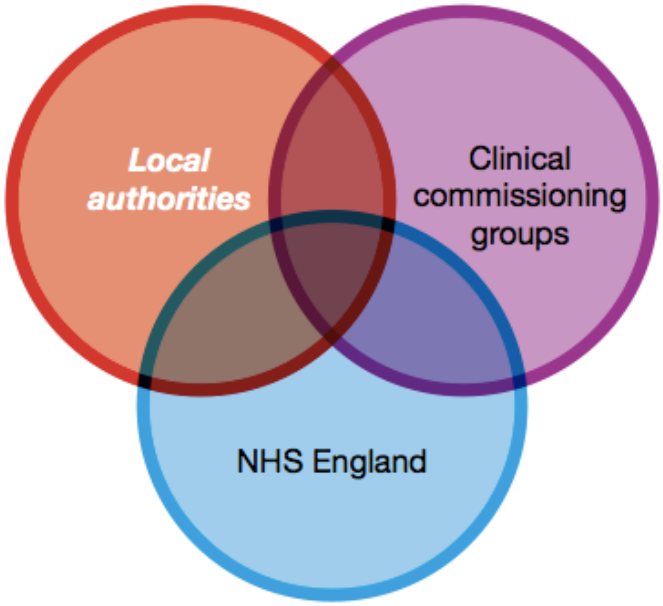
- All

Appendix 1

Commissioning Responsibility for sexual health, reproductive health and HIV [viiiix]

Local Authorities	CCGs	NHS England
• Contraception • STI testing and treatment • Chlamydia testing as part of the National Chlamydia Screening Programme • HIV testing • Sexual health aspects of psychosexual counselling • Sexual services including young people's sexual health, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies	• Abortion services • Vasectomy • Non sexual health elements of psychosexual health services • Gynaecology including use of contraception for non-contraception purposes	• Contraception provided as an additional service under the GP contract • HIV treatment and care including post-exposure prophylaxis after sexual exposure • Promotion of opportunistic testing and treatment for STIs • Sexual health elements of prison health services • Sexual Assault Referral Centres • Cervical screening • Specialist fetal medicine
Original Source: Department of Health Commissioning Sexual Health services and interventions: Best Practice guidance for local authorities, 2013		

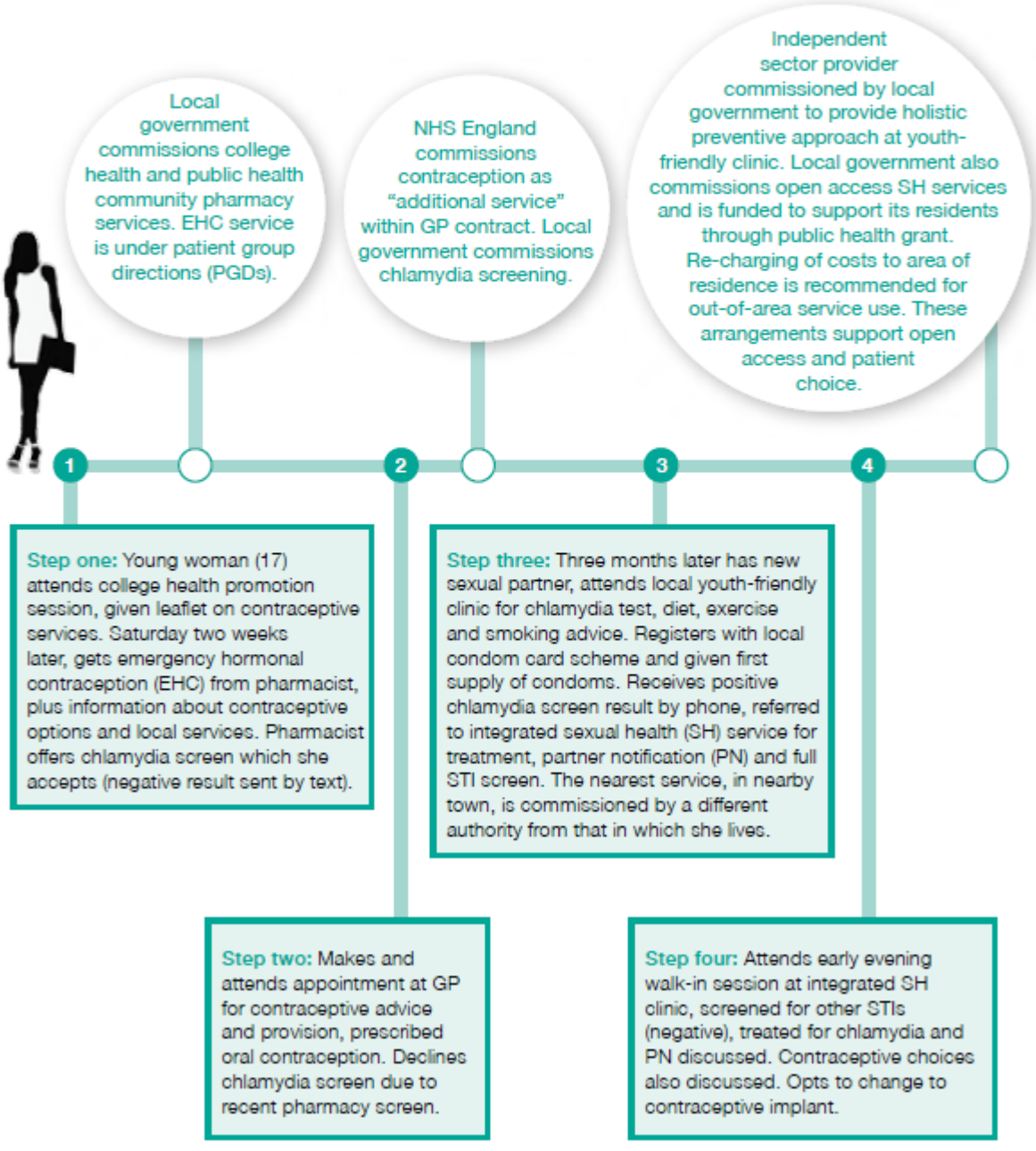
The Venn diagram illustrates the interface and co-dependency of commissioning sexual health, reproductive health and HIV services[x].



Appendix 2 Three people's sexual health journeys (DH 2014)

A young woman's journey

The first service user journey describes a young woman's use of open access sexual health services. It illustrates the need to provide information, advice and care that support her positive sexual health. To avoid unwanted pregnancy and treat an STI, she uses services commissioned by two local authorities and NHS England. Her story underlines the importance of open access and confidential, young person-friendly services.



A woman's journey

The third service user journey is that of an adult woman who has an unplanned pregnancy. The services she accesses are commissioned by a CCG and a local authority. She has wider health needs but these are poorly catered for as she is not able to access a range of other, disparate services. The opportunity to meet her needs in an integrated way is therefore lost.

Local government commissions open access integrated SH service.

CCG commissions abortion service.

Local authority and CCG should ensure service and contracting arrangements support an effective integrated pathway for service users.

1 2 3 4

Step one: Woman (37) attends integrated SH service for pregnancy test (positive result), has full STI screen including HIV test (all results negative), and receives advice on choice of contraception. After discussion, seeks referral to abortion service.

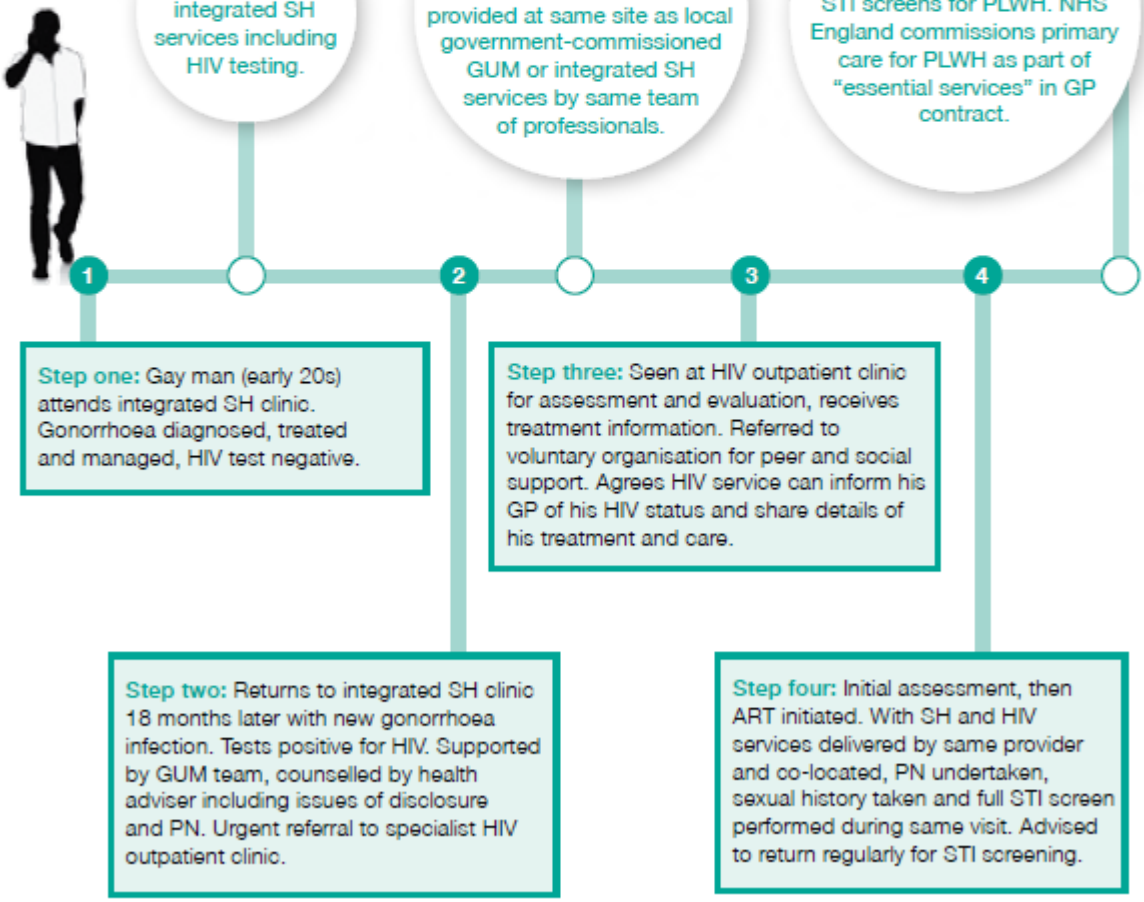
Step two: Attends abortion service, discussion with clinician identifies problems with alcohol use, opts for termination of pregnancy and given appointment.

Step three: Attends for day case abortion, requests condoms, sees counsellor within the service who encourages return to integrated SH service for further contraceptive advice. Also referred to women's alcohol advice service.

Step four: Does not return to SH service nor attend appointment at alcohol advice service. No mechanism exists for follow-up between different services and opportunities to support this woman are lost.

A gay man's journey

The second service user journey describes the sexual health needs of an HIV positive gay man. It underlines the importance of linkages and referral pathways between sexual health and HIV services. It also illustrates the wider needs of people living with HIV (PLWH) for treatment information and social support, which they may seek outside their local authority of residence to maintain confidentiality. Flexible funding mechanisms are required which match patterns of service usage.



Appendix 3 Summary of current contracts for Sexual Health Services

Local Authority Commissioned Services – Sexual Health	
Type of Service	**Provider**
CaSH Service	
South County Community CaSH Clinics	Nottingham University Hospitals
Central Nottinghamshire Community CaSH	Sherwood Forest Hospitals Foundation Trust
Bassetlaw CaSH Clinics	Doncaster and Bassetlaw Hospital
GU Med	
City Hospital	Nottingham University Hospitals
KMH and Newark Hospital	Sherwood Forest Hospitals Foundation Trust
Retford Primary care Centre and Reyton Street	Doncaster and Bassetlaw Hospital
CaSH in the city accessed by county residents	
Health Shop Sexual Health Service - accessed by county Service Users, positive engagement with people increased sexual health needs/risks	Nottinghamshire Healthcare Trust (NHT)
LARC - Long Acting Reversible Contraception	
Intra Uterine Contraceptive Devices	LCPHS – GPs and in CaSH
Contraceptive Implants	
Emergency Contraception	
Emergency Hormonal Contraception	Community Pharmacies and in CaSH
HIV Prevention and Testing	
Outreach advice and Point of Care Testing (POCT)	Terence Higgins Trust
Health Promotion and advice Young People	
SEXions – *only commissioned in Central Nottinghamshire	Sherwood Forest Hospitals Foundation Trust
C Card Scheme	Available at various locations across the county and in the city
Out of Area GUM and Out of Area CaSH	Nottinghamshire County residents can access services out of area and the respective provider invoices the relevant LA
Nottinghamshire County residents can access services when out of area and the respective provider invoices the relevant LA	Any CaSH or GUM provider within England
KEY: **CaSH** – Contraceptive and Sexual health Service **GU Med** – Genito-urinary Medicine (sometimes referred GUM) **GPs** – General Practitioners **LCPHS** –Locally Commissioned Public Health Services **C –Card Scheme** access to condoms for young people and signposting to CaSH and GUM	

Appendix 4 Benefits of investment in effective SH services (DH 2014)

Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) ✓=benefit for specified commissioner(s)
Objective: Continue to reduce the rate of under 16 and under 18 conceptions Commissioning intention: Ensure choice and timely access to young people-friendly reproductive health services and all methods of contraception	Control over fertility through increased use of contraception Greater ability to pursue educational and employment opportunities Improved self-esteem Improved economic status/reduction in family and child poverty	Fewer unwanted pregnancies Improved health outcomes for mothers and babies Better educational attainment Better employment and economic prospects	Improved infant mortality rates ✓CCGs Reduced A&E admissions/childhood accidents ✓CCGs Decrease in abortions ✓CCGs Reduced use of mental health services ✓CCGs Reduced use of social services ✓LAs Fewer young people not in education, employment or training ✓LAs Reduction in family and child poverty ✓LAs
Objective: Reduce rates of STIs among people of all ages Commissioning intention: Encourage uptake of chlamydia screening and testing for under 25 year olds	Treatment of STIs Reduced risk of other health consequences (eg pelvic inflammatory disease, tubal-factor infertility, ectopic pregnancy)	Reduction in prevalence and transmission of infection Opportunities to test for other STIs/HIV in those diagnosed with chlamydia Reaching young people with broader sexual health messages Increased uptake of condom use	Reduced use of gynaecology services (to manage other health consequences) ✓CCGs Increased uptake of sexual health services by young people ✓LAs Increase in chlamydia diagnoses enabling more treatment and consequent reduction in prevalence ✓Las
Objective: Reduce onward transmission of HIV and avoidable deaths from it Commissioning intention: Ensure access to high quality reproductive health se4rvices for all women of fertile age	Access to treatment Better treatment outcomes/prognosis Improved ability to protect partner from HIV	Fewer people acquiring HIV Greater contribution of people living with HIV to workforce and society Less illness and fewer avoidable deaths	Lower health and social care costs for HIV ✓NHS England, CCGs and LAs Lower healthcare costs for associated conditions and emergency admissions ✓CCGs Enhanced public

			health/prevention ✓Las
Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) ✓=benefit for specified commissioner(s)
Objective: Reduce unintended pregnancies among all women of fertile age Commissioning intention: Ensure access to high quality reproductive health services for all women of fertile age	Better control over fertility for women at all life stages, through access to choice of full range of contraceptive methods Optimisation of health for women prior to becoming pregnant Fewer abortions and repeat abortions for individual women Improved quality of family life	Fewer unwanted pregnancies Improved pregnancy outcomes Improved maternal health and reduced maternal mortality	Investment in contraception is cost effective in reducing pregnancies and abortions ✓CCGs Lower healthcare costs through reduced antenatal, maternity and neonatal costs due to better management of pregnancy and improved outcomes ✓CCGs Reduced social care costs for infant and child care ✓LAs

Appendix 5

Early emerging themes form the refresh of the Sexual Health JSNA
A summary of the population groups identified as most at risk of poor sexual health

Early emerging themes from the refresh of the SH JSNA

The highest rates of poor sexual health outcomes across the population are seen in Mansfield and Ashfield districts. Patterns in diagnosis rates for acute STIs broadly follow local deprivation patterns, with the highest rates of poor sexual health outcomes in areas of greatest deprivation. Exceptions to this trend are seen in Bassetlaw, where the second highest rate of new STI diagnosis is seen in the least deprived quintile of the population and in Rushcliffe where there is no clear association between deprivation and rate of new STI diagnosis.

A health equity audit will be needed to fully assess whether we are reaching vulnerable groups, and those in greatest need of sexual health services. An initial assessment of available evidence suggests that there is fairly equitable service provision, with regard to diagnoses rates and access by age group, gender, BME groups and deprivation level. However, this analysis is limited by current availability of appropriately segmented provider activity data for some services.

Despite a low coverage rate of the target chlamydia screening population (ages 15 to 24) in Nottinghamshire, some areas, notably Mansfield Ashfield and Gedling, have high positivity rates in those tested for chlamydia from this age group, and amongst the highest chlamydia diagnosis rates in the East Midlands. Concurrently, Nottinghamshire County has had a crude rate of admissions for pelvic inflammatory disease (PID) over the past 5 years which is significantly higher than the England average, and in 2013 is in the highest 15% of upper tier and unitary authorities. The rates in Ashfield and Mansfield districts are amongst the worst 5 districts in England. There are a number of possible explanations for this pattern, including that there may be a high level of undiagnosed STI infection (primarily chlamydia and gonorrhoea) in these areas leading to poor long term sexual health outcomes. Further investigation and research is needed to understand the reasons underlying this high rate of poor sexual health outcomes.

Whilst rates of diagnosis for gonorrhoea remain significantly below the England average in Nottinghamshire County, the rate of increase in diagnosed gonorrhoea infection is greater than for any other county or unitary authority in the East Midlands, with the exception of Nottingham City. This trend may be due to small numbers and random chance variation, or may reflect a change in testing patterns locally, to use more sensitive tests or introduce dual testing for chlamydia and gonorrhoea. Alternatively there may be a significant increase in gonorrhoea diagnosed in Nottinghamshire County. High rates of gonorrhoea and syphilis in a population reflect high levels of risky sexual behaviour. The reasons underlying the observed increase in Nottinghamshire County need to be explored.

Reinfection rates are higher in some districts than the England average. The highest rates of reinfection are seen in those aged 15 to 19 years. Reinfection is a marker of persistently risky behaviour and potentially of unmet need. Further investigation is needed to understand what may be driving higher rates of reinfection and how behaviour change can be encouraged via sexual health services and health promotion routes.

More than 50% of HIV diagnoses in Nottinghamshire were classed as late diagnosis in 2013. This should be taken in context of a very low prevalence of HIV in Nottinghamshire (0.64 per 1,000 among persons aged 15 to 59 years). Effective strategies for early diagnosis in a low prevalence population need to be considered.

Summary of the population groups identified as most at risk of poor sexual health

- Young people aged under 25 years (in particular those living in the most disadvantaged areas of Nottinghamshire and those who do not routinely access core health services). Specific groups of vulnerable young people include:
    - Those at risk of offending or who are excluded from school
    - Homeless young people
    - Teenage parents
    - Lesbian, gay, bisexual and transgender (LGBT) young people
    - Those not in education, employment or training (NEET)
    - Those with low educational achievement

    - Those with learning disabilities or mental health problems
    - Children in the care of the local authority
    - Young people at risk or involved with CSE
- BME young people
- Black and ethnic minority groups
- Refugees and asylum seekers and people for whom English is a second language
- Sex workers (male and female)
- Women experiencing domestic violence
- Lesbians
- Bisexual, gay men and men who have sex with men
- Transgender

References

[i] WHO Health Topics Sexual Health. Accessed on line on 24.10.2014 at: http://www.who.int/topics/sexual_health/en/

[ii] PHE Laser Summary Report (2012)

[iii] The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. Accessed on line on 24.10.2014 at: http://www.legislation.gov.uk/ukdsi/2012/9780111531679/contents

[iv] NICE (2011) Increasing the uptake of HIV testing among men who have sex with men. Accessed on line on 24.10.2014 at: http://www.nice.org.uk/guidance/ph34

[v] Nottinghamshire County JSNA (2014) Teenage Pregnancy Chapter (including health and wellbeing for young families) 2014

[vi] Development Economics (2013) Unprotected Nation. The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services. A report by Development Economics

[vii] McGuire & Hughes (1995) The economics of family planning services

[viii] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV

[ix] DH (2013) Commissioning Sexual Health Services and Interventions – Best practice guidance for Local Authorities

[x] PHE (2014) Making it work. A guide to whole system commissioning for sexual health, reproductive health and HIV

Nottinghamshire County Council

Report to Public Health Committee

26 November 2014

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

COMMUNITY INFECTION PREVENTION AND CONTROL SERVICE

Purpose of the Report

1. To set out the proposed approach to secure long term improvements in Community Infection Prevention and Control

2. To request the Committee's approval to secure the proposed service from Clinical Commissioning Groups in Nottinghamshire County, via a Section 75 agreement

3. To request that the Committee notes that funding for the new service will include some non-recurrent transition monies designated to address issues relating to the transition of public health to the local authority

Information and Advice

Community Infection Prevention and Control (CIPC)

4. The objective of the CIPC service is to prevent and control healthcare associated infections (HCAIs) amongst people receiving health or social care in community settings. These settings include: nursing homes, residential homes, general practices and dental practices.

5. Examples of HCAIs include organisms such as Clostridium Difficile ("C Diff"), Meticillin-resistant Staphylococcus Aureus (MRSA)and Escherichia coli ("E Coli"). These and other organisms are responsible for infections of the gastrointestinal, respiratory or urinary tracts, surgical sites and the bloodstream.

6. The rationale for maintaining effective infection prevention and control arrangements is that these infections are a significant cause of disease and death. Evidence indicates that much of this is avoidable. CIPC reduces this burden of premature death and disease, and averts the cost of hospital admission and social care.

7. As part of the Health and Social Care Act, responsibility for CIPC transferred from the former Primary Care Trust to the local authority on 1st April 2013.

8. The current service comprises 2.4 full time equivalents (FTE) who are infection control matrons. The salary costs associated with these are £120,445 p.a, of which £81,500 covers the two permanent members of staff (1.6 FTE), and £38,945 covers the cost of a secondee (0.8 FTE). These specialised public health colleagues undertake proactive work (e.g. programme of audits targeted according to risk; local surveillance) and reactive work

(specialist advice and support for the management of outbreaks; root cause analyses; ad hoc audit in response to notifications about concerns from commissioners; investigation and follow-up following serious incidents; advice and guidance in response to queries from providers).

9. The infection control arrangements of providers such as hospitals, mental health trusts and other providers of care in community settings (e.g. County Health Partnerships) remains the responsibility of those providers and therefore falls outside the scope of this paper.

10. The public health significance of HCAI is underlined by the reduction in rates of infection across community and secondary care settings which Clinical Commissioning Groups (CCGs) are required to achieve. These national targets relate to gastrointestinal infection with C Diff and infections of the blood by MRSA. Important as these two organisms are, the proper focus of infection prevention and control work also addresses a range of other organisms associated with infection in health and social care settings.

Needs assessment

11. An assessment of need relating to HCAI in community settings has been completed, a summary of which will be incorporated in the Joint Strategic Needs Assessment. In summary, the pattern of need in Nottinghamshire reflects the national 'picture' with higher rates of recorded HCAI amongst the oldest and youngest in the population. Across Nottinghamshire County there is some evidence of higher levels of need in Mansfield and Ashfield. The assessment found evidence of unmet need especially in residential homes. The summary of recommendations from the needs assessment is listed in Appendix A.

12. Based on these recommendations from the needs assessment, the Council has worked with stakeholders to identify what is required in a well-functioning community infection prevention and control system. The conclusion of this is that there is a significant gap between the capacity of the service which the Council inherited from the former Primary Care Trust and what is required to address need at a reasonable level. This gap in required capacity is costed in the region of £200,000 p.a.

13. A comparison with provision in Nottingham City provides context for assessing the 'reasonableness' of this estimate: an increase of £200,000 p.a. in the funding of the service in Nottinghamshire County would provide for a service of similar intensity (after taking into account County's larger population) as that in place in Nottingham City.

14. The benefits of a service funded at this increased level are important in terms of providing adequate protection in the near term and for enabling change over the longer term. Nevertheless, it is unlikely to be affordable from within the Public Health Grant.

Proposal for the future CIPC service from 2015/16 - 2017/18

Outline of proposal

15. Subject to the Committee's approval, relevant consultation and the conclusion of discussions with the CCGs, the proposed solution for Nottinghamshire County (excluding Bassetlaw) will comprise:

- a service specification (currently in draft) that addresses the needs of the population relating to CIPC, and provides support to independent contractors and local providers to significantly improve their internal capacity to manage risks associated with infection prevention and control
- a Section 75 agreement with Mansfield and Ashfield CCG who will manage the delivery of the specified service across Nottinghamshire over a three year period starting April 2015
- the overall funding envelope for this service (and for the much smaller additional service needed in Bassetlaw – see below) which will comprise approximately £200,000 p.a. of non-recurrent monies provided by the former Primary Care Trust to address transition issues and £81,500 p.a. which represents the current costs of the existing permanent members of staff delivering the service
- a transfer to Mansfield and Ashfield CCG of the current two permanent members of staff under TUPE and employment by the CCG of additional resource to deliver the specified outputs and outcomes
- a small contribution in kind from Mansfield and Ashfield CCG to cover non-salary costs associated with accommodation, IT, etc.
- a clear understanding that at the end of the three year period the non-recurrent funding will finish and that, due to pressures on the Public Health Grant, the Council is unlikely to be in a position to maintain the current level of recurrent funding

16. This is the proposed arrangement for the whole of Nottinghamshire County, with the exception of Bassetlaw, where the CCG has invested in its own infection control capacity. Bassetlaw CCG confirmed last year that their investment in in-house infection control resource is a permanent arrangement reflecting their local priorities, which would be maintained irrespective of the configuration of CIPC arrangements elsewhere in Nottinghamshire. Compared to other areas of the County, this leaves a small residual need in Bassetlaw which relates to the provision of a service to residential homes and adequate cover to manage outbreaks.

17. To meet this lower level of residual need in Bassetlaw, it is proposed that the Council transacts a separate Section 75 agreement with Bassetlaw CCG to secure a small amount of additional capacity to meet the need in that locality, which would be hosted by the CCG. The CCG has indicated that this would be satisfactory. As noted above, this arrangement would be funded from within the overall funding set out above.

Use of Section 75 Agreement

18. The proposal to secure this service through the CCGs using Section 75 agreements rather than through some other procurement approach is based on the following additional considerations:

- In some local authority areas, at the time of the Health and Social Care Act, CCGs retained a CIPC function. There are operational and some strategic grounds for favouring this arrangement.
- The strategic interest of the Council in regard to CIPC is most closely aligned with that of CCGs. Co-commissioning of primary care by CCGs will strengthen their interest in developing the capacity of their practices
- It is only commissioning organisations like CCGs who have the discretion to allocate *additional* resource to address CIPC, and who have the strategic interest in CIPC to prioritise

it. Other organisations such as providers are very constrained in the extent to which they are at liberty to divert resources away from the delivery of contracted services

19. Based on these considerations and their implications for what will deliver greatest value for money for residents, the Council's legal department has confirmed that this proposal represents a reasonable and lawful use of a Section 75 agreement.

Arrangements after 2017/18

20. To be explicit, it is assumed that after 2017/18, any ongoing funding contribution from the Council is likely to reduce significantly (no further non-recurrent transition monies would be available) and would have to be prioritised against other demands on the Public Health Grant. Consequently, any funding available for CIPC after 2017/18 is unlikely to cover the provision of CIPC beyond service settings which are directly commissioned by the local authority (e.g. residential homes). In this case, it is likely that any ongoing funding that is deemed to be required for other parts of the system (e.g.primary care or dental services) would need to be provided by other parties.

Other Options Considered

21. The options of maintaining an in-house service or of pursuing a competitive tender for this service were considered. The in-house option was deemed unfavourable due to the difficulties experienced in attracting specialised NHS nurses to work for the Council and the ongoing operational problems associated with accessing NHS information systems. Pursuing a competitive tender was deemed to pose an additional financial risk due to the uncertainty involved in the pricing of bids, the possibility that the outcome of the procurement would fail to exploit the alignment of our strategic interests with CCGs, and increase the risk of duplication and possibly fragmentation. It also overlooks the fact that in many areas the CCGs are seen as the natural home for most or all aspects of a CIPC service.

Reason for Recommendations

22. The proposed solution meets the needs of the population relating to community infection prevention and control for the next three years in a way that protects the Public Health Grant, during which a foundation can be developed for more sustainable arrangements in the period beyond.

Statutory and Policy Implications

23. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation will be undertaken and advice sought on these issues as required.

Financial Implications

24. The £200,000 per annum will be funded from the Public Health Transition reserve and the remaining £81,500 per annum will be funded from the Public Health Grant for the three year contract.

Human Resources Implications

25. The two permanent members of staff would be transferred under TUPE.

Implications for Service Users

26. The proposal represents a significant increase in funding which will increase capacity and protection.

RECOMMENDATIONS

1) To approve work to secure the proposed community infection prevention and control service from Clinical Commissioning Groups in Nottinghamshire County, via two Section 75 agreements

2) To note that funding for the new service will include some non-recurrent transition monies designated to address issues relating to the transition of public health to the local authority

Chris Kenny,
Director of Public Health

For any enquiries about this report please contact:
Jonathan Gribbin, Consultant in Public Health (jonathan.gribbin@nottscc.gov.uk)
Tracy Burton, Senior Public Health Manager (tracy.burton@nottscc.gov.uk)

Constitutional Comments (SG 30/10/14)

27. The proposals in this report fall within the remit of this Committee.

28. With regard to approval of departmental staffing structures, the Employment Procedure Rules provide that the report to Committee include the required advice and HR comments and that the recognised trade unions be consulted on all proposed changes to staffing structures (and any views given should be fully considered prior to a decision being made).

Financial Comments (KAS 04/11/14)

29. The financial implications are contained within paragraph 24 of the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

Electoral Divisions and Members Affected

- All

Appendix A – Summary of recommendations from the needs assessment

Strategic Recommendations

1. Agree and communicate clear leadership, roles, responsibilities and structure for an integrated Infection Prevention and Control function
2. CIPC services should be commissioned in line with current and future need, with greater provision made for Mansfield and Ashfield and Nottingham City
3. Commissioned capacity should plan for a widening of IPC focus beyond MRSA and CDI targets.
4. Review, via the IPC forum, NHS England Local Area Team and CCG prescribing leads, the implementation of prescribing guidelines on antibiotic prescribing.

Service Recommendations

5. Local Surveillance should be included within CIPC contract
6. Establish the level of need due to catheter associated UTIs in community and develop a work plan to address this.
7. Review education and training approaches to better reach new target audiences
8. A comprehensive IPC support package should be offered to all care providers, including care in the home, learning disabilities residential units and residential care homes
9. Embed risk assessment for infection control within the standard care processes of healthcare professionals in community settings.
10. Commission MRSA screening and decolonisation appropriate to the need of the local population

Nottinghamshire County Council

Report to the Public Health Committee

26 November 2014

Agenda Item: 6

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

NHS ENGLAND COMMISSIONING INTENTIONS FOR PRISON HEALTH

Purpose of the Report

1. This report provides an update on the NHS England commissioning intentions for substance misuse and healthcare services in Nottinghamshire prisons.

Information and Advice

2. The commissioning of prison healthcare services is the responsibility of NHS England. During 2014/15, the responsibility for prison substance misuse services in HMP Ranby and HMP Whatton was delegated to Nottinghamshire County Council. Public Health received funding from NHS England to cover the cost of the contracts and the management of them.

3. From 2015/16, NHS England intends to integrate the substance misuse prison contracts into the overarching healthcare prison contracts. For HMP Ranby and HMP Whatton Nottinghamshire Healthcare NHS Trust provide both the substance misuse and healthcare prison services.

4. NHS England have requested that the contracts are novated back to NHS England as of 31st March 2015 to enable this work to begin.

5. Letters have been sent to providers informing them of NHS England's 2015/16 commissioning intentions.

6. Alongside the current monthly highlight reports, Nottinghamshire County Council Public Health will provide a report to NHS England prior to novation summarising work done and any recommendations for the future.

7. As a result of this change, the funding currently received from NHS England for the contracts and their management will cease as of 31st March 2015. The Public Health Contract Management post is a fixed term post and is also due to end on 31st March 2015.

Other Options Considered

8. Nottinghamshire County Council Public Health to continue to manage the contracts but this would not align with NHS England's commissioning intentions.

Reason for Recommendation

9. Novation of the contracts will align with NHS England's commissioning intentions to integrate prison substance misuse contracts with the wider prison healthcare contracts.

Statutory and Policy Implications

10. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Crime and Disorder Implications

11. Substance misuse is a significant issue for prisoners and the prison estate. Substance misuse services within prisons aim to address substance misuse issues and support individuals to recover and achieve abstinence.

Financial Implications

12. Please see paragraph 7.

RECOMMENDATION

1. That the Committee note the update and the rationale for the change in arrangements.

Barbara Brady – Consultant in Public Health

For any enquiries about this report please contact: barbara.brady@nottscc.gov.uk

Constitutional Comments (LMC 03/11/14)

13. The report is for noting only

Financial Comments (KAS 03/11/14)

14. The financial implications are contained within paragraphs 7 and 12 of the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Electoral Divisions and Members Affected

- All

Nottinghamshire County Council

Report to Public Health Committee

26 November 2014

Agenda Item: 7

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme for 2015.

Information and Advice

2. The County Council requires each committee or sub-committee to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the committee's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and committee meeting. Any member of the committee is able to suggest items for possible inclusion.

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chair, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

4. As part of the transparency introduced by the revised committee arrangements in 2012, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the committee will wish to commission periodic reports on such decisions. The committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme.

Other Options Considered

5. None.

Reason/s for Recommendation/s

6. To assist the committee in preparing its work programme.

Statutory and Policy Implications

7. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the committee's work programme be noted, and consideration be given to any changes which the committee wishes to make.

Jayne Francis-Ward
Corporate Director, Policy, Planning and Corporate Services

For any enquiries about this report please contact: Paul Davies, x 73299

Constitutional Comments (HD)

1. The Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (PS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Meeting Dates	PH Committee	Lead Officer	Supporting Officer
Extra meeting **2pm Thursday, 11 December 2014**	Consideration of the tender / procurement process for obesity prevention and weight management. Tobacco Control Procurement	Barbara Brady John Tomlinson	Anne Pridgeon Lindsay Price
21 January 2015	Presentation on Public Health policy area – Health Protection *School nursing review – TBC* Report on Realignment of Public Health grant 2014-15 *Progress report on Public Health Business Plan - TBC* *Dental Public Health & Fluoridation - TBC* Public Health Services Performance and Quality Report for Health Contracts – July - September 2014	Jonathan Gribbin Kate Allen Cathy Quinn Cathy Quinn Kate Allen Cathy Quinn	 Irene Kakoulis Kay Massingham Kay Massingham Nathalie Birkett
12 March 2015	Presentation on Public Health policy area – Obesity Obesity performance report Follow on report on Sexual Health Public Health Procurement Plan 2015-16 Domestic Abuse update Public Health Services Performance and Quality Report for Health Contracts - October – December 2014	Barbara Brady Barbara Brady Jonathan Gribbin Chris Kenny Barbara Brady Cathy Quinn	Anne Pridgeon Anne Pridgeon Sally Handley Cathy Quinn Nick Romilly Nathalie Birkett

12 May 2015	Presentation on Public Health policy area – Substance Misuse Substance Misuse performance report Winter warmth report Public Health Business Plan 2015-16 (Inc procurement intentions) Report on Realignment of Public Health grant 2014-15	Barbara Brady Barbara Brady Mary Corcoran Cathy Quinn Cathy Quinn	Lindsay Price Lindsay Price
2 July 2015	Presentation on Public Health policy area – General Prevention Progress report on Public Health Business Plan / Health & Wellbeing Strategy Tobacco Control performance report Public Health Services Performance and Quality Report for Health Contracts - Jan-Mar 2015	Mary Corcoran Cathy Quinn John Tomlinson Cathy Quinn	Gill Oliver