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

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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