Nottinghamshire County Council

Public Health Sub-Committee

Tuesday, 16 April 2013 at 14:30

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:-

Customer Services Centre 0300 500 80 80

(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 SUB-COMMITTEE
Date	11 February 2013 (commencing at 2.00 pm)

Membership
Persons absent are marked with `A'

COUNCILLORS

Martin Suthers OBE (Chairman)
Joyce Bosnjak
Steve Carroll
Ged Clarke
John Doddy
June Stendall
Stuart Wallace
Liz Yates
Vacancy (Liberal/Democrat)

A Ex-officio (non-voting): Councillor Mrs Kay Cutts

OTHER COUNCILLORS IN ATTENDANCE

Councillor Keith Longdon
Councillor Mel Shepherd

OFFICERS IN ATTENDANCE

Paul Davies, Democratic Services Officer
Dr Chris Kenny, Director of Public Health
Tristan Poole, Public Health Manager
Cathy Quinn, Associate Director of Public Health
Anna Vincent, Independent Group Administration/Research Officer

CHAIRMAN

The appointment by the County Council of Councillor Martin Suthers as Chairman was noted.

ELECTION OF VICE-CHAIRMAN

Councillor Liz Yates was elected Vice-Chairman of the Sub-Committee.

DECLARATIONS OF INTEREST

There were no declarations of interest.

MEMBERSHIP AND TERMS OF REFERENCE

RESOLVED: 2013/001

That the report be noted.

INTRODUCTION TO PUBLIC HEALTH

Dr Chris Kenny gave a presentation about Public Health, its priorities and its relationships with other health and public services. He responded to members' questions and comments.

RESOLVED: 2013/002

That the presentation be received.

PUBLIC HEALTH GRANT AND BUDGET PLANNING

RESOLVED: 2013/003

(1) That the information on the Public Health Grant for Nottinghamshire be noted, including the allocation, purpose and reporting arrangements;

(2) That approval be given, with effect from 1 April 2013, to the Outline Financial Plan, and the creation of an innovation/development fund;

(3) That a further report on Public Health proposals be presented to a future meeting.

PUBLIC HEALTH TRANSITION

RESOLVED: 2013/004

That the progress being made on the transition of Public Health from the NHS to the County Council be noted.

PUBLIC HEALTH LEGACY DOCUMENT

RESOLVED: 2013/005

That the Public Health Legacy Document be endorsed, with effect from 1 April 2013.

COMMUNITY BASED SUBSTANCE MISUSE TREATMENT AND RECOVERY SERVICES

RESOLVED: 2013/006

That the proposals in the report be approved.

The meeting closed at 3.10 pm.

CHAIRMAN

Nottinghamshire County Council

Report to the Public Health Subcommittee

16 April 2013

Agenda Item: 4

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH SERVICE DEVELOPMENTS REPORT

Purpose of the Report

1. To provide the Public Health Sub-Committee with an outline of the proposed Public Health Service Developments totalling £2.71m for approval.

Information and Advice

Public Health Finance Plan

2. The Public Health 2013/14 Finance Plan was presented to and approved by the Public Health Subcommittee on the 11th February 2013. Table 1 summarises the plan and shows how the Public Health Grant of £35.1m will be utilised.

Table 1

	£
Pre-commitments (inc Staff costs and Directorate expenses)	29.9
Estimated Local Authority Overheads	0.4
Income from Police and Crime Commissioner	(0.6)
Prescribing Costs relating to Primary Care Services	0.9
PH Directorate proposals	2.8
Innovation/Development fund	1.2
Earmarked Reserves for recurrent items (premises, service growth)	0.5
Total £	**35.1**

Public Health Development Proposals

3. This report provides further information on the Public Health service developments totalling £2.71m, which are evidence based and have been requested by Public Health Policy leads to address local need.

4. Table 2 below provides an outline of developments by policy areas along with supporting rationale and anticipated outcomes. Further detail around each policy proposal can be found in **Annex 1**.

1. Sexual Health Services - £507k

- To introduce an initiative to prevent HIV and achieve earlier diagnosis
- Extending the Sexions model for sexual health promotion to include the southern boroughs to achieve county wide coverage
- To introduce a viral messaging service to increase the uptake of sexual health services by key target groups
- To fund Chlamydia testing and treatment element of CASH clinics across the county

Rationale:	Outcomes:
• Sexually transmitted infections (STI's) and unintended pregnancy are preventable • Many STI's have long term effects on health • There has been an increase in risky sexual behaviour, with continued ignorance about the possible consequences • There is a clear relationship between sexual health and health • Interventions which promote good sexual health are cost effective	• Reduction in teenage pregnancies • Increased uptake of sexual health services by target population groups • Reduction in STI's and re-infections • Increased awareness about prevention of HIV and an increase in uptake at point of care testing

2. NHS Health Checks - £459k

- Multifaceted approach to underpin the current GP based model to provide a targeted population-based and opportunistic schemes to achieve coverage of age groups not currently engaged and target hard to reach at risk of poorer health outcomes
- Public Health 'lifestyle intervention basket' to enhance and enable the delivery of the mandatory Health Check scheme to include Alcohol identification and brief advice, Obesity pathway and Smoking Cessation services
- Social media and Behaviour change for social marketing and communication

Rationale:	Outcomes:
• Commissioning a single provider model with GP practices will not achieve mandatory targets • This approach will reduce the risk of widening health inequalities • Will alleviate capacity issues associated with increased uptake	• Delivery of a primary prevention programme that encompasses public health intervention basket schemes to improve the health and wellbeing of the local population and reduce inequalities

3. Obesity, Nutrition and Exercise - £540k

- To commission countywide Tier 2 and Tier 3 Community Weight Management services for adults (including pregnant women) and children across Nottinghamshire

Rationale:	Outcomes:
• Current provision of Tier 2 services is inequitable and there is no Tier 3 service across the county • If we do not provide weight management services the number of individuals that become obese and morbidly obese requiring weight loss	• Equitable provision of county wide community weight management services for overweight and obese adults and children to access support on weight, diet and physical activity • Reduction in excess weight in adults and children

drugs and surgery is likely to increase • There is an increasing amount of evidence of the need to tackle obesity before, during and after pregnancy to improve the outcome for both mother and child	• Improved outcomes for both mother and child in pregnancy • Reduction in the numbers requiring weight loss drugs and surgery
4. Tobacco Control - £767k	
• To commission a Go Smoke Free service to raise awareness of the harm caused by second hand smoke, focussing on the impact of tobacco smoke in the home and on children's health • Commission a tobacco control specific education programme for young people about the dangers of smoking and equip them with the skills challenge perceptions around cigarette smoking • Work with colleagues across public health to commission lifestyle programmes e.g. peer support for young people/social norms campaigns • Maintain the current quitter rates previously commissioned on a non-recurrent basis	
Rationale:	**Outcomes:**
• Currently only £5k of the budget is spent on prevention and reducing the number of young people who start to smoke • Build on smoke free legislation and extend smoke free areas across Nottinghamshire • To invest with partners in the regional collaborative to tackle illegal and illicit tobacco across the whole county	• Reduce the demand and supply of tobacco in Nottinghamshire and tackle the harm caused by smoking • Reduce health inequalities and associated wider determinants of health in the longer term
5. Workplace Health - £227k	
• For Nottinghamshire County to become an exemplary role model for health and wellbeing • To establish a workplace health and wellbeing award scheme • To establish partnership initiatives to assist people back into the workplace after periods of ill health	
Rationale:	**Outcomes:**
• An opportunity for an integrated approach to improving workplace health and wellbeing • Evidence suggests the better people feel at work the greater their contribution, the higher their personal performance and the performance of their organisation	• Improved health outcomes for staff • Improvements in performance, lower sickness absence, staff turnover, presenteeism and HR/Manager time on conflicts, disputes, tribunals etc.. • Improved involvement, innovation, energy, motivation, engagement, commitment and trust leading to greater financial efficiency, improved reputation and resilience
6. Public Mental Health - £38k	
• Suicide Prevention Training to raise awareness and provide skills to primary care and other professionals to identify individuals at risk of suicide (£35k) • Books on prescription to build, strengthen and improve the existing scheme by replacing, purchasing new books and marketing the service (£3k)	

Rationale:	Outcomes:
• No mental health awareness/suicide prevention training taking place to identify 'at risk' individuals • Evidence based cost effective intervention recommended through both national suicide and mental health strategies • To provide this self help scheme and ensure that Nottinghamshire supports the new national books on prescription scheme being introduced in 2013 • NICE intervention to help individuals with common mental health problems such as anxiety and depression	• Professionals are aware of where to signpost individuals when there is a concern • Reduce the number of suicides in Nottinghamshire • To enable people to access self help to understand and manage their wellbeing • Through self help reduce the demand on other mental health services
7. Community Safety, violence prevention and response - £153k	
• Implementation of a domestic violence training, support and referral approach consistently across general practice	
Rationale:	**Outcomes:**
• Domestic violence has been identified as a priority for action for the Safer Nottinghamshire Board, the Nottinghamshire Health & Wellbeing Strategy and for the recently elected Police and Crime Commissioner • 1:4 women in their lifetime and 1:10 women a year are victims of domestic violence. Survivors of domestic abuse experience chronic health problems	• General Practice can play an instrumental role in responding to and preventing further domestic violence. Implementing this approach will lead to increased case findings, improved support available sooner, reduction in people accessing emergency care, reduction in safeguarding issues and improvement in the quality of care for patients
8. Other Public Health Developments - £19k	
• Falls Awareness (£5k) • Dementia Awareness (£5k) • Loneliness (£5k) • Health Protection, incidents and emergencies (£3k) • Infection prevention and control services (£1k)	
Rationale:	**Outcomes:**
• To support a range of different public health related issues e.g. raising awareness of falls and dementia, enhancing the quality of life for people with long term conditions and/or care and support needs • To create a small non pay budget to support the Infection prevention and control services and Health Protection policy areas	• To develop plans identifying the most effective initiatives to support and tackle these issues

5. It was recommended in the last report that a Public Health Innovation/Risk Reserve is created with the remaining Public Health Grant balance of £1.2m. The first call on this budget should be any additional funding required from the finalisation of NHS Contract envelopes. Further proposals against this fund will be prioritised in line with the Health & Wellbeing Strategy, the Business Plan and the Public Health Outcomes Framework. A further report will be presented to the Public Health Subcommittee for approval of any proposed plans and any changes to plan shown in Table 1.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service 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

The Public Health Sub-Committee are asked to:

1) Consider and approve each of the Public Health service developments outlined in Table 2 of this report.

2) Receive a further update on the Innovation fund/Risk Reserve and the Summary Finance Plan following agreement of final NHS contracts for 2013/14.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health

Constitutional Comments (NAB 28.03.13)

7. Public Health Sub-Committee has authority to approve the recommendation set out in this report by virtue of its terms of reference.

Financial Comments (ZM 28.03.13)

8. The financial implications are set out in paragraphs 1 to 5 of this report.

Background Papers

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 Division(s) and Member(s) Affected

All

Annex One: Public Health Service Development Proposals April 2013

Area	**Sexual Health Services**
Proposal	An investment of **£507,000** to address gaps in services to meet the sexual health needs of people within Nottinghamshire, comprising of: • HIV prevention and diagnosis £90,000 • Extension of Sexions (young peoples sexual health promotion)programme to southern Boroughs £90, 000 • Sexual health promotion, viral messaging programme for key target groups £10,000 • Folk house young persons sexual health and contraceptive services clinic £38, 000 • Increasing access to LARC £23, 000 • Chlamydia Screening and prevention programme £250,000 • C card condom scheme £6, 000 Summary of Proposed programme commissioning model: Contracts are currently being reviewed to determine if a different model is required to best meet the Sexual health needs of the population. For 2013/14 it is proposed the current model continues, although activity within the GUM services are rising which may require a speedier change. There is also national debate on the use of cross charging/ and open access services which may require a different approach. The East Midlands are also currently road testing the London Sexual Health Tariffs, which will give an indication of costs against activity under this costing model. A Comprehensive Health needs assessment may result in a different approach to the commissioning of Sexual Health services to include Children and Young people specific services. Commissioning of opportunistic Chlamydia will need to be delivered from Colleges/ FE colleges and robustly within Core Clinical Provision. NB: there is no proposed change to the commissioning Model for HIV- (THT).
Rationale	**Why is Sexual health a priority?** 1. *Many Sexually Transmitted Infections (STIs) have long-term effects on health.* • Some genital wart infections and Chlamydia are associated with cervical cancer. • Untreated, Chlamydia can result in pelvic inflammatory disease, leading to ectopic pregnancy and infertility. • Teenage pregnancy can affect long-term health and social outcomes of both parents and children. • Genital warts are caused by the Human Papilloma Virus (HPV) and these do not usually have any long term effects on health. However other strains of HPV which are also sexually transmitted are associated with cervical cancer. • The natural progression of the Human Immunodeficiency Virus (HIV) is to develop profound immunosuppression, which can lead on to the Acquired Immunodeficiency Syndrome (AIDS), which can lead to death. • Syphilis can mimic a range of conditions and the long term

	consequences, which may occur many years later, can affect the cardiovascular and neurological systems. Untreated it can lead to serious complications or even death. In pregnancy it can lead to miscarriage or stillbirth and can be passed on to the baby. • Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection and has risen by 232% from 1995-2004. • HIV new diagnoses among men who have sex with men remains high in 2008,and four out of every five probably acquired their infection abroad. • In 2008, there were 7,298 new diagnoses of HIV in England, double the 3,646 diagnosis in 2000. • New HIV diagnoses among those who acquired their infection heterosexually within the UK has risen, from an estimated 740 in 2004 to 1,130 in 2008. • Uptake of HIV testing in antenatal and genito-urinary medicine clinics continued to improve in 2008, reaching 95% and 93% respectively. • Preventing the 3,550 HIV infections that were probably acquired in the UK, and subsequently diagnosed in 2008, would have reduced future HIV-related costs by more than £1 billion. 2. *There has been an increase in risky sexual behaviour, with continued ignorance about the possible consequences***.** • The average (median) age which people start having sex is now 16; forty years ago it was 21 for women and 21 for men. • Between a third and a half of teenagers do not use contraception at first intercourse. • Nationally approx 40,000 under age 18 conceptions occurred in 2007. Across Nottinghamshire there were 524 for the same period. • Half of all under 18 conceptions occur in the 20% most deprived wards. • Babies of teenage mothers have a 60% higher risk of dying in the first year of life and have a significantly increased risk of living in poverty, achieving less at school and being unemployed in later life. • The 2000 National Survey of Sexual Attitudes and Lifestyles (NATSAL) identified that the East Midlands had the highest percentage of women aged 16-29 that had had 2 or more partners in the last year and did not use a condom. *3. Health inequalities* The highest burden of sexually related ill-health is borne by women, gay men, teenagers, young adults, black and minority ethnic groups, and more deprived communities.
Financial Implications	Preventative services not only promote well-being but positively impact upon financial costs. **It is suggested that the prevention of unplanned pregnancy by the NHS contraception services saves the NHS over £2.5 billion a year**, and through activities such as Chlamydia screening there is the potential to dramatically reduce costs associated with preventable infertility and pelvic inflammatory disease. **For every £1 spent on contraceptive services, this saves the NHS £11.** The cost of teenage pregnancy to the NHS alone is estimated to be £63 million per annum. In October 2006 NICE guidelines on Long Acting

	Reversible Contraception (LARC) suggested that an 8% shift from oral contraceptive to LARC methods would result in a net saving to the NHS of over £102 million. Finance implications: Total Budget £ 6,553,500 (County & Bassetlaw) Due to the new indicator within the Public Health outcomes framework re late diagnosis of HIV, there will need to be more preventative work undertaken than is presently, this may be achieved by current services working differently or there may be a need for additional elements to be procured. The current work on Sexual Health tariffs and where this will lead nationally may also impact on the allocated finances.
Proposed Outcomes	**<u>There is a significant cost associated with not taking action to address local sexual health needs</u>** • Some genital wart infections and Chlamydia are associated with cervical cancer. • Untreated, Chlamydia can result in pelvic inflammatory disease, leading to ectopic pregnancy and infertility. • Teenage pregnancy can affect long-term health and social outcomes of both parents and children. • Genital warts are caused by the Human Papilloma Virus (HPV) and these do not usually have any long term effects on health. However other strains of HPV which are also sexually transmitted are associated with cervical cancer. • The natural progression of the Human Immunodeficiency Virus (HIV) is to develop profound immunosuppression, which can lead on to the Acquired Immunodeficiency Syndrome (AIDS), which can lead to death. • Syphilis can mimic a range of conditions and the long term consequences, which may occur many years later, can affect the cardiovascular and neurological systems. Untreated it can lead to serious complications or even death. In pregnancy it can lead to miscarriage or stillbirth and can be passed on to the baby. • Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection and has risen by 232%. • HIV new diagnoses among men who have sex with men remains high, and four out of every five probably acquired their infection abroad.. • New HIV diagnoses among those who acquired their infection heterosexually within the UK has risen, from an estimated 740 in 2004 to 1,130 in 2008. • Uptake of HIV testing in antenatal and genito-urinary medicine clinics continued to improve reaching 95% and 93% respectively. • Preventing the 3,550 HIV infections that were probably acquired in the UK, and subsequently diagnosed in 2008, would have reduced future HIV-related costs by more than £1 billion. • It is suggested that the prevention of unplanned pregnancy by the NHS contraception services saves the NHS over £2.5 billion a year, and through activities such as Chlamydia screening there is the potential to dramatically reduce costs associated with preventable infertility and pelvic inflammatory disease. For every £1 spent on contraceptive services, this saves the NHS £11. • The cost of teenage pregnancy to the NHS alone is estimated to be

	£63 million per annum. In October 2006 NICE guidelines on Long Acting Reversible Contraception (LARC) suggested that an 8% shift from oral contraceptive to LARC methods would result in a net saving to the NHS of over £102 million. • Rates of teenage pregnancy are higher among communities affected by deprivation and poverty and where educational attainment is lower. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next • Teenage mothers and their children are less likely to do as well as their peers and there is a 63% chance that their children will be living in poverty. • The health inequalities for teenage parents and their babies is also greater; rates of infant mortality are around 60% higher for babies born to mothers aged under 20. • Teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner, and are less likely to have any qualifications. • Despite Nottinghamshire's teenage conception rates being just below the national average, there are 'hot spot' wards across Nottinghamshire with teenage conception rates among the highest 20% in England. In total there are 26 'hotspot' Wards in Nottinghamshire (2009 national data, ONS).
Performance Indicators	Indicators are included in the Public health Outcomes Framework **Domain 2 Health Improvement – Under 18 conceptions** a reduction in teenage pregnancy rates, are stated as an indicator in domain 2 as actions to improve healthy lifestyles and assist in healthy choices. **Domain 3 Health Protection- Chlamydia Diagnosis (15-24years), People presenting with HIV at a late stage of diagnosis** Improving Chlamydia diagnosis is an indicator detailed in domain 3 as being an essential action to be taken to protect the public's health as is the reduction of those presenting at a late stage of HIV infection.

Area	**NHS Health Checks**
Proposal	An investment of **£459,000** to address gaps in service provision for NHS Health Checks within Nottinghamshire. The proposal includes a multifaceted approach to underpin the current GP based model to provide a targeted population-based and opportunistic schemes to achieve coverage of age groups not currently engaged and target hard to reach at risk of poorer health outcomes. This includes: 1. The creation of a Public Health 'lifestyle intervention basket' service agreement will enhance and enable the delivery of the mandatory Health Check scheme to include Alcohol identification and brief advice, Obesity pathway and Smoking Cessation services. 2. Social media and Behaviour change for social marketing and communication
Rationale	Under the 2012 Health and Social Care Act, local authorities now have a mandatory responsibility to have offered an NHS Health Check to everyone in the eligible population by the end of March 2015. The original 5-year budget plan was: Year 1 (2010-11) £ 997,471 Year 2 (2011-12) £1,436,130 Year 3 (2012-13) £1,486,459 Year 4 (2013-14) £1,056,990 Year 5 (2014-15) £1,056,990 Total 5 years £6,034,040 (NHS Nottinghamshire County Board Papers June 2011) We significantly slowed down the roll out of the programme during 2011-12 in order to contribute £0.5 million savings to the PCT's QIPP initiative, reducing the budget spend to £930,801. This was agreed on the basis that we assured the SHA and DH that we would accelerate the programme in subsequent years in order to catch up, with a corresponding shift of expenditure into years 3-5. This slow-down / speed-up has been difficult for practices to manage and this year's activity remains below target, however practices are now committed to the increased pace of delivery from April 2013 to March 2015, and this is evident in the considerable increase in activity from January 2013 to date (supported by a targeted health promotion campaign). The current proposal to augment the funding by £0.5 million is therefore the continuation of the agreed strategy to bring us back on track to deliver our mandate. The mandatory content of the NHS Health Check will now incorporate two additional elements: 1. Audit C - screening for potentially harmful levels of alcohol use, and consequent intervention as appropriate 2. Dementia - raising awareness, provision of advice and information This will increase the time required to undertake a Health Check by approximately 10-20 minutes per person, thereby further increasing the cost per unit of activity.
Financial Implications	Mandatory values based on an uptake rate of 85% using current GP model (100% for Bassetlaw). This will require a complimentary service to work on

	the hard to reach groups and the costings provided are based on a model carried out in Birmingham. A marketing campaign is also costed into this template and a risk reserve is requested for a period of 2 years based on an uptake rate of 95%. Recurrent funding: Mandatory £1,165,557, Non mandatory £65,490. Non recurrent funding required: Marketing Campaign £32k, Earmarked contingency for 2 years £122,626. Total funding for 13/14 required: £1,385,673. Modelling of costs and benefits to us was undertaken using the national modelling tools. By implementing this scheme it was predicted that the programme would detect: 1,082 high risk individuals 1,721 individuals with undiagnosed hypertension and other cardivascular disease The annual report data for years 1 and 2 shows that the programme actually found: 5,350 high risk individuals 1,536 individuals with undiagnosed hypertension and other cardivascular disease
Proposed Outcomes	This scheme will identify People aged 40-74 years old who are at high risk of, or already have undiagnosed cardiovascular disease and ensure they are offered appropriate advice and / or treatment and intervention.
Performance Indicators	A set of activity measures are used to keep track of the service as the outcomes from this service are broad reaching across many long term conditions. **Measures include:** Offers made, (number and proportion of eligible population) and Health Checks completed (number and proportion of the eligible population), number of high risk individuals identified, and number of cases of undiagnosed disease identified

Area	**Obesity, Nutrition and Exercise**
Proposal	An investment of **£540,000** to address gaps in services to manage the rising needs associated with obesity, nutrition and exercise. The proposal includes plan to commission countywide Tier 2 and Tier 3 Community Weight Management services for adults (including pregnant women) and children across Nottinghamshire The proposed obesity model, fully funded, will ensure that there is equitable service provision across the whole of Nottinghamshire for both adults and children. In order to do this, there is a need to: a. Serve notice on all current contracts b. Re-commission primary prevention services across County to secure more effective use of resources c. Commission an integrated weight management services for Tiers 2 &3 of the obesity pathway for both children and adults. Resources will need to be realigned to areas of highest need and additional funds are requested to meet the current gaps in service provision.
Rationale	Obesity is a major public health problem. Unhealthy diets combined with physical inactivity have contributed to an increase in obesity in England and almost a quarter of adults and almost a sixth of children under the age of 11 are obese (the Information Centre, 2009). It is predicted that by 2050, 60% of adult men, 50% of adult women and 25% of children may be obese (Foresight, 2007). Alongside this, being overweight has become usual, rather than unusual. Obesity threatens the health and wellbeing of individuals and will place a national financial burden in term of health and social care costs, on employers through lost productivity and on families because of the increasing burden on long-term chronic disability (Butland et al. 2007). It is responsible for an estimated 9,000 premature deaths per year in England (National Audit Office, 2001). There is a need to harmonise service across County as the Current service provision: - does not secure the most effective use of resources and is - inequitable across the county e.g. Tier 2 weight management services are currently only available in Bassetlaw • Current provision of Tier 2 services is inequitable and there is no Tier 3 service across the county. • If we do not provide weight management services, the numbers of individuals that become obese and morbidly obese requiring weight loss drugs and surgery is likely to increase. • There is an increasing amount of evidence of the need to tackle obesity before, during and after pregnancy to improve the outcome for both mother and child. The National Child Monitoring Programme is a mandatory function of LA from April 2013 with the cost and resource covered within the School Nursing Contract.
Financial Implications	It is estimated that obesity is responsible for 1%-3% of total health expenditure and health care expenditures for obese individuals are at least 25% higher than for those of a healthy weight and rapidly rise as excess weight increases.

	Investing in obesity will help to reduce the risk of many long term conditions such as with type 2 diabetes and heart disease therefore reducing health care costs within both primary and secondary care including GP consultations, prescription costs, hospital admissions and outpatient appointments. The financial consequences are not limited to direct costs to health and NHS but also impact on the wider economy through, working days lost, increased benefit payments and social care costs. The social care requirements for very obese people are costly and include housing adaptations and carer provision.
Proposed Outcomes	The burden of obesity is uneven across our communities, with certain groups being more at risk e.g. lower socio-economic and socially disadvantaged groups, particularly women. Data on the prevalence of obesity in different ethnic groups is limited because national surveys tend to sample only relatively small numbers from minority groups. However, according to The Health Survey for England (2007), obesity is currently greatest in the Caucasian and Bangladeshi populations (Butland, 2007). Other groups of people at risk includes people with physical disabilities (particularly in terms of mobility which makes exercise difficult), people with learning difficulties, people diagnosed with a severe and enduring mental illness, particularly schizophrenia or bipolar disease (Department of Health, 2006) and older people. The proposed outcomes from this investment are: • Short term: Equitable provision of county wide community weight management services for overweight and obese adults and children to access support on weight, diet and physical activity • Longer term: Reduction in excess weight in adults and children • Longer term: Improved outcomes for both mother and child in pregnancy. • Longer term: Reduction in the numbers of adults requiring weight loss drugs and surgery
Performance Indicators	Indicators are included in the Public health Outcomes Framework **Domain 1: Improving the wider determinants of health** • Utilisation of green space for exercise/health reasons. **Domain 2: Health Improvement** • Excess weight in 4-5 and 10-11 year olds • Excess weight in adults • Proportion of physically active and inactive adults • Diet

Area	**Tobacco Control**
Proposal	An investment of **£767,000** to address the gaps in services to meet the smoking related needs for people within Nottinghamshire. As part of a wider commissioning model, the main elements include: 1. Roll out Go Smoke-free across the county. An equivalent initiative in Lincolnshire, including staffing = £300k (can pump prime with £20k 12/13 non recurrent.) 2. Commission a tobacco specific education programme for young people to be delivered across the county. Eg Smokescreen/Assist/Operation Smokestorm. = £50-£100k 3. Work with partners to deliver an education and information campaign around illegal and illicit tobacco =£50 4. Work with colleagues across the Directorate to commission lifestyle programmes eg Peer support programmes for young people/Social norms campaigns=£50k **The following programme commissioning model is proposed:** **2013/2014** From 2013, the Public Outcomes Framework will measure smoking prevalence and will not have a mandatory smoking quitter target. Any targets will be locally set in line with local ambitions. From 2013 the overarching strategic intentions will be to increase the commissioning of prevention services and to target smoking cessation services at key groups of smokers. • Specialist Provider New Leaf This service will continue to be commissioned from Nottinghamshire Healthcare Trust for 2013/14. However, without an NHS led quitter target there is unlikely to be an increase in numbers commissioned and the specialist provider may be requested to deliver smaller numbers from hard to reach groups. This will need to be supported by Local Authority procurement. • GPs The proposal for 2013/14 is that this service is commissioned from GPs using an appropriate model. For 13/14 the numbers will remain static bit this will be pending review by the Strategic Tobacco Alliance Group. • Pharmacies The proposal for 2013/14 is that this service is commissioned from Pharmacies using an appropriate model. For 13/14 the numbers will remain static bit this will be pending review by the Strategic Tobacco Alliance Group. • Voucher Scheme The proposal for 2013/14 is that this service is commissioned from Pharmacies using an appropriate model; however the proposal is to halve the number of weeks of support offered from 12 to 6 as there is

	no evidence to support this longer period of support.(I am unsure what commissioning variations this may require). This will be discussed at the STAG workshop in November. **2014/2015** The commissioning intentions for 2014/15 need to support the commissioning of services for prevention, working more closely with other lifestyle interventions to maximise effectiveness as well as smoking cessation services targeted at key groups of smokers. Various commissioning models, such as Any Qualified Provider, will need to be explored in order to deliver the maximum, cost effective impact upon smoking prevalence. The main elements of the commissioning model are to: • Commission a standardised countywide, community embedded secondhand smoke initiative called Steps to Go Smokefree • Commission and implement a consistent, evidence-based, smoking-specific programme in schools across Nottinghamshire. • Work with colleagues across public health to commission a lifestyle focused peer support programme for young people. • Maintain the current quitter rates previously commissioned on a non-recurrent basis • Use established partnerships to ensure public facing staff have the skills to raise the issue of tobacco use and signpost appropriately, expanding Brief Intervention training to all partners across Nottinghamshire This will aim to: • To raise awareness of the harm caused by secondhand smoke, focussing on the impact of tobacco smoke in the home and on children's health and build on smokefree legislation and extend smokefree areas across Nottinghamshire • To provide tobacco specific education about the dangers of smoking/tobacco use and equip them with the skills to challenge perceptions around smoking • To enable and support young people to promote positive health messages within their communities and prevent the uptake of smoking amongst children and young people. • To ensure all public facing staff have the skills and knowledge to raise issues around health at every opportunity and sign to appropriate services.
Rationale	There is clear evidence that effective tobacco control measures can reduce the demand and supply of tobacco in communities and tackle the harm caused by smoking. Reducing smoking rates will have an impact on: • number of low birth weight babies • number of pregnant women smoking at time of delivery • smoking prevalence rates in adults and children • infant mortality • all-cause preventable mortality • mortality from cardiovascular disease, cancer, respiratory

	disease There are three National Ambitions: • Reduce adult smoking prevalence in England to 18.5% or less by 2015. • Reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015. • Reduce rates of smoking during pregnancy to 11% by the end of 2015 These ambitions will be challenging and will require on-going work across the wider Tobacco agenda. The impact of work delivered across partner agencies will be crucial to this achievement. Programme Budget of £2.1m. See finance spread-sheet**.** • Currently only £5k of the budget is spent on prevention and reducing the number of young people who start to smoke. Whilst this needs to increase, in order to impact the prevalence rates current levels of stop smoking support need to be maintained.
Proposed Outcomes	Proposed outcomes from this development include: • Reduce the demand and supply of tobacco in Nottinghamshire and tackle the harm caused by smoking • Reduce health inequalities and associated wider determinants of health in the longer term • Reduce adult smoking prevalence in England to 18.5% or less by 2015. • Reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015. • Reduce rates of smoking during pregnancy to 11% by the end of 2015
Indicators	There are several indicators in the Public Health Outcomes Framework directly relating to Adult and childhood smoking. These are:- • Smoking status at time of delivery This information is currently based on the number of maternities, the number of mothers recorded as smoking at delivery, and the number of mothers recorded as not smoking at delivery and is collected by the acute hospitals. The robustness of this data is currently being investigated as part of a national project. • Smoking prevalence – aged 15 Years This information is currently recorded by a series of surveys of secondary school children in England which provides the national estimates of the proportion of young people aged 11 to 15 who smoke, drink alcohol or take illegal drugs. In 2011 by the age of 15, 11% of girls and boys were regular smokers. Nationally this information meets the government's 2011 ambition to reduce rates of regular smoking among 15 year olds from a baseline of 15% in 2009 to 12% or less by 2015. • Smoking prevalence – aged 18 years + (adults)

	Currently this information is captured through the integrated Household survey (IHS) at a locality level. The integrated Household Survey (IHS) is a new survey published by the Office for National Statistics (ONS). The survey comprises of a core set of approximately 100 questions from six current ONS household surveys and contains information from nearly 450,000 individual respondents. This is a yearly survey using experimental data. This is not in real time.

Area	**Workplace Health - £227k**
Proposal	An investment of **£227,000** to develop workplace health initiatives to support improvement sin health and wellbeing for people who live and work in Nottinghamshire. The proposal is in its early stages of development but aims to support Nottinghamshire County in becoming an exemplary role model for health and wellbeing. The proposal will include: • Establishment of a workplace health and wellbeing award scheme - £107,000 • Establishment of partnership initiatives to assist people back into the workplace after periods of ill health, address presenteeism and increase individual resilience £100, 000 • Establishing Notts County Council as an exemplary employer for heath and well being £20,000
Rationale	Workplace health initiatives provides an opportunity for an integrated approach to improving health and wellbeing for working age people. Evidence suggests the better people feel at work the greater their contribution, the higher their personal performance and the performance of their organisation.
Proposed Outcomes	Proposed outcomes include • Improved health outcomes for staff • Improvements in performance, lower sickness absence, staff turnover, presenteeism and HR/Manager time on conflicts, disputes, tribunals etc. • Improved involvement, innovation, energy, motivation, engagement, commitment and trust leading to greater financial efficiency, improved reputation and resilience
Performance Indicators	A set of activity measures will be developed and used to keep track of the service as the outcomes from this service are broad reaching across health and wellbeing.

Area	**Public Mental Health - £38k**
Proposal	An investment of **£38,000** to support the following: **Suicide Prevention Training – (£35,000)** to raise awareness and provide skills to primary care and other professionals to identify individuals at risk of suicide **Books on prescription** – **(£3,000)** to build, strengthen and improve the existing scheme by replacing, purchasing new books and marketing the service Books on Prescripiton is a self help reading scheme delivered in libraries. Reading material is available on the open shelves as a source of early intervention self help and as part of a prescribed treatment pathway by GP's, primary care staff and mental health practitioners. Funding is required for general maintenance of books, to purchase additional copies of the more popular titles and the black dog books.
Rationale	The Joint Strategic Needs Assessment (JSNA) identifies that mental ill health is widespread; at least one in four people will experience a mental health problem at some point in their life, and at any one point in time one in six of the adult population in England will be experiencing a mental health problem. Mental health problems have complex causes and effects, involving social and economic circumstances, and having a mental health problem also increases the risk of physical ill health. Mental health and emotional wellbeing is a priority in the Health and Wellbeing strategy. The Government's policy is ensuring that mental health has equal priority with physical health, and this needs to be reflected locally. Therefore additional funds are requested to support work on mental health promotion, mental illness prevention and suicide prevention. **Suicide Prevention Training** For men under 35, suicide is the most common cause of death and men are three times more likely than women to take their own lives. Overall, people aged 40-49 have the highest suicide rate. Nottinghamshire has a lower overall rate of death by suicide than the England average, but a higher rate of suicides in people over 75. Currently there is no mental health awareness /suicide prevention training taking place to support professionals and others to encourage early identification and intervention of 'as risk' individuals Evidence based cost effective intervention recommended through both the national suicide and mental health strategies The national strategy preventing suicide in England (2012) identifies suicide prevention training as an effective local intervention: "Appropriate training on suicide and self-harm should be available for staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems (p17)." The World Health Organisation recommends that providing training to GPs in

	early identification and intervention for those at risk of suicide is an effective strategy in suicide prevention. There is evidence that the provision of suicide awareness training in health settings is effective in raising awareness and providing healthcare professionals with the necessary skills to identify patients at risk of suicide. The cost-effectiveness of provision of suicide awareness training to GPs has been modelled based on the assumption that improvements in identification of those at risk leads to reductions in suicide. This has concluded that investment in GP suicide prevention training is cost effective from the first year of investment and that even with conservative assumptions made about the gains in life overall and in the quality of life, the cost per QALY (Quality Adjusted Life Year) saved is £1,573 over one year, rising to £2004 over 5 years . Based on the provision of suicide prevention training delivered locally in Nottinghamshire by RCAN (Big Lottery Funded which ended August 2010) £35,000 would commission a part time suicide prevention training programme which could be tailored to a target audience of primary care and other health professionals. If there is no funding available this will make it difficult for us to meet the PH outcomes relating to mental health and emotional wellbeing. **Books on Prescription** This is a NICE approved intervention to help individuals with common mental health problems such as depression and anxiety.
Financial Implications	Self-help support of common mental health problems will reduce the need for individuals to be referred to more costly interventions such as IAPT (psychological therapies). Suicide prevention training has been identified as cost effective from the first year of investment through gains in life overall and in quality of life. The cost saved is £1573 over 1 year to £2004 over 5 years
Proposed Outcomes	**Suicide Prevention** ***Short term:*** Professionals are aware of where to signpost individuals when there is concern for a person's mental health and wellbeing, therefore ensuring an effective use of services ***Longer term***: Reduce the numbers of suicides in Nottinghamshire **Books on Prescription** **Short term:** Provision of books to enable people to access self help to understand and manage their well-being. **Longer term**: Through self help reduce the demand on other mental health service
Indicators	Indicators are included in the Public health Outcomes Framework **Domain 1: Improving the wider determinants of health** • People with mental illness or disability in settled accommodation • Employment for those with a long term health condition including those with a learning difficulty/disability or mental illness

	• Social connectiveness **Domain 2: Health Improvement** • Self-reported wellbeing **Domain 4: Healthcare public health and preventing premature mortality** • Excess under 75 mortality in adults with serious mental illness • Suicide

Area	**Community Safety, violence prevention and response**
Proposal	£152,895 is required to address the impact domestic violence has on health. The proposals are in their early stages but include the implementation of a training, support and referral approach consistently across general practice.
Rationale	Domestic Violence has been identified as a priority for action both for the Safer Nottinghamshire Board (SNB), the Nottinghamshire Health & Wellbeing Strategy, and for the recently elected Police and Crime Commissioner. 1:4 women in their lifetime and 1:10 women a year are victims of domestic violence. Survivors of domestic abuse experience chronic health problems
Outcomes	General Practice can play an instrumental role in responding to and preventing further domestic violence. Implementing this approach will lead to: • Increased case findings • Improved support available sooner • Less people needing to use emergency care • Less safeguarding issues • Improved quality of care for patients • A reduced dependency on medication • Savings - through reduced prescribing costs • Improved health and wellbeing for our population
Indicators	A range of indicators will be developed through the safer Nottinghamshire Board to monitor success.

Area	**Other Public Health Developments**
Proposals	Falls Awareness - £5,000 Dementia Awareness - £5,000 Loneliness - £5,000 There is a public health role in awareness raising and education in respect of both falls and dementia that has not been identified as part of the PH grant. Detailed proposals for this will be developed via existing multi-agency fora: the 3 Falls groups in the county and the Dementia Strategic Initiative Group • Prevention and awareness for falls £5,000 • Prevention and awareness for dementia £5,000 Continued funding for schemes to maintain independence.
Rationale	Currently, a number of services are supported jointly with Notts CC and in some cases the district councils that were initiated with Linkage Plus monies from the DWP some years ago. Those services that evaluated well in respect of maintaining independence and value for money have been continued. These are: • Handy Persons Adaptation Scheme This scheme provides approved tradesmen to carry out minor adaptations e.g. stair rails etc to older peoples' houses. It complements the services provided to those in council maintained housing or the equivalent • Community Outreach Advisors COAs visit older people in their own home to provide support and care. There are proposals to integrate this aspect of the service into the future Notts CC Older People's Support Services, the tender for which has been delayed. • First Contact This service provides the resources to ensure that staff from all agencies visiting older or vulnerable people in their own homes carry out a short, standardised check at the first visit to identify the need for input from other agencies, which is then arranged. • Home from Hospital The services provides volunteer coordination and support for recently discharged and about to be discharged patients who need help with shopping, pet care etc which are outside the remit of the statutory agencies All the costs of the following programmes are within the CCG budgets, with no specified allocation for prevention and awareness campaigns: • Falls prevention • Dementia
Potential Outcomes	Awareness campaigns and schemes to promote independence will help support wider programmes related to these areas of work
Performance Indicators	Ageing Well initiatives contribute substantially to: • Public Health Outcomes Framework Indicators (see para 4 above) • NHS Outcomes Framework – especially: Domain 3: Helping people recover from episodes of ill-health or following injury (3a, 3b, 3.1, 3.4, 3.5, 3.6) • Adult Social Care Outcomes Framework – especially:

	Domain 2: Delaying and reducing the need for care and support (2a, b and c) Domain 1 social contentedness (placeholder) Domain 2 Proportion of physically active and inactive adults Self-reported well-being Falls and injuries in the over 65s Domain 4 emergency admissions within 30 days of hospital discharge (placeholder) Health-related quality of life for older people (placeholder) Hip fractures in over 65s Dementia and its impacts (placeholder)

Nottinghamshire County Council

Report to the Public Health Subcommittee

16 April 2013

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

NOTTINGHAMSHIRE COUNTY OVERWEIGHT/OBESITY PREVENTION AND WEIGHT MANAGEMENT SERVICES

Purpose of the Report

1. The purpose of this report is to provide a case for the decommissioning of the current overweight/obesity prevention and weight management services across Nottinghamshire County and put in place new arrangements no later than March 31st 2015.

Information and Advice

Definitions

2. In the context of this report, the terms overweight and obesity (excess weight) refers to when weight gain, in the form of fat, has reached a point which affects a person's health. Excess weight gain in adults is caused by an imbalance between 'energy in' and 'energy expenditure'. It is important to maintain weight in a healthy range (rather than having a weight that is too high or too low).

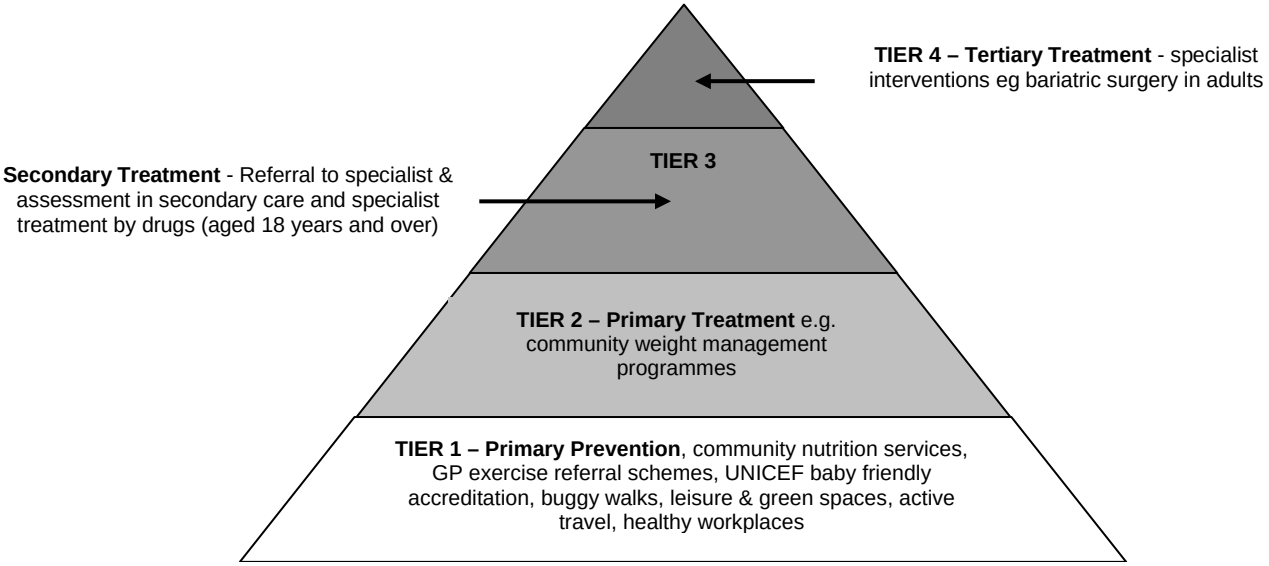
The Context

3. Excess weight threatens the health and wellbeing of individuals and has a financial burden in term of health and social care costs, on employers through lost productivity and on families because of the increasing burden on long-term chronic disability. It is responsible for an estimated 9,000 premature deaths per year in England.

4. Unhealthy diets combined with physical inactivity have contributed to an increase in excess weight in England and almost a quarter of adults and almost a sixth of children under the age of 11 are obese. It is predicted that by 2050, 60% of adult men, 50% of adult women and 25% of children may be obese. Alongside this, being overweight has become usual, rather than unusual.

5. The Nottinghamshire Health and Wellbeing Strategy has identified excess weight, this complex yet common condition, as a key priority. The complexity and interrelationships of the causes of excess weight require the need for a multi-dimensional approach to deal with it. The Nottinghamshire prevention and management of excess weight model consists of four tiers:

Nottinghamshire Prevention and Management of Excess Weight Model



- Tier 1 focuses on the prevention of excess weight for the wider population, with an emphasis on those who are more at risk e.g. lower socio-economic and socially disadvantaged groups, particularly women, people with physical disabilities, people with learning difficulties, people diagnosed with a severe and enduring mental illness and older people.
- Tier 2 focuses on the provision of community weight management services for those who are overweight or obese
- Tier 3 focuses on the provision of a specialist multidisciplinary weight management service for those with complex obesity. This tier includes the use of anti-obesity drugs which should only be considered in adults aged 18 years and over after dietary, exercise and behavioural approaches have been started and evaluated.
- Tier 4 focuses on the provision of weight loss (bariatric) surgery for adults defined as morbidly obese, when all other measures have failed. In the East Midlands, people must have a BMI of 50 kg/m² and above may be eligible for surgery. The NHS Commissioning Board will be responsible for the commissioning of bariatric surgery from April 2013.

6. From April 2013, Public Health in the Local Authority will become the responsible commissioner for obesity interventions, locally led nutrition and physical activity initiatives via funding from the Public Health ring-fenced Grant. Nottinghamshire currently invests approximately £960K in overweight/obesity prevention and management services through a large number of different contracts and providers. An additional £540K has been requested from the Public Health ring fenced Grant to meet the current gaps in service provision. Future spend for overweight/obesity prevention and weight management services will therefore be £1.5 million.

The Rationale

7. In October 2011 the Department of Health issued "Healthy Lives, Healthy People: a call to action on Obesity in England". This sets out the national strategy to tackling excess weight and sets new national ambitions:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020.

8. The new level of ambition involves adopting a 'life course' approach from pre-conception through to older age. There are specific opportunities and challenges at each stage of the life course and action is needed at all ages to avert the short and long-term consequences of excess weight and to ensure health inequalities are addressed. Action needs to encompass an appropriate balance of investment and effort between prevention, treatment and support.

9. The National Institute for Health and Clinical Excellence (NICE) has produced several guidance documents in relation to the reduction of obesity. This guidance is used to inform our local strategic approach and service provision.

10. Obesity prevention and management services in Nottinghamshire have historically been funded and commissioned through a variety of funding streams and managed by various commissioners using different performance frameworks. This has included the separate commissioning and management of obesity prevention and weight management services by NHS Bassetlaw. Developments have tended to consist of extensions or adjustments to existing contracts and across Nottinghamshire there has been no formal procurement exercise to test for value for money.

11. A new approach to the prevention and management of excess weight is required as:

- The current service provision does not meet the identified needs of the local population in which around a quarter of adults are estimated to be obese and one in five children in reception is overweight or obese and nearly one in three children in Year 6 is overweight or obese. Neither does it support the management of obesity during pregnancy. Maternal obesity increases childhood obesity and infant mortality as well as impacting on the mother's immediate (complications of pregnancy) and future health.
- There are parts of the overweight/obesity pathway in which there are gaps (for example there is no Tier 3 specialist weight management service) and some parts in which there is risk of duplication (Tier1).
- Resources are not currently aligned to those areas of highest need or to those groups most at risk of excess weight.
- Currently there is not an appropriate balance of investment and effort between prevention and treatment.
- There is inequity in current service provision across the county with Tier 2 community weight management services only being delivered in Bassetlaw.
- Overweight and obesity pathways and services are not currently integrated to ensure they deliver clinically effective outcomes whilst being cost efficient and providing value for money.
- Current commissioned interventions may not be compliant with NICE national guidance.

12. The short-comings of the current service provision (which consists of many different disconnected service providers across the county) affect both the equity of access and quality of service provision. The commissioning of an integrated overweight/obesity prevention and weight management service should overcome these issues, as well as being more cost efficient and providing value for money.

Expected Outcomes

13. By having new arrangements in place will ensure that future prevention and management of excess weight services are:

- Designed and focussed on improved outcomes for service users, their family members and carers as well as the wider community
- Equitable across the county
- Responsive to (changing) local needs
- Cost effective
- Fit for purpose
- Innovative by creating new models of delivery and ways of working
- Linked to the National Child Measurement Programme and Health Checks (both of which will be mandatory functions of the local authority from April 2013), providing evidence based obesity prevention and weight management interventions that individuals and families can be signposted to.
- Supportive of the outcomes specified in the Nottinghamshire Obesity Strategy currently being refreshed, and the Public Health Outcomes Framework
- Contributing to a reduction in excess weight in children and adults in Nottinghamshire.
- Reducing the need for access to higher tiers of the Nottinghamshire prevention and management of excess weight and therefore the need to use anti-obesity drugs and surgery.

Other Options Considered

14. **Maintain the status quo.** This option would not address the issues specified in section 11 nor secure the outcomes identified in section 13 above. In addition the Local Authority needs to meet its legal obligations in relation to procurement processes.

15. **Internally review services and make changes to the system via variation and/or extensions of current contracts**. This option may fail to disentangle the short comings that there are within the current system identified in section 12 above. Without a whole system redesign, it is unlikely to ensure value for money and cost efficiencies may not be maximised. The risk of inequity across the county would potentially remain. Utilising formal procurement options will increase transparency of process and decision making.

16. **Consider the provision of an overweight/obesity prevention and management service as part of the Health and Wellbeing Integrated Lifestyle Service proposal.** This option may ensure value for money, prevent duplication of work by building on 'making every contact count', may be more attractive to the potential provider market and will again utilise formal procurement options that will increase transparency of process and decision making. However it may mean that a service is not established as quickly as if it was undertaken as a separate project.

Statutory and Policy Implications

17. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such

implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications for Service Users

18. The local population of Nottinghamshire and those are increased risk of an excess weight will be able to access high quality obesity prevention and weight management services across the county.

Financial Implications

19. The remodelling and re-commissioning of service provision and ways of working will address issues of cost efficiency and value for money. Any expenditure related to the re-commissioning of services will be met within the £1.5m budget allocation.

RECOMMENDATION/S

20. That the Public Health Sub-Committee are asked to:

i. Approve the review of existing overweight/obesity prevention and weight management services across Nottinghamshire County with a view to decommissioning existing services and commissioning new services no later than March 31st 2015.

ii. Receive a follow up report in 6 months' time to outline progress made and on the commissioning of the proposed new services.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Anne Pridgeon (Public Health)

Constitutional Comments (NAB 28.03.13)

Public Health Sub-Committee has authority to approve the recommendation set out in this report by virtue of its terms of reference.

Financial Comments (ZM 28.03.13)

The financial implications of re-commissioning the service are outlined in paragraph 19 of this report.

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to the Public Health Subcommittee

16 April 2013

Agenda Item: 6

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

SUBSTANCE MISUSE REPORT

Purpose of the Report

1. To seek approval of the Public Health Sub-Committee to commit funding from the Substance Misuse Section 256 Funding, to three long term projects.

Information and Advice

2. As a result of the change in Governance and Funding arrangements, an underspend in the 2011/12 combined budgets for overall Substance Misuse was identified.

3. This amounted to £ 590,000. It was agreed at the Substance Misuse Strategy Board that this sum would be made subject of a Section 256 agreement, and ring fenced for new Substance Misuse projects of a prevention and education nature.

4. The broad principles of a Section 256 agreement are:
   - that the fund will effectively be "red circled" for spending purely on substance misuse education and prevention.
   - that it cannot be used for anything other than this purpose.
   - that spending will be on new projects and initiatives, and that it cannot be used for previously funded matters.
   - that there are no time scales by which the fund must be used.
   - that initiatives or projects must be non-recurrent funding commitments, and that no organisation will be exposed to a future financial commitment as a result of this funding.

5. Furthermore it is anticipated that there will be a further underspend from Substance Misuse services from 2012/13, which will be in the region of £600,000.

6. Again, the Substance Misuse Strategy Board have agree to add this underspend to that existing Section 256 fund.

7. The Substance Misuse Strategy Board have debated and agreed to support three long term projects:
   - Intensive Youth Support to Prevent Substance Misuse in Manton.
   - Intensive Youth support to Prevent Substance Misuse in Coxmoor
   - Enhanced Alcohol Diversion Scheme for Nottinghamshire.

8. Separate reports are included in **Appendices 1 & 2** to provide further information on these projects.

Statutory and Policy Implications

9. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service 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

The Public Health Sub-Committee are asked to:

1) Approve this expenditure.
2) Receive reports on the progress of these projects in due course.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact:

Adrian Pearson. Substance Misuse Strategy Co-ordinator

Constitutional Comments (SG 05/04/2013)

10. The Sub-Committee is the appropriate body to decide the issues set out in this Report. Under its Terms of Reference the Sub-Committee has responsibility for Public Health with the exception of functions reserved to the Heath and Wellbeing Board.

Financial Comments (ZKM 08/04/13)

11. The financial implications are outlined throughout this report and appendices.

Background Papers

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 Division(s) and Member(s) Affected

All

Nottinghamshire County Council | NHS Bassetlaw | NHS Nottinghamshire County

Agenda item: SMSG-13-06

Substance Misuse Strategy Group

Intensive Youth Support to Prevent Substance Misuse in Priority Localities

Prepared by: Laurence Jones, Group Manager, Targeted Support and Youth Justice, Nottinghamshire County Council

1.0 PURPOSE OF THE REPORT:

1.1 This report presents the business case for investing a portion of the amount from previous substance misuse under-spend, now kept in a ring fenced reserve, on projects to reduce the likelihood of young people commencing problematic substance misuse. The proposal would be to commission two Junior Youth Inclusion Support Programmes in identified hot-spots.

2.0 BACKGROUND:

2.1 The main aim of the project would be preventing vulnerable young people, aged 8-12 years, from becoming substance misusers in the future. As the same causal factors for substance misuse are also seen in the risks of offending, school non-attendance and teenage pregnancy the project will have secondary aims of reducing these factors.

2.2 It would be proposed to commission a service from the voluntary/community sector for a project in a discrete geographical area. The model would be a lightly modified version of the Junior Youth Inclusion Programme model, which has a set of quality standards and is evidenced in terms of its impact.

2.3 The principal aim of a Junior Youth Inclusion Programme (JYIP) is to reduce and prevent the involvement of children and young people aged 8 to 12 years in behaviour that could result in their social exclusion. It seeks to achieve this by providing those children and young people who are most at risk of this with a range of activities designed to reduce the impact of those factors most associated with exclusion, and to enhance those 'protective' factors that reduce its likelihood.

2.4 The JYIP ensures that any child or young person referred to it only participates after their full, informed consent, and that of their parent or carer has been obtained, and that this is given on an entirely voluntary basis. Participants have the right to withdraw from the programme at any point without prejudice (i.e. he or she could re-engage at a later, perhaps more appropriate time in their lives).

2.5 The JYIP ensures that it focuses its work on a 'Core Group' of children and young people aged 8 to 12 years who are identified by two or more partner agencies as being those who are:

- most at risk of involvement in substance misuse, offending and/or anti-social behaviour
- most at risk of exclusion from education
- behaving in ways that require a multi-agency response.

In order to engage this Core Group, the JYIP may also need to engage their peers in the neighbourhood.

2.6 The JYIP is committed to involving children, young people and families in planning activities and participating in all aspects of programme delivery and review. This is shown through policies and standards being in place that foster participation on an equal opportunity basis and that is proportional to age and maturity.

2.7 The JYIP recognises the paramount importance of the needs of the child or young person. It is

committed to safeguarding the health and well-being of those engaged in JYIP activities at all times. All JYIP activities are based on assessment of the child or young person's needs, in line with the Common Assessment Framework Guidance and informed by knowledge of the risk and protective factors associated with social exclusion. Effective assessment requires the establishment of a strong information-sharing protocol between JYIP partner agencies.

2.8 Identification of appropriate young people can come from the full range of local voluntary and statutory agencies. Relationship with schools, local policing and YOTs will be key.

2.9 The proposal would be to tender for services for a three year period. As this would be a competitive tender it is not possible to state the exact cost but looking at projects elsewhere a ball park figure would be £100,000 per project per year. For two projects, running for a minimum 3 year commitment, the total cost would be estimated at £600,000. There is a developed market for JYIP activity with a number of experienced national providers and a history of grass roots organisations also successfully running schemes.

	2013-14	**2014-15**	**2015-16**
Project One	£100,000	£100,000	£100,000
Project Two	£100,000	£100,000	£100,000
Total	£200,000	£200,000	£200,000

Proposed Geographical Areas for Consideration

2.10 JYIP projects work best when focused on a discrete geographical area such as a large housing estate. The following areas have been identified as the most in need of such a project.

Manton, Worksop

- Ryton Park Primary School, serving Manton has 194 (35%) young people of the of its 559 children on frees school meals.
- South East Worksop is a child poverty hot-spot and a Partnership Plus area for the Safer Nottinghamshire Board.
- The area has been highlighted in previous substance misuse needs assessments.

Coxmoor, Ashfield

- Morvern Park Primary has 125 (35%) young people of the of its 360 children on frees school meals.
- South Kirkby is a child poverty hot-spot and a Partnership Plus area for the Safer Nottinghamshire Board.
- The area has been highlighted in previous substance misuse needs assessments.

3.0 OUTCOMES:

3.1 As with all early intervention projects proving the success of outcomes can take time. It would be proposed to look at performance during the length of the project but also for an extended period post-project (allowing for data protection legislation and data retention guidance, approximately 7 years).

The following measures are proposed:

	Project Measures	Longitudinal Measures
Substance Misuse Measures	% JYIP cohort reporting onset of substance misuse % JYIP cohort requiring a substance misuse intervention	% JYIP cohort reporting onset of substance misuse % JYIP cohort requiring a substance misuse intervention
Proxy Measures	% change of JYIP cohort in relation to school attendance % JYIP cohort entering the youth justice system or re-offending	% change of JYIP cohort becoming NEET % JYIP cohort entering the youth justice system or re-offending % JYIP cohort receiving a custodial sentence % JYIP cohort becoming a parent prior to age 18

4,0 RECOMMENDATIONS:

4.1 The Substance Misuse Strategy Board is asked to;

- Consider committing £600,000 from the reserves for two JYIP projects, with a duration of three years, on the Manton and Coxmoor estates.

NOTTINGHAMSHIRE SUBSTANCE MISUSE STRATEGY COMMISSIONING GROUP

"A TRULY TEACHABLE MOMENT"

Introduction

The purpose of this report is to highlight the potential that exists to extend the current Alcohol Diversion Scheme, the benefits that this would bring, and the relatively straightforward work required to deliver significant benefits that would support the overarching Substance Misuse Strategy.

Alcohol Diversion Scheme

The Alcohol Diversion Scheme is offered to any person arrested in the Nottingham City boundaries for being Drunk and Disorderly, and in Mansfield and Ashfield for Drunk and Disorderly and for Using Insulting and Threatening Words or Conduct.

People have 21 days from the issue of their fine to make contact with Last Orders and 60 days from the point of contact to attend a course which will see a reduction in their fine from £80.00 to £40.00. Courses are run in the evening and on Saturday mornings to accommodate students and those who work.

The emphasis is on the person who has received a fine to make contact but Last Orders will send reminders to those showing on the ticket office spreadsheet

Of particular significance, is that if an individual completes the course, then they will not be subject of a disclosable conviction for the offence they were arrested or given the fixed penalty notice for. In the current economic climate, that has significant implications for an individual's employment prospects.

The course content covers such areas as alcohol and its relationship to offending behaviour and the dangers of mixing alcohol and cocaine. It uses evidence based MI techniques proven to effect behaviour change.

The course also supports the Manchester based 'Punched Out Cold' campaign and uses Police CCTV of the assault to instil how vulnerable people are to danger when intoxicated.

The Alcohol Diversion scheme therefore aims to deliver information that will be effective in achieving long term behavioural change in relation to peoples drinking behaviour.

The scheme was created in partnership with Nottinghamshire Police, Framework Housing Association (FHA) and the Crime and Drugs Partnership. FHA was a natural choice to deliver the course as they hold the contract for the Last Orders Alcohol Services. Last Orders offer assessment and treatment for drinkers in Nottingham in addition to delivering training to many workers including health care staff and the Police.

The scheme is a recent venture in Nottingham starting in November 2011, but has been successfully piloted in other areas namely Hertfordshire and Derbyshire

The course is not aimed at chronic dependent drinkers but at the younger binge drinkers who are able to display control over their drinking patterns

FHA and the Police have a confidentiality protocol and a service level agreement signed by both parties. Attendees willing to be contacted at three and six months sign a consent form with a contact number, Last Orders staff are bound by their service confidentiality policy and no personal information is shared with any other party.

The learning outcomes are as follows:

- Physical effects of alcohol misuse
- Psychological effects of alcohol misuse
- Why people are vulnerable when intoxicated
- Dangers of mixing certain drugs with alcohol
- How to calculate units
- Relationship between alcohol and offending behaviour

The course is designed to be interactive and starts off with a quiz to establish knowledge about alcohol and there are case studies focusing on what led to the attendees being arrested on that night but not others.

The course focuses on reward in the form of a 50% reduction in their fine as opposed to a punitive approach. The course trainer is however very clear with all attendees that the Police still have their details on file and that the course is a one off option. Should they be arrested again for drunk and disorderly they may be treated differently by the criminal justice system and could acquire a criminal record.

Headlines from the evaluations have been…..

- Every attendee has been sober, polite and willing to engage. Most look embarrassed and are quiet when they first arrive and most expect to see some sort of Police presence. Once they realise that it is an informal process run by nursing staff people tend to relax and are happy to share their stories and experiences.
- Typical offences people have been arrested for are urinating in the street and then becoming verbally inappropriate with the police, refusing to move on from night clubs they have been ejected from and becoming verbally aggressive in the Emergency Department.
- Interestingly, the majority of attendees think the Police were heavy handed and too authoritative and think the arrest was unfair. However, when challenged about this and asked about what their behaviour would have been like had they been sober, all stated that they would have walked away from the situation without incident.
- During the course all attendees are given exercises to do; the first tries to ascertain how much alcohol was drank on the night of the offence. The majority of people have no real recollection and drinking excessively (pre loading) before they go out is a common theme.
- Most attendees are 'unit' naive and have no idea how many units are in what drink but all so far have made a real effort to try and calculate the amount they drank on the night of their arrest. Units have varied from the lowest at 18 to the highest at 38 with these being possible conservative estimates.
- When informing attendees that it takes about one hour for the body to metabolise a unit of alcohol they have been shocked at the realisation that they would probably have been drink driving the next day and for those with children, unable to care for them properly.
- When asked about what they would have done differently the overwhelming response has been to not pre load before they go out. If the diversion course can affect that sort of behaviour change in some of the attendees then this will have a positive impact on people's behaviour when on a night out.
- No attendee so far has been aware that it is dangerous to mix cocaine and alcohol and that a by product call cocaethylene is produced in the body when the two are mixed. This in turn can cause cardiac problems in some, especially if pre-disposed. If this message can be spread to friends and family and reduce the use of the two this could prevent premature deaths.

It was extended to include Mansfield and Ashfield in Autumn 2012.

From interviews with stakeholders the following observations have been recurrent messages:

- Awareness and utilisation of the scheme by the operational Police officers could be improved.
- Proactive utilisation of the scheme within the Custody environment could be improved.
- That there were missed opportunities to market the scheme in other than police environments, such as Jobcentres, Health environments etc.
- The implications to an individual, on their criminal record status need to be more explicitly pushed, if they do not take advantage of the scheme.
- That those potentially subject of the scheme, who are in the City and who fit the "student" profile, are more likely to take advantage of the scheme.
- At Mansfield custody suite, the feedback was that those arrested simply wish to forget about the whole matter and did not wish to have the embarrassment of attending the course, or that their employment status would be unaffected by another conviction.

- That whilst the administration and co ordination of the scheme has been to date effective, that the larger target cohort will require dedicated support, which will need resourcing. To give the type of control over all the elements of the process, which protects the reputations of all the responsible authorities involved, needs to be put on the professional footing it deserves. Even on the relatively small numbers involved now, there are anecdotal stories of administrative matters involving mix ups. Whilst this is to be to some extent understood within a pilot phase, given the fact that this course will involve the crucial basic question of whether an individual receives a conviction which will have implications on their character, this is too reputationally significant to risk.

DEVELOPMENT PROPOSALS

1. Extending the Scheme

- Now that the scheme is functioning, there is no reason why it cannot be extended to the whole County. The Crime and Disorder partnerships in Bassetlaw and South Nottingham have indicated that they would support this.
- Framework has confirmed that they can accommodate additional demand, and that they have the flexibility to offer additional venues other than the existing City base.
- The Probation Trust has indicated that they would support this, and it has no implications on any other bodies.
- In order to provide a robust and effective administration of the scheme will require the appointment of an administrator by them.
- Framework is confident that after this period, they could support this post through their income generation process and through mainstreaming the then income created by the scheme itself.

Recommendation One

That the scheme be extended to the whole County.

Recommendation Two

The Substance Misuse Strategy Commissioning Group has recommended that funding be allocated from the Substance Misuse budget, as it fulfils the aims and objectives of the strategy.

2. Broadening the Offences covered by the Scheme

- The current offences are quite narrow, namely Drunk and Disorderly, Drunk and Incapable, and Using Threatening or Insulting Language or Behaviour Section 5 Public Order Act.
- Other schemes have successfully extended the remit to include:
  - Minor criminal damage where alcohol is a significant contributing factor.
  - Possession of controlled drugs where alcohol is a significant factor or the offence takes place within the night time economy or within licensed premises generally.

- Section 4 Public Order Act where alcohol is a significant factor.

➢ This will have no impact on overall recorded crime figures, or on the detections thereof.

➢ This will allow more scope for Restorative Justice.

Recommendation Three

That the scheme be extended to the offences outlined above.

3. Inclusion of Pubwatch

Pubwatch schemes exist across the County, and deal with a large number of people who have caused problems within licensed premises. Pubwatch schemes have the capability to ban people for up the three years within that locality

In Mansfield and Ashfield alone, there are 250 people banned from Licensed Premises. The process by which an individual can be readmitted to the schemes' premises varies, but attendance on this course could be very easily made a condition of remittance, would be of great benefit to the Licensees themselves, and extend the scope of the cohort.

Additionally, when an individual receives a criminal conviction for conduct or actions within a Licensed Premises, the relevant Pubwatch scheme will consider whether that individual should be banned, additionally to any criminal sanction the court imposes.

Attendance on a scheme would be an added benefit to achieve the aims of the strategy.

Recommendation Four

That the Pubwatch be included on a City and County wide basis, to include individuals in those categories above.

4. Conditional Cautions

The scheme could be extended to include all persons who would be the subject of a Conditional Caution, whatever its nature, if a contributory factor is alcohol. Successful attendance and completion of the course could be made a condition for receiving the caution.

This would be relatively easy to introduce, would enhance the overall impact of the caution, and lead to reduced reoffending rates.

Recommendation Five

That Conditional Cautions for relevant offences be included in the scheme.

CONCLUSION

Whilst these proposals may appear to be very focussed on the criminal justice system, they actually are clearly tilted to a public health approach, in that they seek to actually change behaviour over a longer period.

I strongly recommend that these proposals are supported and implemented as soon as possible, with a significant communication plan to maximise the impact.

Adrian J.J.Pearson
Nottinghamshire Substance Misuse Co-ordinator

Budget proposal for the extension of the Nottinghamshire Diversion Scheme		
Administrator	£17000 + NI and pension and on costs @20%	£20400
Trainer	£350 per session +VAT(24 sessions over one year)	£10080
Laptop, Power Click Projector		£2250
Mileage for trainer	.45p per mile	£1200 per year
Tea Coffee etc		£150.00 per year
Leaflet production		£250.00
Mobile		£350.00
.1 Management		£2880
Total		£37560
Overheads at 15%		£43194

Nottinghamshire County Council

Report to the Public Health Subcommittee

16 April 2013

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH TRANSITION

Purpose of the Report

1. This report provides information on the transfer of the Public Health Department and associated functions from NHS Nottinghamshire County and NHS Bassetlaw to Nottinghamshire County Council. It describes progress made to date, risks and planned actions to resolve issues for the 1 April 2013 transfer.

Information and Advice

Context

2. The Health & Social Care Act 2012 will come into force on 1 April 2013. The Act gives all upper tier Local Authorities the statutory responsibility for promoting health improvement in the local population. This responsibility is underpinned by the creation of Health & Wellbeing Boards and the transfer of Public Health staff and functions from the NHS into upper tier Local Authorities.

Transition Plan

3. A detailed transition plan has managed the transition process since November 2011 and describes the actions being taken to make sure the Public Health transfer runs smoothly and to time. The plan covers four main elements:
    - **Maintaining the day-to-day Public Health Function during Transition** – a Public Health Business Plan and regular reporting has kept an overview of progress on a daily basis during transition.
    - **Delivering the Health & Wellbeing Public Health Function from April 2013** – The Nottinghamshire shadow Health & Wellbeing Board has been meeting since May 2011. Significant progress has been made to prepare the Board for its statuary function from 1 April 2013.
    - **Transfer and maintenance of an effective Public Health Workforce** – a joint management and trade union working group is in place to manage the transfer of staff.
    - **Transferring the Public Health function and infrastructure to support delivery** – a series of work streams is in place to manage the transfer of services, contracts and supporting structures connected to the Public Health function.

4. A dedicated Project Board has been established within the Council to manage the transition to give in depth support to areas of transition that require detailed action. The project is

sponsored through David Pearson and Chris Kenny and led by Cathy Quinn, Associate Director of Public Health.

5. **Appendix One** provides detail on the transition, giving the latest position (including performance against local and national milestones), along with outstanding risks and mitigating actions.

Legacy Report

6. The transition planning process has also been used to collate all legacy information relating to Public Health. This has then been compiled into a legacy report to describe historic agreements, services and contacts that could be lost during the transfer.

7. The report was endorsed within the Council by the Corporate Leadership Team and new Public Health Subcommittee during February.

Statutory and Policy Implications

8. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service 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) The Public Health Sub-Committee are asked to note the current position on the Public Health transition to Nottinghamshire County Council, along with the progress made and outstanding actions.

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health.

Constitutional Comments (NAB 28.03.13)

9. Public Health Sub-Committee has authority to consider the matters set out in this report by virtue of its terms of reference.

Financial Comments (ZM 28.03.13)

10. There are no financial implications arising directly from this report.

Background Papers

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.

Public Health Transition Plan March 2012.

Public Health Business Plan 2012-13 revised July 2012.

Electoral Division(s) and Member(s) Affected

All

Appendix One: Public Health Transition Report

Contact :	Cathy Quinn, Associate Director of Public Health
Status Report as at 4 April 2013	A dedicated Project Board has been established to manage the remaining months of transition to give in depth support to areas of transition that require detailed action. The project is sponsored through David Pearson and Chris Kenny and led by Cathy Quinn, Associate Director of Public Health. A revised detailed project plan is in place to monitor progress. Current issues include: • **IT project plan:** The PH switch to NCC systems commenced on 23rd March 2013, with the migration of email accounts. Although the migration is almost complete the process was very protracted and there are still some outstanding issues as of Friday 4th April. Outstanding issues include resolution of incorrect email accounts (which has meant that some staff have not had access to emails for 2 weeks), access to shared files by some staff, resolution of undeliverable emails to some accounts, access to new laptops for some staff and security issues related to emails and folders. • **N3 connection** is in place, but access to required applications for the Intelligence and infection control teams is still pending. A contingency is in place but testing of a long term solution for access is outstanding. Lessons from the current transfer will be considered in the planning of this next stage of transfer. • **Information Governance: There are ongoing concerns over the national solution to allow a legal basis to share NHS information with Public Health**. NB: A short-term contingency arrangement is in place for April, but national action is critical to find a long term solution across health and public health. • **Review of miscellaneous support functions for Public Health:** The Associate Director of PH has met with each Department to clarify support requirements for PH. Actions have been agreed to ensure arrangements are in place for April 13. • **Staff Transfer:** The legal transfer of staff took place on 1 April 2013 following the approval of the transfer scheme. There have been delays in access to HR information to allow the payroll system to be built in time for staff transfer. PH, PCT and NCC Staff have worked together to identify missing data and check information for accuracy in time for the April payroll deadline on 9th April. • **Staff Consultation:** Trade Unions have been consulted on local changes to terms and conditions and

	agreement was reached on final measures on 25th March. To date, staff have not received formal notification of any changes to local terms, but local staff consultation and briefings have ensured staff are informed. NB: most terms and conditions are being agreed nationally. • **BMS:** Work has taken place to build the PH HR and finance/procurement aspects of the BMS system. The Finance coding structure and organisational structures are now in place, but there are still some outstanding issues around vendor details, the purchase order process, and staff training. • **Contract management –** a contract team has been established within PH to ensure a safe transfer of contracts and effective on-going management. A quality and governance procedure has been developed to ensure that clinical governance issues are managed within the council and linked back to the NHS as appropriate. • **Public Health core offer –** a memorandum of understanding has been developed to describe the core offer for public health advice to the NHS. This has been through each CCG and is being presented at the April Public health Subcommittee. Following the confirmation of the PH Grant, an outline plan has been agreed by the PH Subcommittee. A further plan for investment in areas of development is currently being consulted through the Health & Wellbeing Board and will be presented for approval to the PH Subcommittee in April. The PH legacy document has been completed and has been endorsed by the PH Subcommittee. The PCT Board will formally approve the document at its Board meeting in March. Risk register and progress against Milestones are described below. Mitigating actions are managing the risk at present.

Key Milestones between 1.11.12 and 31.03.13	**Updated March 2013**			
No.	Milestone	Date for completion	Current RAG rating	Your Confidence level in achieving the milestones ((High, Medium, Low)
1	Workable information governance arrangements agreed and in place that will	Date	Amber	Medium

	ensure public health teams will have access to the information they need to carry out their duties from April 1 2013	dependent on national solution		
2.	Arrangements tested for delivery of public health services including screening and immunisation	31 Oct 12	Green	**Completed**
3.	Arrangements for role of PH in emergency planning tested	31 Jan 13	Green	**Completed**
4.	Legacy and handover document produced	31 Jan 13	Green	**Completed**
5.	Transfer of employment from NHS to CC complete	31 Mar 2013	Green	**Completed**
6.	Full integration of PH into NCC IT support systems	Amended to end April 13	Amber	High
7.	Contracts stabilised and listed for second return	12 Dec 12	Green	**Completed**
8.	Contracts transfer agreed for third return	16 Jan 13	Green	**Completed**
9.	Contracts transfer completed	Amended to end April 13	Amber	High
10.	HWB ready to take on role	31 Mar 2013	Green	**Completed**

Risk Register **Updated March 2013**

Risk	Impact	Likelihood	Consequence	Level	Remedial Action undertaken or planned	Residual risk
Information Governance solution not available in time for PH transfer	Inability to access data will prevent PH undertaking core role.	3	3	High	National work ongoing to agree legal basis to share data. Local actions identified to remove all access to patient identifiable data, but longer term solution is critical for	MOD

					the work of PH.	
IT transfer of data and equipment not completed in time for staff transfer	Inability to access data will prevent PH undertaking core role.	2	3	Mod	IT transfer in progress. Problems being resolved slowly but work is being affected	MOD
N3 connection not available in time for PH transfer	Inability to access data will prevent PH undertaking core role.	1	3	Low	Connection in place & upgrade authorised. Contingency arrangements to maintain access via health network.	LOW
Functions unable to transfer in line for PH transfer due to lack of established structures in receiver organisations e.g. Imm and Vaccs, screening	Possible disruption to services	1	3	Low	Transition planning in place which includes contingency arrangements to ensure functions maintained in either sender or receiver organisation.	LOW
Supporting structure not in place in time for PH transfer	Lack of specialist support such as IT, HR and communications	1	3	Low	Basic Support structures agreed, but there is an on-going need to consider more detailed needs after April	LOW
Contracting arrangements for all areas of PH delivery are not agreed and novated, decommissioned/recommissioned/SLA etc achieved for April 2013	Disruption in services	2	3	Mod	All contracts identified, and new contracts drawn up. Work ongoing to chase vendor details to establish payment systems for April onwards.	MOD
BMS system not complete to allow timely payment of vendors and PH staff management	Payments delayed and system unable to accommodate PH requirements	1	3	Low	Outstanding actions identified and plans in place to address gaps	LOW
Clinical Quality arrangements not in place in Council to cover	Inability to identify and take action in the vent of a clinical	1	3	Low	PH developing quality and performance framework to	LOW

commissioning of PH services	governance concern				include clinical governance and establishing mechanism to action clinical governance concerns	
All arrangements for transfer of staff is not complete on time i.e. payroll information is not transferred in a timely way	Staff employment and pay delayed	2	3	Mod	Some outstanding issues around staff payment systems, but work identified to resolve issue before April pay date.	LOW
Current PH staff may apply for vacant posts within PHE/NCB	Loss of staff knowledge may disrupt delivery of PH function	1	3	Low	Maintain oversight of situation and arrange contingency cover within Dept as required	LOW
Property Risk identified connected to delivery of current PH functions	Council will need to agree to take on risk of empty property if PH function (that are currently operating out of PCT-owned premises) is decommissioned in future.	1	3	Low	Risk escalated and information confirmed to quantify risk. PH grant will cover any financial risk	LOW

LIKELIHOOD	1 Insignificant	2 Minor	3 Moderate	4 Major
1 – Very unlikely	1 LOW	2 LOW	3 LOW	4 MODERATE
2 – Unlikely	2 LOW	4 MODERATE	6 MODERATE	8 HIGH
3 – Possible	3 LOW	6 MODERATE	9 HIGH	12 Very high
4 – Likely	4 MODERATE	8 HIGH	12 Very high	16 EXTREME

National milestones

Milestone	Date	STATUS
PCT clusters to enable their emerging CCGs to work with their local authority to establish their local HWB in	Mar 2012	Achieved

shadow form by end March 2012 and begin refreshing JSNA		
PCT clusters to enable emerging CCGs to jointly lead their local HWB. Identify high level priorities from JSNA as basis for HWS and begin developing HWS by April 2012	April 2012	Achieved
PCT clusters to: • enable their emerging CCGs to use their JSNA and HWS as evidence for the authorisation process by July 2012 • by September 2012, use agreed HWS as foundation for 2013/14 planning process. Involve partners in HWB in the planning progress. Begin developing JSNA for 2014/15	July 2012 Sept 2012	Achieved Achieved and ongoing work taking place
PCT clusters to begin developing HWS for 2014/15 by December 2012. Continue to work with partners in HWB to develop commissioning plans	Dec 2012	Achieved – Process for review established
PCT clusters to enable emerging CCGs to work with partners in HWB to ensure that commissioning plans fully reflect the local priorities in the HWS by February 2013	Feb 2013	Achieved - Process for engagement established

Milestone	End Date	STATUS
PCT clusters to: • agree local transition plans for public health as part of integrated plan by March 2012 • develop a communication plan and engagement plan, first draft produced by March 2012	Mar 2012	Achieved
PCT clusters to agree approach to the development and delivery of the local public health vision by June 2012	June 2012	Achieved
PCT clusters to agree workable information governance arrangements and have these in place to ensure public health teams will have access to the information they need to carry out their duties from April 1 2013 (Revised definition)	Dec 2012	In Progress – delay in achieving milestone. Contingency in place for N3 connection. Outstanding concerns around national agreement to allow legal basis to share information with PH
PCT clusters to: • test arrangements for delivery of specific PH services (esp. screening & immunisation) by October 2012 • test arrangements for the role of PH in emergency planning (esp. role of DPH and LA based PH) by October 2012 • ensure early draft of legacy and handover documents by October 2012	Oct 2012	Achieved Achieved in Jan 2013 Achieved
PCT clusters to ensure final legacy and handover document produced by January 2013	Jan 2013	Achieved
PCT clusters to agree arrangements for Local Authorities to take on PH functions	Apr 2013	Achieved
Each local area is clear about the new arrangements for specific public health services, in particular immunisation and screening	Mar 2013	Achieved

New milestone		
Handover of immunisation and screening to PHE and NHS using the NCB framework New milestone	Mar 2013	Some final issue with capacity in NCB, discussions taking place between DPH and NCB re short-term contingency

Nottinghamshire County Council

Report to the Public Health Subcommittee

16 April 2013

Agenda Item: 8

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

MEMORANDUM OF UNDERSTANDING FOR PUBLIC HEALTH ADVICE TO NOTTINGHAMSHIRE COUNTY CLINICAL COMMISSIONING GROUPS

Purpose of the Report

- The purpose of this report is for the Public Health Sub-Committee to ratify the Memorandum of Understanding (MoU) for Public Health (PH) advice to the Nottinghamshire County Clinical Commissioning Groups for the period 2013 - 2016.

Definition

- A MoU is often created between parties who should not need a contract. It is used as a confirmation of agreed terms between two or more parties that is not legally approved but is more binding than an informal agreement. It can be used to agree the basic principles and guidelines under which the parties will work together to accomplish their goals

The Context

- *Healthy Lives, Healthy People: update and way forward* (July 2012) laid out the role public health professionals have in ensuring NHS services are designed to meet the needs of the whole population and are based on the best available evidence.

- Under the Health and Social Care Act 2012 (the Act) Public Health (PH) will transfer to the Local Authority (LA) or Public Health England (PHE) from April 2013. In Nottinghamshire the Director of Public Health (DPH) is responsible for the Nottinghamshire County Council PH functions.

- One of the mandatory responsibilities within the Act is to ensure local NHS commissioners receive the Public Health advice they need so they can discharge their statutory duties. It is important to note that PH support will mainly occur through the NCC PH team but there will also be support from Public Health England (PHE) and the PH teams at the NHS Commissioning Board.

- To ensure NCC meets the requirements within the Act a three year 'core offer' (MoU) for public health advice from PH to the Nottinghamshire County Clinical Commissioning Group (CCG) has been developed in partnership with the CCGs and NHS Commissioning Board. As a result the MoU has been extended to show the full range of

interdependencies with other statutory commissioners in the health and wellbeing commissioning structures

- Each CCG has received their MoU which has been adapted to reflect local need. This is captured in table 5 of the MoU.
- The CCG Governing Bodies for Bassetlaw, Mansfield and Ashfield, Newark and Sherwood, Rushcliffe, Nottingham West and Nottingham North and East all approved the MoU at their meetings during March 2013.

The Rationale

- Public Health expertise is an indispensable and essential part of commissioning NHS services. With the NHS facing major financial challenges, these functions are more important than ever.
- The DPH and his team will provide public health expertise, advice and analysis to CCGs and the Health and Wellbeing Board in order to improve outcomes and secure optimum health services for individuals and local populations in Nottinghamshire County as a whole

Expected Outcomes

The MoU will be the basis for partnership working and the outcomes from PH are expected to:

- Produce and deliver a refreshed Joint Strategic Needs Assessment based on provision of timely, robust evidenced based information and actionable intelligence, gathered from across the health and social care community that measures improvement as defined in the three national outcomes frameworks
- Validation and analysis of the information available to inform what needs to change or be sustained at CCG level where possible
- Development and management of a local outcomes framework and an information sharing agreement reflected in the Health and Wellbeing Strategy and implementation plans.
- Production of the Health and Wellbeing (HWB) strategy based on the JSNA and local Health Needs Assessment (HNA) at CCG level where able
- Present reports to the Health and Wellbeing Group as requested to provide assurance against delivery and performance targets
- Produce technical reports to the HWB Board and other CCG committees/boards on the full range of policy areas
- Produce a Public Health annual report which will be CCG specific where possible
- Provide evidence that all PH staff meet the national and statutory requirements and deliver a service to CCGs that is equal to historical standards and levels
- Training Network Annual Deanery Report
- Coordinate the regional PH professional appraisal programme to meet all standards
- Complete annual professional appraisals for all consultants
- Deliver a local learning and development programme
- Develop and refresh strategic plans and action plans for each policy and topic area to reduce inequalities and promote equality

- Develop and lead programmes around improving lifestyles into front line services, including support to primary care.
- Produce service specifications
- Report on contract performance monitoring of PH activity at PH Subcommittee and with others as appropriate
- Report on relevant quality and safety issues
- Advice on the implementation of national infection control initiatives across the health and social care community
    - Clinical advice to health and social care professionals in the prevention and reduction of communicable diseases, healthcare-associated infections and decontamination
    - Develop and maintain safe effective infection control policy and guidance documents
    - Provide targeted infection control training
    - Support infection control audits
    - Advise on design/refurbishment of clinical premises
    - Advise on the procurement of products
- Lead and facilitate local clinical networks and policy groups
- Membership of Strategic Clinical Networks and Academic Health Science Network (AHSN)
- Advice on pathways, service specifications and action plans for delivery using evidence based intelligence e.g. NICE
- Lead/assist prioritisation plans to inform NHS commissioning with consultant input into prioritisation panels
- Produce guidance and evidenced based reports at CCG level and for contracting purposes
- Provide specialist technical and PH support and evidenced based reports to CCGs and NHS CB
- Provide specialist PH support to Area Prescribing Committee.
- Provide guidance on health community prescribing where specialist PH view required.
- Produce predicative modelling and case for change evidence
- Produce Health Equity Audits
- Monitor, evaluate, collect and interpret data presented in reports to HWB board and other Boards/Committees
- Support Quality Innovation Productivity and Prevention and other efficiency programmes by analysing information and the evidence base
- Share plans and commission for the PH areas identifying possible impact on other parts of the system
- On behalf of the NHS lead commissioning including contract and performance management for:
    - Substance Misuse (prison and community)
    - School nursing and special school nursing
- Deliver cross cutting community and neighbourhood work plans to address determinants of health and associated inequalities in Bassetlaw (e.g. troubled families, partnership plus, neighbourhood management)
- Produce and support plans for locality partnership for health work e.g. LSP, community safety (including local domestic violence programmes)
- Guidance and evidence based reports for effective interventions to reduce inequalities and impact positively on social determinants of health

- Cost effective and equitable provision of specialist public health advice to the South Yorkshire Area Team
- Lead Bassetlaw Wellbeing at Work programme
- Provide PH leadership to the CCG Governing Bodies and Clinical cabinet/committees with regard to value, variation and inequalities
- Provide PH leadership in the development and implementation of the CCG's HWB strategy
- Provide PH advice on commissioning healthcare via the CCG leads for NHS contracts including Nottingham University Hospital, Sherwood Forest Hospitals, Nottinghamshire Healthcare Trust County Health Partnerships and Bassetlaw Health Partnership

Other Options Considered

14. **Do not have a MoU.** This option would not assure the CCGs that a robust process was in place to access PH advice and therefore discharge their functions

15. **Secure the agreement in a legally binding contract**. This should not be required as the organisations are required to work together through the Health and Wellbeing Board which will be held to account for delivering improved outcomes

Statutory and Policy Implications

16. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications for Service Users

17. The local population of Nottinghamshire can expect public services to be commissioned in partnership, underpinned by the best available evidence and PH advice

Financial Implications

18. The public services are required to work together to deliver the local efficiencies required to meet the national economic challenge

RECOMMENDATION/S

19. The Public Health Sub-Committee are asked to approve the Memorandum of Understanding

Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Cathy Quinn Associate Director of Public Health.

Constitutional Comments (NAB 28.03.13)

Public Health Sub-Committee has authority to approve the recommendation set out in this report by virtue of its terms of reference.

Financial Comments (ZM 28.03.13)

The financial implications are set out in paragraph 18 of this report.

Electoral Division(s) and Member(s) Affected
All

Nottinghamshire County Council

MEMORANDUM OF UNDERSTANDING

BETWEEN

CLINICAL COMMISSIONING GROUPS AND

NOTTINGHAMSHIRE COUNTY COUNCIL

THE CORE OFFER FOR PUBLIC HEALTH ADVICE TO CLINICAL COMMISSIONERS

2013 - 2016

Purpose of the Memorandum of Understanding (MoU)

1. To agree a three year 'core offer' for public health advice from Public Health (PH) to the Nottinghamshire County Clinical Commissioning Group (CCG) which clearly defines outputs. It is important to note that PH support will mainly occur through the Local Authority PH team but there will also be support from Public Health England (PHE) and the PH teams at the NHS Commissioning Board.

2. The MoU has been developed with each CCG within Nottinghamshire County and has been extended to show the full range of interdependencies with other statutory commissioners in the health and wellbeing commissioning structures. Table 5 details the specific requirements requested by the individual CCG.

3. In the event of concerns with the 'core offer' a dispute resolution agreement can be enacted by any of the parties affected (Appendix 1).

4. Diagram A below provides a summary of the core offer and Tables 1 – 5 describe the detail.

Context and rationale

5. From April 2013 PH will transfer to the Local Authority or Public Health England (PHE) http://www.dh.gov.uk/health/2012/06/act-explained/. In Nottinghamshire the Director of PH is jointly responsible for the City and County Public Health LA functions.

6. One of the mandatory responsibilities of the Local Authorities is to ensure NHS commissioners receive the public health advice they need (**the core offer**).

Principles

7. A number of principles have been agreed between the CCG and PH. These are:
    - Putting the needs of patients and citizens first;
    - Public and patient involvement in decision making;
    - Sharing of risks and benefits for local population improvement in outcomes;
    - No cross charging in 2013/14 for services/functions/resources;
    - Locally agreed additional investment in services;
    - Mutually supportive;
    - Open and transparent, sharing information and committing to 'no surprises';
    - Clear accountability and governance arrangements;
    - Greatest cost and volume to determine lead commissioner status;
    - Joint working to ensure delivery against health and wellbeing plans and priorities.

Diagram A


The Core offer
Health Protection
Share information and advice on health protection
Strategy
JSNA (Pharmaceutical and Health Needs asssessments)
Health and Wellbeing Strategy
Health & Wellbeing Board
Public Health Outcomes Framework
Local Outcomes Framework
Information and Intelligence
Health Improvement
Local health needs assessments
Local support for health improvement & reducing inequalities (e.g obesity, smoking)
Population Healthcare
Advice on Commissioning intentions
Prioritisation
Lead clinical networks & develop pathways
Advice on QIPP and other efficiency programmes
Advice to specialised commissioning
Monitoring & evaluation
Support to contract teams
Develop CQUIN and quality incentives
Advice on Individual Funding Requests
Quality and risk management framework
Membership of clinical and strategic committees/ forums (Clinical Commissioning Groups / NHS Commissioning Board / Academic Health Science Network)
Provide Public Health input to Area Prescribing Committee

8. **Table 1: Strategy**

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
Director of Public Health (DPH) with a multi-disciplinary expert team of Consultants in Public Health and Public Health Managers including experts in information and intelligence	Produce and deliver a refreshed **JSNA** based on provision of timely, robust evidenced based information and actionable intelligence, gathered from across the health and social care community that measures improvement as defined in the three national outcomes frameworks http://www.dh.gov.uk/health/tag/outcomes-framework/ Validate and analyse the information available to inform where we are now, what needs to change or be sustained and where we need to be; the JSNA will show this in as much detail as possible, within the limits of the current information systems and at CCG level where able.	Collate information at local level Named lead per CCG for JSNA Share all information including that not available through current information systems Commissioning plans aligned to JSNA	Share all information including that not available through current information systems Commissioning plans aligned to JSNA	
Public Health Senior Manager lead and experts in information and intelligence	Development and management of a **local outcomes framework a**nd an information sharing agreement[1] reflected in the Health and Wellbeing Strategy and implementation plans.	Commissioning for outcomes described in commissioning intentions and plans	Commissioning for outcomes in commissioning intentions/plans	
Senior Public Health Manager leading the development and overseeing actions, reporting to the DPH	Produce **the Health and Wellbeing (HWB) strategy** based on the JSNA and local HNA at CCG level where able Produce and lead action plans in the local area that target deprived areas and inequalities	Executive level and public/patient contribution to developing the strategy Commissioning plans directly relate to JSNA and HWB strategy, targeting inequalities and pockets of deprivation	Executive level and public/patient contribution to the strategy	Lead elements of the JSNA, contributing to the overall JSNA. Lead the production of the HWB strategy
DPH member of the Health and Wellbeing Board	Provide leadership to the Health and Wellbeing board and relevant sub committees	Senior attendance at HWB Board Annual delivery plans explicitly	Senior attendance at HWB Board	Lead the HWB Board with the key leaders

[1] *Under development.*

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
		refer to Health and Wellbeing strategy priorities reflecting the JSNA and local need to reduce health inequalities		from the health and social care system working together to improve the health and wellbeing of their local population and reduce health inequalities
Information and Intelligence Team and lead consultant for each policy area Named consultant on governing bodies and other agreed CCG committees/boards	Produce technical reports to the HWB Board and other CCG committees/boards on the full range of policy areas	Maintain and share up to date information	Maintain and share information	Co-produce reports as appropriate. Maintain and share information with partners
DPH and consultant team	Public Health annual report which will cover the biggest health and wellbeing achievements in the year and also highlights the biggest health and wellbeing issues and how these can be addressed. This will be CCG specific where possible	Collate information at local level Commissioning plans aligned to JSNA and show actions to address the biggest health issues	Commissioning plans aligned to JSNA and show actions to address the biggest health issues	Commissioning plans aligned to JSNA and show actions to address the biggest health issues
Appropriately trained and qualified PH workforce	Provide evidence that all PH staff meet the national and statutory requirements and deliver a service to CCGs that is equal to historical standards and levels Training Network Annual Deanery Report Coordination of the regional PH professional	Clinical involvement in the governing bodies		To support statutory professional appraisal and revalidation

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
PH consultant lead for professional appraisal and revalidation (currently hosted by PH for the region) for all relevant PH staff	appraisal programme to meet all ORSA standards Annual professional appraisals for all consultants Annual report to the RDPH and all ROs Delivery of learning and development Future workforce competency assurance		RDPH ratifies annual report NHS CB provide RO for revalidation of medical staff	arrangements

9. **Table 2: Health Improvement**

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
PH consultant leads with support from a number of PH managers leading/assisting partnership work PH leadership of the Health and Wellbeing Implementation Group	Develop and refresh strategic plans and action plans for each policy and topic area to reduce inequalities and promote equality Present reports to the Health and Wellbeing Group as requested to provide assurance against delivery and performance targets	Provide a named lead and lead CCG for each policy area Provide input, support and critical review of progress	Develop commissioning and delivery plans that directly relate to strategic plans	Align wider determinants of health to HWS Strategy and implement the policy in relation to employed staff and commissioning with respect to tier 1 and tier 2 responsibilities e.g. housing
PH information and intelligence team PH leadership of the Health and Wellbeing Implementation Group	Maintenance and refresh of information and intelligence linked to JSNA Present reports to the Health and Wellbeing Group as requested to provide assurance against delivery and performance targets	Support development of JSNA Provide input, support and critical review of progress	Measurement of progress against JSNA and plans Support primary care development and align commissioning	Contribute to the development of the JSNA, leading key elements

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
PH Quality and Performance Contract Team including membership of relevant quality and contract monitoring processes PH leadership of the Health and Wellbeing Implementation Group	Develop and lead programmes around improving lifestyles into front line services, including support to primary care. Production of service specifications and procurement Present reports to the Health and Wellbeing Group as requested to provide assurance against delivery and performance targets	Support locally driven public health campaigns Provide input, support and critical review of progress	Increase uptake of prevention activity including in commissioning and within the workforce Strategic alignment with local need with responsive commissioning Increase uptake of prevention activity within practices including practice staff	Supporting development of programmes and increase uptake of prevention activity including in commissioning and within the workforce
PH information and intelligence team PH leadership of the Health and Wellbeing Implementation Group	Local HNA Present reports to the Health and Wellbeing Group as requested to provide assurance against delivery and performance targets	Lead/assist partnership work Provide input, support and critical review of progress	Local plans and actions to drive improvement Lead/assist partnership work	Lead/assist partnership work
PH Quality and Performance Contract Team including membership of relevant quality and contract monitoring processes	Sharing of contract performance monitoring of PH activity at PH Subcommittee and with others as appropriate Present reports to the Health and Wellbeing Group as requested to provide assurance against delivery and performance targets	Lead commissioner for PH activity in contracts where appropriate Provide input, support and critical review of progress	Contract changes as required Sharing of information to inform local planning	Joint procurement with NHS and other LAs

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
Lead PH manager for quality PH Quality and Performance Contract Team including membership of relevant quality and contract monitoring processes Named investigating officer for all events with submission of reports to the CCG/NHS CB Area Team Senior Manager member of the corporate committees for risk and emergencies DPH member of the Quality Surveillance Group	Sharing of data from quality monitoring of PH activity with relevant commissioners and local partners. Details of quality and risk policies and processes shared with relevant CCGs and NHS CB Area Team(s). Ensure relevant quality and safety policies and processes are consistent with guidance and best practice as issued by the NHSCB and other organisations (for example serious incident management guidance, safeguarding guidance etc.) Uploading of incident reports, significant events to the National Reporting and Learning System via eform submission (unless otherwise submitted via organisations' own Local Risk Management Systems to the NRLS) PH contracts with providers adhere to Care Quality Commission guidance and principles. Ensure requirements for reporting incidents to CQC are met. Monthly performance and risk reporting, including specific incident reports to PH Subcommittee and the LA corporate committees and Quality Surveillance Group (QSG)	Quality leads share information and learning Provide input, support and critical review of progress	Quality reports at local level shared with PH Director of Nursing and Medical Director accountable for clinical governance for PH **clinical** commissioning[2] Access and oversight with Serious Incident Management (SPICE) Professional leadership across the system Lead the QSG	Sharing of local information to drive up quality Receive performance data and advise the system Lead the corporate committee for managing performance and risk Member of the QSG

[2] Only applies to **clinical** commissioning within Public Health

10. **Table 3: Health protection**

PH inputs	**Local Authority Public Health offer and accountability**	**CCG actions and accountability**	**Actions NHS CB and *PHE***	**Actions LA tier 1 & 2**
PH consultant lead for sexually transmitted disease commissioning	Commissioning plans and monitoring of performance for GUM and CaSH	Co-commissioner Commissioning plans reflect PH requirements	Commissioning plans and promotion of best practice across the workforce and in care settings	Promotion of best practice
PH consultant lead for community Infection control of HCAI	Advice on the implementation of national infection control initiatives across the health and social care community Clinical advice to health and social care professionals in the prevention and reduction of communicable diseases, healthcare-associated infections and decontamination Develop and maintain safe effective infection control policy and guidance documents Provide targeted infection control training Support infection control audits Advise on design/refurbishment of clinical premises Advise on the procurement of products Advise on the development of new services Complete service review and needs assessment and refine the offer from April 2014	Provide a named lead Commissioning plans and promotion of best practice	Commissioning plans and promotion of best practice	Commissioning plans and promotion of best practice across the workforce and in care settings

11. **Table 4: Population Healthcare**

PH inputs	**Local Authority Public Health offer and accountability**	**CCG actions and accountability**	**Actions NHS CB and *PHE***	**Actions LA tier 1 & 2**
PH consultant membership of strategic and/or clinical committees	Lead and facilitate local clinical networks and policy groups Membership of Strategic Clinical Networks and Academic Health Science Network (AHSN)	One CCG to host each network and policy groups with named leads from other CCGs Share membership of networks between CCGs as appropriate Develop and amend commissioning plans in line with clinical network recommendations Lead CCG to cascade actions for implementation to the named leads in other CCGs	Host Strategic Clinical Networks and Senates and AHSNs involving key partners Provide strategic oversight of the commissioning system across Derbys/Notts and South Yorks	Develop and commission services in partnership to meet the objectives of the Council and HWB Strategy
PH consultant lead on all policy and priority areas supported by specialist team including PH information and intelligence Support systems including the licence for Scenario Generator	Advice on pathways, service specifications and action plans for delivery using evidence based intelligence e.g. NICE	Provide named CCG clinical leads for pathway development and named leads for integrated commissioning groups Share developments and agree joint pathways for commissioning working with all partners	Lead the Strategic Commissioning Collaboration, providing oversight to the system. Sharing best practice for quality Aligning commissioning for QIPP and other efficiencies across large geographical areas	Lead integrated commissioning groups with membership from across the health and social care community Share developments and agree joint pathways for commissioning Lead partnerships with other LA to maximise quality and value for

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
				money commissioning Implement local plans (tier 2)
PH consultant membership of contracting team(s) and panels	Lead/assist prioritisation plans to inform commissioning Provide consultant input into prioritisation panels	Lead prioritisation and commissioning intentions process Validate prioritisation plans for commissioning Produce commissioning intentions based on prioritisation	Produce commissioning intentions based on prioritisation	Produce commissioning intentions and implementation plans
Provide PH named leads for associate commissioner arrangements Provide PH consultant support and input into all NHS contracting and quality monitoring forum both in and out of area, attending clinical commissioning forum at individual (i.e. CCG) and collective levels (i.e. Clinical Commissioning	Produce guidance and evidenced based reports at CCG level and for contracting purposes	Lead commissioning and quality process Produce activity plans and contract management Produce and monitor CQUIN Apply contract levers	Produce activity plans and contract management Produce and monitor CQUIN Apply contract levers	Lead commissioning Produce activity plans and contract management

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
Congress) Gather intelligence from a range of sources and partners on the wider determinants of health feeding back to all our partners on developments				
Senior PH membership of Individual Funding Request (IFR) group	Provide specialist technical and PH support and evidenced based reports to the process to CCGs and NHS CB	Manage and lead the local IFR process Produce and implement the outcomes of the IFR process	Lead/support IFR process based on PH evidence base Implement outcomes	Use information from IFR process as 'lessons learned' and application to NHS Share learning and processes
Senior PH membership on Area Prescribing Committee	Provide specialist PH support to Area Prescribing Committee. Provide guidance on health community prescribing where specialist PH view required.	Manage and lead the local process Produce and implement the outcomes	Support implementation	Share learning
PH consultant lead on all policy and priority areas supported by specialist team including PH	Produce predicative modelling and case for change evidence	Identify priority areas for modelling and provide named lead Commissioning plans and case for change include modelling outcomes	Identify areas and adjust commissioning plans and case for change to include modelling	Identify priority areas for modelling and provide named lead

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
information and intelligence			outcomes	
PH consultant lead on all policy and priority areas supported by specialist team including PH information and intelligence	Produce Health Equity Audits	Identify priority areas Amend commissioning plans in line with findings	Amend commissioning plans in line with findings	Identify priority areas. Amend commissioning plans in line with findings
PH consultant lead on all policy and priority areas supported by specialist team including PH information and intelligence	Monitor, evaluate, collect and interpret data presented in reports to HWB board and other Boards/Committees	Forward plan for presentations aligned to HWB strategy Boards/Committees receive and act on report findings	Forward plan for presentations and receive/act on findings	HWB Board forward plan aligned to priorities and contracting timelines
PH consultant lead on all policy and priority areas supported by specialist team including PH information and intelligence	Support QIPP and other efficiency programmes by analysing information and the evidence base Produce clinical case for change	Provide named clinicians for QIPP areas Agree clinical sign up of the case for change	Agree actions at Strategic Clinical Networks and Senates and AHSNs as appropriate	HWB strategy and implementation plan agreed
PH consultant lead on all policy and priority areas supported by specialist team including PH information and	Share plans and commission for the PH areas identifying possible impact on other parts of the system Provide and share performance and quality monitoring against the mandatory functions and local targets Produce reports showing the evidence for change	Provide named leads for PH commissioning areas where appropriate Agree commissioning plans	Agree commissioning plans *PHE Information and intelligence service* *PHE design and delivery of nationwide*	Provide commissioning support and scrutiny against delivery

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
intelligence			*communications and interventions* *National lead for public health.* *Supporting the development of the specialist and wider PH workforce*	

12. **Table 5: Locally agreed**

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHS CB and *PHE*	Actions LA tier 1 & 2
Locally agreed with all CCGs				
PH consultant and team with expertise in different policy areas	Under a section 75 agreement lead commissioning including contract and performance management for: • Substance Misuse (prison and community) • Children and young people - including school nursing and special school nursing • Community dietetics This will include: • Commissioning plan and specification • Procurement plan • Quality and activity reporting • Securing efficiencies for each commissioner Lead the review of CAMHS	Share commissioning intentions and plans for connected services such as Emergency Department attendances for substance misuse Work in collaboration with the work plan identifying clinical leads and officers to support progress Delivery of actions to secure efficiencies are realised	PH Consultant input to contribute to joint commissioning and reciprocal arrangements for public health specialist advice	Commission services at tier 2 that support the policy area such as access to housing and leisure
Rushcliffe CCG				
PH consultant and team with expertise in	Provide PH leadership to the Rushcliffe CCG board and Clinical Cabinet including on value, variation and inequalities	Lead the development and implementation of the CCG's local HWB Strategy	Contribute to the CCG strategy, align	Commission services at tier 2 that support

different policy areas	Provide PH leadership in the development and implementation of the CCG's local HWB Strategy Ensure that Health Implementation Group action plan and partners support the delivery of the CCG's local HWB Strategy		commissioning and implementation with regard to NHS CB direct commissioning responsibilities	the policy area such as access to housing and leisure
PH consultant and team with expertise in different policy areas	Provide specific PH advice on commissioning healthcare via the Nottingham Treatment Centre.	Lead commissioning and quality process Produce activity plans and contract management Apply contract levers	Lead commissioning and quality process Produce activity plans and contract management Apply contract levers	
Nottingham North and East CCG				
PH consultant and team with expertise in different policy areas	Provide specific PH advice on commissioning healthcare via County Health Partnerships	Lead commissioning and quality process Produce activity plans and contract management Apply contract levers	Lead commissioning and quality process for direct commissioning functions	
Nottingham West CCG				
PH consultant and team with expertise in different policy areas	Provide specific PH advice on commissioning healthcare via Nottingham University Hospitals	Lead commissioning and quality process Produce activity plans and contract management Apply contract levers	Lead commissioning and quality process for direct commissioning functions	

Mansfield and Ashfield and Newark and Sherwood CCGs				
PH consultant and team with expertise in different policy areas	Provide specific PH advice on commissioning healthcare via Sherwood Forest Hospitals and Nottinghamshire Healthcare Trust	Lead commissioning and quality process Produce activity plans and contract management Apply contract levers	Lead commissioning and quality process for direct commissioning functions	
Bassetlaw CCG				
PH consultant and team with expertise in different policy areas with liaison role with South Yorkshire Area Team	Deliver cross cutting community and neighbourhood work plans to address determinants of health and associated inequalities in Bassetlaw (e.g. troubled families, partnership plus, neighbourhood management) Produce and support plans for locality partnership for health work e.g. LSP, community safety (including local domestic violence programmes) Lead Bassetlaw Wellbeing at Work programme	Identify priority areas Amend commissioning intentions plans in line with findings	Commission services that support the policy area	
PH consultant and team with expertise in different policy areas with liaison role with South Yorkshire Area Team	Guidance and evidence based reports for effective interventions to reduce inequalities and impact positively on social determinants of health Cost effective and equitable provision of specialist public health advice to the South Yorkshire Area Team	Leadership and participation in the Health and Wellbeing Board and relevant local networks Commissioning plans adjusted to meet Lead Clinical Commissioning Networks need	Commission services that support the policy area	
DPH and PH team	Equity of PH service to Bassetlaw equivalent to that elsewhere in the County	Bimonthly performance oversight of the PH service through the Notts Group	Maintain direct links with Notts PH team	

Appendix 1

DISPUTE RESOLUTION PROCEDURE

1. NEGOTIATION

1.1 If any Dispute arises out of or in connection with this Memorandum of Understanding, the Parties shall attempt in good faith to negotiate a settlement within 30 Working Days of either party notifying the other of the dispute.

1.2 Initially the party who wishes to bring the dispute to the notice of the other will do so in writing, including a concise statement of the nature and substance of the dispute. The other party will respond to this in writing within 5 Working Days of receiving the notification of a potential dispute.

1.3 During the 15 Working Days following receipt of the response (the "Negotiation Period") each of the Parties shall negotiate in good faith and be represented:

1.3.1 for the first 10 Working Days, by a senior representative who where practicable has not had any direct day-to-day involvement in the matter that led to the Dispute and has authority to settle the Dispute; and

1.3.2 for the last 5 Working Days, by its chief executive, director, or board member who has authority to settle the Dispute,

Provided that no Party in Dispute where practicable shall be represented by the same individual under paragraphs 1.3.1 and 1.3.2.

2. MEDIATION

2.1 If the Parties are unable to settle the Dispute by negotiation, they must within 5 Working Days after the end of the Negotiation Period submit the Dispute to mediation by CEDR or other independent body or organisation agreed between the Parties.

2.2 The Parties will keep confidential and not use for any collateral or ulterior purpose all information, whether given orally, in writing or otherwise, arising out of or in connection with any mediation, including the fact of any settlement and its terms, save for the fact that the mediation is to take place or has taken place.

2.3 All information, whether oral, in writing or otherwise, arising out of or in connection with any mediation will be without prejudice, privileged and not admissible as evidence or disclosable in any current or subsequent litigation or other proceedings whatsoever.

3. EXPERT DETERMINATION

3.1 If the Parties are unable to settle the Dispute through mediation, then either Party may give written notice to the other Party within 10 Working Days of closure of the failed mediation of its intention to refer the Dispute to expert determination. The Expert Determination Notice must include a brief statement of the issue or issues which it is desired to refer, the expertise required in the expert, and the solution sought.

3.2 If the Parties have agreed upon the identity of an expert[i] and the expert has confirmed in writing his readiness and willingness to embark upon the expert determination, then that person shall be appointed as the Expert.

3.3 Where the Parties have not agreed upon an expert, or where that person has not confirmed his willingness to act, then either Party may apply to CEDR for the appointment of an expert. The request must be in writing, accompanied by a copy of the Expert Determination Notice and the appropriate fee and must be copied simultaneously to the other Party. The other Party may make representations to CEDR regarding the expertise required in the expert. The person nominated by CEDR will be appointed as the Expert.

3.4 The Party serving the Expert Determination Notice must send to the Expert and to the other Party within 5 Working Days of the appointment of the Expert a statement of its case including a copy of the Expert Determination Notice, the Memorandum of Understanding, details of the circumstances giving rise to the Dispute, the reasons why it is entitled to the solution sought, and the evidence upon which it relies. The statement of case must be confined to the issues raised in the Expert Determination Notice.

3.5 The Party not serving the Expert Determination Notice must reply to the Expert and the other Party within 5 Working Days of receiving the statement of case, giving details of what is agreed and what is disputed in the statement of case and the reasons why.

3.6 The Expert must produce a written decision with reasons within 30 Working Days of receipt of the statement of case referred to in paragraph 1.9, or any longer period as is agreed by the Parties after the Dispute has been referred.

3.7 The Expert will have complete discretion as to how to conduct the expert determination, and will establish the procedure and timetable.

3.8 The Parties must comply with any request or direction of the Expert in relation to the expert determination.

3.9 The Expert must decide the matters set out in the Expert Determination Notice, together with any other matters which the Parties and the Expert agree are within the scope of the expert determination. The Expert must send his decision in writing simultaneously to the Parties. Within 5 Working Days following the date of the decision the Parties must provide the Expert and each other with any requests to correct minor clerical errors or ambiguities in the decision. The Expert must correct any minor clerical errors or ambiguities at his discretion within a further 5 working Days and send any revised decision simultaneously to the Parties.

3.10 The Parties must bear their own costs and expenses incurred in the expert determination and are jointly liable for the costs of the Expert.

3.11 The decision of the Expert is final and binding, except in the case of fraud, collusion, bias, or material breach of instructions on the part of the Expert at which point a Party will be permitted to apply to Court for an Order that:

3.11.1 the Expert reconsider his decision (either all of it or part of it); or

3.11.2 the Expert's decision be set aside (either all of it or part of it).

3.12 If a Party does not abide by the Expert's decision the other Party may apply to Court to enforce it.

3.13 All information, whether oral, in writing or otherwise, arising out of or in connection with the expert determination will be inadmissible as evidence in any current or subsequent litigation or other proceedings whatsoever, with the exception of any information which would in any event have been admissible or disclosable in any such proceedings.

3.14 The Expert is not liable for anything done or omitted in the discharge or purported discharge of his functions, except in the case of fraud or bad faith, collusion, bias, or material breach of instructions on the part of the Expert.

3.15 The Expert is appointed to determine the Dispute or Disputes between the Parties and his decision may not be relied upon by third parties, to whom he shall have no duty of care.

[i] An 'expert' can be a Director of Public Health from another Local Authority or the Regional Director of Public Health

Nottinghamshire County Council

Report to the Public Health Subcommittee

16 April 2013

Agenda Item: 9

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH DEPARTMENTAL STRUCUTRE

Purpose of the Report

1. This report provides information on the current staffing structure within Nottinghamshire County Public Health.

Information and Advice

2. Before April 2013, Public Health was the responsibility of NHS Primary Care Trusts. Within Nottinghamshire, the larger Public Health function was held within Nottinghamshire County PCT, and a small team was also employed by Bassetlaw PCT. From 1 April 2013, Public Health becomes a statutory function of the County Council, and the two teams will merge to form the new Public Health department within the Council.

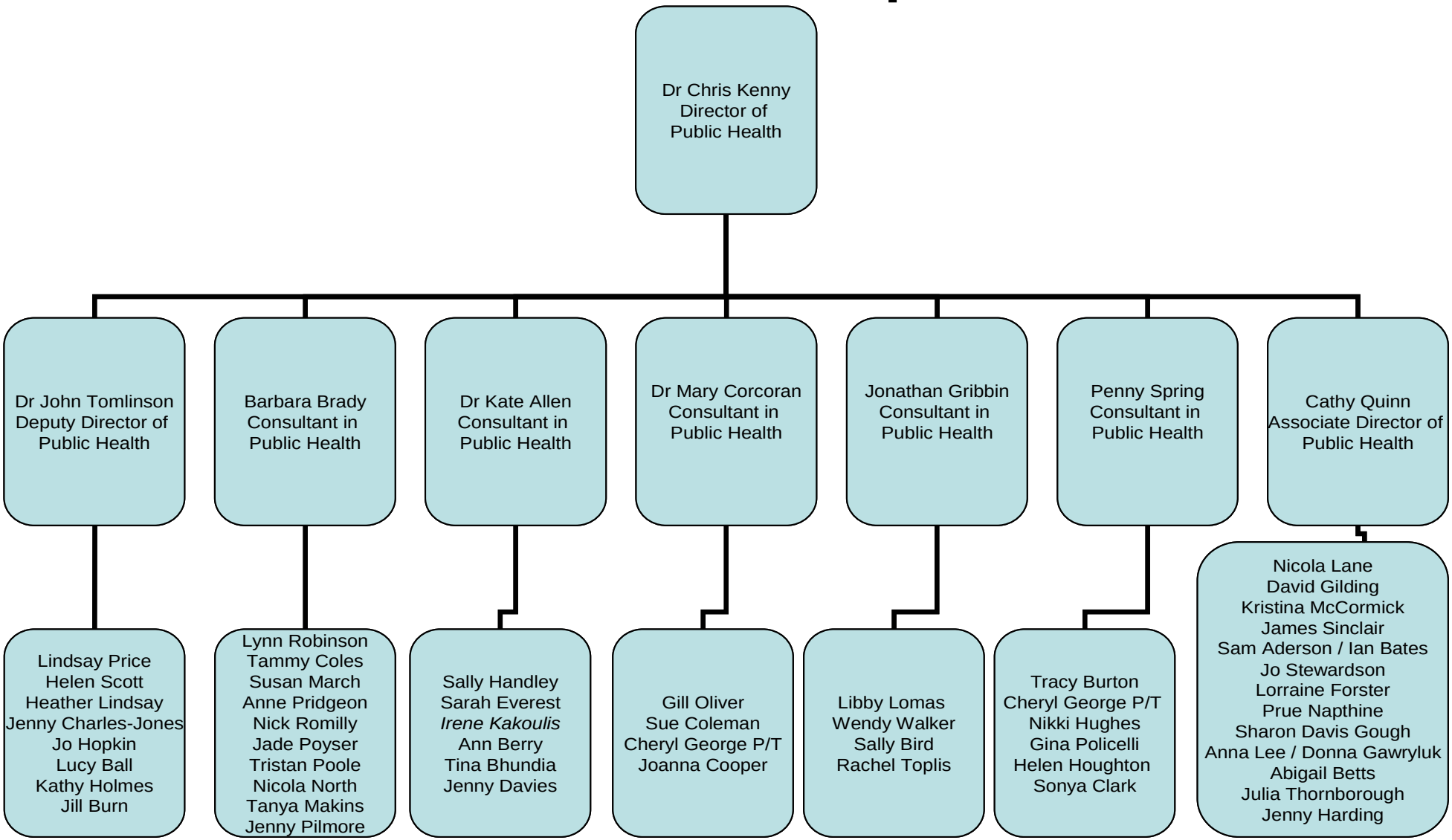
3. At the last meeting, the Public Health Subcommittee members asked for further information on the structure of Public Health department within the Council. A high level structure is illustrated in **Figure One**, along with a full description of teams and functions in **Appendix One.** (NB: Appendix One includes both Nottinghamshire County and Nottingham City departments and is correct as for 1 February, but is currently being reviewed for April onwards.)

4. The Department is accountable to Dr Chris Kenny, Director of Public Health, who in turn, is accountable to the Chief Executive. Dr Kenny provides overall leadership of both County and City Public Health departments and management of all senior staff. He is also a member of Corporate Leadership Teams of Nottinghamshire County Council and Nottingham City Council, and has overall responsibility for ensuring Public Health leadership, input and support for all Clinical Commissioning Groups across Nottinghamshire and Nottingham City.

5. The senior management team within Nottinghamshire County Council includes six Consultants in Public Health (including the Deputy Director of Public Health) and one Associate Director of Public Health.

Figure One

Public Health Department



6. Each member of the senior team has a range of staff that report to them providing support to their areas of work. The department consists of:
    - 11 Senior Public Health Managers
    - 23 Public Health Managers
    - 5 Public Health Information Analysts
    - 1 Reablement Evaluation Officer
    - 2 Infection Control matrons
    - 1 Public Health assistant
    - 9 Administrative staff

7. The Public Health workforce have specialist training and experience to undertake intelligent commissioning of Public Health services which improve health and wellbeing and reduce health inequalities across local communities. The department performs this role through using Public Health and scientific skills to:

    - Identify the level of Public Health needs within local communities
    - Analyse evidence to define the services and interventions that are known to work;
    - Compare cost effectiveness (or value for money) of a range of interventions;
    - Set service quality standards based on evidence
    - Define, monitor and analyse Public Health information and outcomes, comparing these with neighbouring areas.
    - Improve collaboration and integration across health, social care and third sector organisations.

8. The Public Health department also holds a training responsibility, in conjunction with the Public Health departments across Nottinghamshire, Derbyshire and Leicestershire Northamptonshire and Lincolnshire. This role includes the mentoring of Public Health speciality registrars and Foundation Year Two doctors. These members of staff are not employed by the Council but undertake a placement within the Public Health department.

Statutory and Policy Implications

9. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service 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) The Public Health Sub-Committee are asked to note the information provided on the Public Health Department.

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact:
Cathy Quinn, Associate Director of Public Health

Constitutional Comments (NAB 28.03.13)

10. Public Health Sub-Committee has authority to consider the matter set out in this report by virtue of its terms of reference.

Financial Comments (ZM 28.03.13)

11. There are no financial implications arising directly from this report.

Background Papers

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.

Public Health Business Plan 2012-13 revised July 2012.

Electoral Division(s) and Member(s) Affected

All

New PH function for Nottinghamshire County and Nottingham City - Areas of responsibilities as at 1 February 2013

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
DPH *Consultant scale or VSM* **CHRIS KENNY**	Overall leadership of both County and City PH departments and management of all staff Member of NHS Notts County Nottm City Cluster Board until Mar 2013 Member of Corporate Leadership Teams of Notts County Council and Nottm City Council	Health and wellbeing Boards x2 Strategic link with all District Councils Safer Nottinghamshire Board	Overall responsibility for ensuring PH leadership, input and support for all Clinical Commissioning Groups across Nottinghamshire and Nottingham City	*Public Health leadership* for Clinical Commissioning Groups and local authorities *Health Outcomes* ensuring all health outcomes are achieved via a Health and Wellbeing Strategies *Advocacy* - Principal source of PH advice to LAs, officers and elected members, Health and Wellbeing Boards *Health Intelligence* - Public Health Reports, JSNA, *Population Healthcare* – support for NHS commissioning via CCGs *Health Protection* including health emergency preparedness *Health Improvement* including a focus on locality health, and reducing health inequalities *Workforce development*	**Consultants** John Tomlinson Barbara Brady Mary Corcoran Kate Allen Jonathan Gribbin Penny Spring Peter Cansfield Ian Bowns (until March 2013) Alison Challenger Lynne McNiven (from Feb 2013) Mary Orhewere (covering Jo Copping on maternity leave from Dec 2012) Caroline Hird (until Mar 2013) **Associate Directors** Tracy Madge Cathy Quinn Andrew Hall (until Mar 2013)

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Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH (also Deputy DPH county) *Consultant scale or Band 8d* **JOHN TOMLINSON**	General Consultant Notts County Regional Lead for PH professional appraisal system	Principal PH link with Adult Social Care within Notts County Council	PH leadership and support for Nottingham West and Nottingham North and East CCGs PH support for Quality panel for County Health Partnerships	LTCs - CHD, Diabetes (diabetic retinopathy screening, health checks), Renal and COPD End of life care PH information (including JSNA, Link with HIS, EMPHO, Dr Foster and other info sources) Tobacco control AAACM, life expectancy AAA screening Sustainability	Lindsay Price (8b) Helen Scott (8a) Heather Lindsay (7) Jenny Charles-Jones (7) Jo Hopkin (7) Lucy Ball (6) Kathy Holmes (6) Jill Burn (5) Helen Ross (7) (joint sustainability role across city and county) ***Leonie Race (SpR) currently on maternity leave*** ***Rachel Cloke (SpR)***

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Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **BARBARA BRADY**	General Consultant Notts County Training Network coordinator Notts County / Nottm City	Principal link with Policy and Performance (including community safety) section of Notts County Council	PH leadership and support for Mansfield and Ashfield CCG PH Support for Quality panel with SFHT / Notts HC Trust (with KA) PH mental health link with N+S CCG as lead commissioner	Obesity / diet / physical activity (adult and children), community nutrition Oral Health, including dental public health services Fluoridation LA role Mental Health / LD (adults and older people but not CAMHS); public mental health services All aspects of substance misuse (including former DAAT role); offender health, prison health, violence prevention (including Domestic violence), promotion of community safety	Lynn Robinson (8a) Tammy Coles (8a) Susan March (8a) Anne Pridgeon (8a) Nick Romilly (7) Jade Poyser (7) Tristan Poole (6) Nicola North (6) Tanya Makins (5) Jenny Pilmore (5) *Adrian Pearson on secondment from Notts Police until mid 2013*

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **PENNY SPRING**	General Consultant Notts County Principal link to NHS Bassetlaw (until Mar 2013) Member of NHS Senior Management Team in Bassetlaw Currently supported by 5 staff all of whom are employed by NHS Bassetlaw	Locality support for Bassetlaw DC	PH leadership and support for Bassetlaw CCG	Accidental injury prevention Vaccination and Immunisation programmes (including childhood V+I, seasonal flu, pneumococcal, HPV) PH audit Sexual Health (including sexual health services, GUM, chlamydia testing, HIV, teenage pregnancy, SARC, TOP) *county north only*	Tracy Burton (8b) Nikki Hughes (7) Iolanda Shaker (7) until Mar 2013 Gina Policelli (6) (Plus BPCT staff Cheryl George P/T (8a) Helen Houghton (7) Sonya Clark (6) *mat leave* Jenny Harding (3)) ***Ruth Bunting (SpR)***

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **JONATHAN GRIBBIN**	General Consultant Notts County	Principal link to Emergency planning section of Notts County Council and Nottm City Council	PH leadership and support for Rushcliffe CCG PH support for Quality panel for NUH	PH input into NHS financial assurance, including planned care and non elective care Programme budgeting Integrated Pollution Prevention and Control Health Protection, including management of incidents and emergencies Community Infection control including TB strategy, Blood borne viruses Health Emergency Planning Pandemic Flu	Libby Lomas (7) Debbie Brown (7) until Mar 2013 Rachel Toplis (4) Wendy Walker (7) Sally Bird (7) ***(Iain Little SpR)*** Carrie Jordan (8b) until Mar 2013 Elaine Cathcart until Mar 2013 Jackie Thom until Mar 2013 Rosalind Woods until Mar 2013
Consultant in Health Protection (currently employed by HPA) *VANESSA MACGREGOR*	*Consultant focused on health protection*	*Health protection*	*All*	*TBC following on from agreement about how the HPA functions will be discharged at local level*	*Unknown*

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Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **KATE ALLEN**	General Consultant Notts County *Screening programmes work also covers Nottm City* Chair Regional Cancer QA committee	Principal link to the Children Families and Cultural services section of Notts County Council	PH leadership and support for Newark and Sherwood CCG PH Support for Quality panel with SFHT / Notts HC Trust (with BB)	Children and Young People (including CAMHS); Maternity <not screening>, Healthy schools, Disabled children, Breast feeding, health visitors, safeguarding children, Maternal and childhood Screening programmes (including antenatal and neonatal screening eg neonatal hearing, Down's, Childhood screening programmes) Prevention of birth defects Cancer screening (of Cervix, Breast, Bowel)	Sally Handley (8b) Clare Probert (8a) until Mar 2013 Irene Kakoulis (50:50 funding from PH and NCC) Sarah Everest (8a) – now funded 50:50 by PH and NCC Ann Berry (7) Tina Bhundia (6) Jenny Davies (6) *fixed term until 31 March 2013* ***(David Pearce SpR)***

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **MARY CORCORAN**	General Consultant Notts County Faculty Advisor / Foundation Programme Director	Principal link with the Adult Social Care section of Notts County Council	Support for all CCGs via implementation of policy work	Older People (including Stroke, osteoporosis, falls); excluding functional MH, but including Dementia; seasonal mortality NSF Long Term Neurological Conditions, including physical disability and sensory impairment Continuing Care Cancer policy; prevention and early diagnosis (city and county) EMSCG PH support for regional Cardiovascular Network PH Support for IFR team	Gill Oliver (8a) Yesmean Khalil (8a) for city cancer lead role Sue Coleman (7) *Cheryl George P/T BPCT (8a)* Joanna Cooper (7) fixed term until mid 2013 (TBC) ***(Samia Latif SpR)*** ***(Mandeep Grewal FY2)***

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Associate Director of PH *Band 8d* **CATHY QUINN**	Responsibility for the overall Health and wellbeing agenda within Notts County on behalf of DPH	All – coordination of approach to all outcomes; monitoring of progress Health and Wellbeing Board Implementation Group	CCG role on H+WB Board	Health and Wellbeing (including the Board, the strategy and a coordinating role for NHS and PH outcomes) PH Transition and Business Plan (including PH resources, MOU between PH and the CCGs, PH development, PH communication) PH business management (CMO cascades, PH standards, PH part of Assurance framework, PH Risk Register) NICE Guidance – coordination of PH implementation PH support for Medicines Management agenda (APC, PNA) Management of PH Analysis team and all admin staff	Sarah Godber (8a) Nicola Lane (7) David Gilding (8a) Kristina McCormick (7) James Sinclair (6) Sam Aderson (6) Ian Bates (6) Jo Stewardson (5) Lorraine Forster (4) Prue Napthine (4) Sharon Davis Gough (4) Anna Lee (3) Donna Gawryluk (3) Abigail Betts (3) Julia Thornborough (3) Main link to Procurement officers (x2) within NCC funded by PH

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Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Associate Director of PH *Band 8d* **TRACY MADGE**	Support for DPH Notts County	Transition	None specific	Workplace Health Transition of PH contracts from PCT to LA MOU with CCGs	

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **PETER CANSFIELD**	General Consultant Nottm City	Principal PH link with Community Safety section of Nottm City Council	PH leadership and support for Nottingham City CCG on all relevant policy areas	Mental Health / LD (adults and older people but not CAMHS); public mental health services All aspects of substance misuse; offender health, prison health, violence prevention (including Domestic violence), promotion of community safety PH information (including JSNA, Link with NHIS datawarehouse, EMPHIN, eHealthscope, Nottingham Insight and other info sources) IFR panel Knowledge and Resources PH audit CCG Clinical Executive committee Research and Evaluation	Jean Robinson 8b Kate Fletcher 6 David Millington 4 Zoe Turner 5 Dale Burton 6 Des Conway 8a Mandy Tidswell 5 Yvonne Finnegan 4 Amy Pellow 4 Gill Clark 4 Matthew Ramsey 3 *Rachel Illingworth 8a (transferred to CCG from Jan 2013 but key PH research link)* Louise Noon 7 Liz Pierce 7 Lisa Hoole 7 Stephen Willott GP staff grade Mike ONeill GP staff grade ***Mandy Clarkson SpR***

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **ALISON CHALLENGER**	General Consultant Nottm City	Principal PH link with H+WB Board within Nottm City Council	PH leadership and support for Nottingham City CCG corporately MOU with CCG	Health and Wellbeing (strategy, board) from April 2013 Sexual Health (including sexual health services, GUM, chlamydia testing, HIV, teenage pregnancy, SARC, TOP) *city plus county south* Accidental injury prevention Tobacco Health promotion contract with Citicare and other providers CCG Governing Body and principal link with CCG (routine deputy for DPH)	Dara Coppel 8a (on secondment until Nov 2013) John Wilcox 7 Rachel Doherty 7 Lisa Ryan 6 (until Mar 2013) Carl Neal 7 Sarah Quilty 7 (from April 2013) Ellyn Dryden 5 Sarah Bolstridge 5 Robin Smith 6 (until mid 2013 TBC) Andrew Turner 7 (until Mar 2013) Helen Robinson 4 Michelle Ball 4 Hayley Benosman 4 (until Mar 2013) Gwendoline Williams 4 (until Mar 2013) Ana-Ruth Soloman 4 (until Mar 2013) Krystyna Campbell 3 Jemma Hancock 3 (until Mar 2013) ***Kiran Loi (SpR)***

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Consultant in PH *Consultant scale or Band 8d* **CAROLINE HIRD (until Mar 2013)** **LYNN McNIVEN (from Feb 2013)**	General Consultant Nottm City	Principal link with childrens section of Nottm City Council	PH leadership and support for Nottingham City CCG with relevant policy areas	Children and Young People (including CAMHS); Maternity <not screening>, Healthy schools, Disabled children, Breast feeding, health visitors, school nurses, safeguarding children, Prevention of birth defects Obesity / diet / physical activity (adult and children), community nutrition Oral Health, including dental public health services Fluoridation LA role	Sarah Diggle 7 Helen Ross 7 Jennifer Burton 7 Paul Dodsley 6 Judy Bullimore 6 Uzmah Bhatti 6 Robert Stephens 5 Anne Kelleher 5 Samira Riaz 6 (until Mar 2013) ***Michael Dunlop (sports medicine SpR)*** ***Yee Song Lee (FY2)***
Consultant in PH *Consultant scale or Band 8d* **MARY OHEWERE (from Dec 2012 covering Jo Copping Maternity leave)**	General Consultant Nottm City	Principal link with adults section of Nottm City Council	PH leadership and support for Nottingham City CCG with relevant policy areas	LTCs - CHD, Diabetes (health checks), Renal and COPD End of life care Older People (including Stroke, osteoporosis, falls); excluding functional MH, but including Dementia; seasonal mortality NSF Long Term Neurological Conditions, including physical disability and sensory impairment	

Member of Staff	General role	LA role	Named CCG link role	Health policy areas / Commissioning role	Senior Manager support / Admin (Underlined names are City PCT employees)
Associate Director of PH *Band 8d* **ANDREW HALL (until Mar 2013)**	Responsibility for the overall transition of the PH function from the PCT to the LA	Principal link between PH and all aspects of the LA in relation to transition	None	PH Transition and Business Plan (including PH resources, and movement of all contracts from the PCT to the LA) PH grant, including integrating financial systems into the LA Health promotion review, including reinvigorating and relaunching Decade for Better Health Health and Wellbeing Board (set up and work programme) Workplace health Migrant health	Yesmean Khalil 8a Nathan Wilkins 5 (until Mar 2013) Anne Cunningham 7 (until Mar 2013)

Chris Kenny
Director of Public Health
Nottinghamshire County and Nottingham City
Feb 2013

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Nottinghamshire County Council

Report to the Public Health Sub Committee

16 April 2013

Agenda Item: 10

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

SECTION 75 ARRANGEMENTS FOR PUBLIC HEALTH SERVICES

Purpose of the Report

1. To seek approval from the Public Health Subcommittee to enter into Section 75 agreements for Public Health services with the Clinical Commissioning Groups in Nottinghamshire and the new Nottinghamshire and Derbyshire NHS Commissioning Board Area Team.

Information and Advice

2. Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 of the NHS Act 2006) to exercise certain local authority functions and for local authorities to exercise various NHS functions. Section 75 gives NHS bodies and local authorities the flexibility to be able to improve services, either by joining up existing services, or by developing new, coordinated services. These flexibilities can be broadly categorised as:

   - lead *commissioning* for both health and social care
   - lead *provision* of an integrated health/social care service
   - *pooled* funding

3. The Audit Commission recommend that separate S75 arrangements are established for commissioning and provision in order to ensure a clear separation of the decision-making for both functions.

4. A S75 Partnership Agreement is a legal, contractual agreement between two parties. In entering into a S75 Partnership agreement, both parties continue to remain legally accountable for its statutory functions. However, the S75 agreement allows one party to delegate delivery of these functions to the other on a day-to-day basis. Integrating provision and commissioning remains a priority for both the NHS and Local Authority to improve outcomes for patients by joining up services, reducing duplication and making efficiencies by pooling funds and commissioning to a shared strategic plan.

5. The Health & Social Care Act 2012 directs Health & Wellbeing Boards to encourage health and social care services to work in an integrated manner and utilise Section 75 agreements.

6. In accordance with Regulations made under the National Health Services Act 2006, the section 75 agreement must be in writing and specify:

   - The agreed aims and outcomes of the arrangements
   - The payments to be made by the NHS bodies to the local authorities
   - How those payments may be varied
   - The NHS functions and the health-related functions which are the subject of the arrangements
   - The persons and the kinds of services likely to be affected by the functions.
   - The staff, goods, services or accommodation to be provided by the partners in connection with the arrangements.
   - The duration of the arrangements and provision for the review or variation or termination of the arrangements.
   - The arrangements in place for monitoring the exercise by the local authorities of the functions.

7. Public Health is reviewing the commissioning of services in light of the transfer to Nottinghamshire County Council and has identified several areas where section 75 agreements offer advantages to commissioning Public Health services. These may include school nursing, community nutrition, prisons, dental epidemiology and fluoridation.

8. The Public Health Sub-Committee is asked to support the establishment of section 75 agreements where they will help to streamline or improve commissioning of services and delegate the authority to approve the agreements to the Director of Public Health in consultation with the Deputy Leader of the County Council (and Chair of the Public Health Subcommittee).

Statutory and Policy Implications

RECOMMENDATION/S

1. To Approve the entering into S75 agreements for Public Health services with the Clinical Commissioning Groups and the NHS Commissioning Board from 1 April 2013.

2. To delegate authority to the Director of Public Health in consultation with the Deputy Leader of the Council to approve the necessary details to execute this agreement in line with the relevant regulations.

3. To authorise the Group Manager Legal Services to enter into any and all necessary documentation to give effect to the recommendations set out above.

DR CHRIS KENNY
DIRECTOR OF PUBLIC HEALTH

Financial Comments (ZKM 03.04.13)

The financial implications are contained within paragraphs 4 to 8 of this report.

Constitutional Comments (NAB 03.04.13)

Public Health Sub-Committee has authority to approve the recommendation set out in this report by virtue of its terms of reference.

Background Papers

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 Division(s) and Member(s) Affected

All.