Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 04 February 2015 at 14:00

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) 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.

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

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 3 December 2014 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Joyce Bosnjak (Chair)
Reg Adair
Stan Heptinstall MBE
Liz Plant
Martin Suthers OBE

DISTRICT COUNCILLORS

	Jim Aspinall	-	Ashfield District Council
A	Simon Greaves	-	Bassetlaw District Council
	Jacky Williams	-	Broxtowe Borough Council
	Henry Wheeler	-	Gedling Borough Council
	Debbie Mason	-	Rushcliffe Borough Council
A	Tony Roberts MBE	-	Newark and Sherwood District Council
A	Phil Shields	-	Mansfield District Council

OFFICERS

A	David Pearson	-	Corporate Director, Adult Social Care, Health and Public Protection
A	Anthony May	-	Corporate Director, Children, Families and Cultural Services
	Dr Chris Kenny	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group
A	Dr Steve Kell OBE	-	Bassetlaw Clinical Commissioning Group (Vice-Chairman)
	Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
A	Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
	Dr Paul Oliver	-	Nottingham North & East Clinical Commissioning Group
	Dr Judy Underwood	-	Mansfield and Ashfield Clinical Commissioning Group

LOCAL HEALTHWATCH

	Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

A	Helen Pledger	-	Nottinghamshire/Derbyshire Area Team, NHS England

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Chris Cutland	-	Deputy Police and Crime Commissioner

SUBSTITUTE MEMBERS IN ATTENDANCE

Dr Kelvin Lim	-	Nottingham West CCG
Tracy Madge	-	NHS England
Jon Wilson	-	Adult Social Care and Health Department
Councillor Griff Wynne	-	Bassetlaw District Council

OFFICERS IN ATTENDANCE

Kate Allen	-	Public Health
Barbara Brady	-	Public Health
Lucy Dadge	-	Mansfield and Ashfield CCG
Paul Davies	-	Democratic Services
Gary Eves	-	Public Health
Chris Few	-	Chair of Nottinghamshire Safeguarding Children Board
Sarah Fleming	-	Mansfield and Ashfield CCG
Karon Glynn	-	Newark and Sherwood CCG
Nicola Lane	-	Public Health
Susan March	-	Public Health
Kim Molloy	-	Nottinghamshire Police
Cathy Quinn	-	Public Health

MINUTES

The minutes of the last meeting held on 1 October 2014 having been previously circulated were confirmed and signed by the Chair.

MEMBERSHIP

Councillors Reg Adair and Liz Plant had been appointed to the Board in place of Councillors Kay Cutts and Muriel Weisz, for this meeting only.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Simon Greaves, Dr Steve Kell, Dr Guy Mansford, Anthony May, David Pearson, Helen Pledger and Councillor Tony Roberts.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2013/14

Chris Few, Chair of the Nottinghamshire Safeguarding Children Board (NSCB) presented the Board's annual report for 2013/14. He drew attention to the key points in the report, and highlighted the main challenges for agencies and partners, which included breaking cycles of behaviour; the time it would take to implement changes to CAMHS; the impact on children and young people of people with mental health or substance misuse problems; and the impact of child sexual exploitation on children and young people and into adulthood.

He was asked how the Board could help NSCB to secure children's safety. In relation to parents with mental health difficulties, he suggested that agencies working with such adults should check whether they had children, and then explore how services could be targeted. There was praise for the multi-agency safeguarding hub (MASH), but some concern expressed about coordination between agencies.

RESOLVED: 2014/048

That the Nottinghamshire Safeguarding Children's Board Annual Report 2013/14 be noted.

MENTAL HEALTH ISSUES

OVERVIEW OF CHIEF MEDICAL OFFICER'S ANNUAL REPORT 2013 – PUBLIC MENTAL HEALTH PRIORITIES: INVESTING IN THE EVIDENCE

Chris Kenny introduced a summary of the Chief Medical Officer's annual report, which had focussed on mental health. The report also proposed actions under the local Mental Health Framework for Action to respond to the CMO's recommendations.

During discussion, Board members referred to the need to share good practice, examples of which were the Recovery College at Duncan Macmillan House, and a project in Bassetlaw for people with post-traumatic stress disorder. There was recognition of the valuable contribution by voluntary sector organisations, and the pressure on them from changes in funding.

It was pointed out that Nottinghamshire was in the lowest quartile for people with mental health difficulties being in employment. This was probably due to incomplete reporting, and the Board was urged to encourage improved reporting.

RESOLVED: 2014/049

1) That the actions proposed in the report be endorsed to align the No Health without Mental Health: Nottinghamshire's Mental Health Framework for Action 2014-17 with the CMO's report.

2) That organisations be encouraged to improve the recording of people with mental health difficulties who are in employment.

NOTTINGHAMSHIRE CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) PATHWAY REVIEW UPDATE

Kate Allen and Gary Eves introduced the review of the CAMHS pathway and recommendations for a new service model. Overall spending on CAMHS reflected the national picture, although there were variations between the CCGs. Proposals included merging Tier 2 and 3 services, and extending contracts for three years to enable implementation and evaluation of the new model.

Board members referred to the need for effective Tier 1 services which would reduce the demand for Tiers 2 and 3. They also saw value in providing services in schools (primary as well as secondary) and through social media. More responsive services would be welcomed, as would a family-centred approach. They asked for assurance that risks to young people would be minimised during implementation. There was some disappointment that City and County CAMHS services would differ.

RESOLVED: 2014/050

1) That the findings from the review of the Nottinghamshire CAMHS pathway, the resulting recommendations and expected benefits of the proposed new CAMHS model be noted.
2) That the next steps required or approval and implementation of the proposed CAMHS model be noted.
3) That a future report be requested on the work planned and underway to promote mental resilience and prevent mental health problems in children and young people in Nottinghamshire.
4) That the proposal to hold a Nottinghamshire CAMHS summit early in 2015 be supported, to develop a co-ordinated response to the recommendations of the House of Commons Health Committee report, *Children and Adolescents' Mental Health and CAMHS.*

MENTAL HEALTH CRISIS CARE CONCORDAT

Mark Jefford, Karon Glynn and Chief Insp Kim Molloy introduced the report on the national Mental Health Crisis Concordat, and the work by agencies in Nottinghamshire to improve mental health crisis care. An action plan was being prepared to reduce the use of police custody suites and improve support to people experiencing a mental health crisis.

Board members queried the impact of ward closures at the Queen's Medical Centre, and asked for a progress report on the Nottinghamshire response to the Concordat in due course.

RESOLVED: 2014/051

That the report be noted, and the next steps for the development and implementation of the local Crisis Concordat action plan be endorsed.

DELIVERY OF THE HEALTH AND WELLBEING STRATEGY

Cathy Quinn introduced the report on the Health and Wellbeing Board delivery plan, which was being overseen by the Implementation Group. The integrated commissioning groups were preparing more detailed actions. The report summarised progress on implementation of the strategy. As discussed at previous meetings, each Board members had been nominated to sponsor one of the Strategy's priorities. There was also discussion about relationships between the Board and district councils' bodies responsible for health and wellbeing.

RESOLVED: 2014/052

1) That the leads for each Health and Wellbeing Strategy priority area be approved as set out in Appendix 1 to the report.
2) That the progress made in delivering the Health and Wellbeing Strategy be noted.
3) That the Board receive an exception report in February 2015.

BETTER CARE FUND GOVERNANCE STRUCTURE AND POOLED BUDGET

Sarah Fleming and Lucy Dadge introduced the report which proposed creating a Better Care Fund Programme Board to replace the existing BCF Working Group. The Programme Board would have oversight of delivery of the BCF plans, and be responsible for operation of the pooled budget, which would be hosted by the County Council.

Board members saw value in gaining a better understanding of the mechanisms for the pooled budget and BCF outcomes. Reference was made to concerns elsewhere about the implications of the BCF for secondary care. The Board was assured that the integration of health and social care would continue to grow, with the BCF as a catalyst, while reflecting local circumstances. It was pointed out that providers were represented on the Programme Board.

RESOLVED: 2014/053

1) That the Better Care Fund Programme Board be established as a formal sub-group of the Health and Wellbeing Board in place of the BCF Working Group, with the same membership as the Working Group, subject to the Programme Board's terms of reference being approved by the Health and Wellbeing Board in February 2015.
2) That the plans to establish a pooled budget hosted by Nottinghamshire County Council be approved in principle, subject to further work on the Section 75 agreement.

CHAIR'S REPORT

The report summarised a number of developments nationally and locally relating to health and wellbeing. Tracy Madge referred to the forthcoming restructuring of NHS England as a possible future item for the report.

RESOLVED: 2014/054

That the report be noted.

WORK PROGRAMME

RESOLVED: 2014/055

That the work programme be noted.

The meeting closed at 4.45 pm.

CHAIR

Nottinghamshire County Council

Report to the Health and Wellbeing Board

4 February 2015

Agenda Item: 4

REPORT OF THE CLINICAL LEAD, NHS BASSETLAW CLINICAL COMMISSIONING GROUP

THE NHS FIVE YEAR FORWARD VIEW

Purpose of the Report

1. To provide Board members with an overview of the NHS Five Year Forward View which sets out how the health services needs to change, a vision of a better NHS and the steps which will be required to achieve this vision.

Summary

- The NHS Five Year Forward View sets a clear direction for the NHS.
- There is a focus on prevention and public health by national campaigns to target obesity, smoking and alcohol consumption as well as workplace health initiatives.
- Patients will get greater control over their own care, including the option for shared health and social care budgets.
- The NHS will take steps to break down barriers between primary and hospital care, mental and physical health and between health and social care.
- New models of care will be available offering the opportunity for GPs to work together to provide integrated out of hospital care, possibly taking control of the NHS budget or for opportunities for primary and acute care systems which will provide integrated hospital and primary care.
- To allow these new models of care to be implemented, commissioning arrangements for primary care will change.
- To enable the changes, the NHS will provide national leadership to effect local change, allow innovation, support a modern workforce and exploit developments in information technology.
- The NHS can be maintained and developed but only by improving efficiency within the NHS and working with other national and local partners.

Information and Advice

2. At the end of October 2014 NHS England published its Five Year Forward View which has been developed jointly with Monitor, the CQC, Health Education England, Public Health England and the Trust Development Agency.

3. The Five Year Forward View sets out how the health service needs to change, a vision of a better NHS and the steps required to deliver that vision.

4. The document sets out the case for change identifying three key issues:

   - The health & wellbeing gap addressing health inequalities
   - The care & quality gap addressing variations in care & outcomes
   - The funding & efficiency gap to match reasonable funding levels with system efficiencies

5. The Forward View aims to dissolve the classic divide within health & social care, physical & mental health & between prevention & treatment.

6. Chapter Two of the Forward View offers a new relationship with patients & communities & a focus on prevention, particularly in tackling obesity, smoking and harmful drinking, through hard-hitting & broad based national action as well as through local democratic leadership on public health.

7. It also commits to support new workplace incentive to promote employee health and cut sickness related unemployment and advocate for stronger public health powers for local government.

8. People will also be better supported to manage their own health, to stay healthy and make informed choices about treatment, managing conditions & to avoid complications.

9. Chapter 3 of the Forward View outlines a number of significant changes to future models of locally determined integrated care.

10. The Forward View recognises that one size will not fit all across areas of England but also that is cannot 'let a thousand flowers bloom'. A number of models are proposed which local communities will have the option of implementing locally. These models are described below.

11. **Multispecialty Community providers (MCPs)** would allow a group of GP practices to develop & manage a full range of community services, potentially including employing consultants to develop specialist services. This could also be extended to elements of social care and possibly the management of community hospitals. In time this could also extend to delegated responsibility for managing the health service budget for their registered patients. In this model CCGs would act as commissioner and provider of primary and community services.

12. **Primary and acute care systems (PACS)** would allow vertical integration, enabling acute trusts in some areas to open GP and community services and reinforcing out-of-hospital community based care. At its most radical PACS would take responsibility for the whole health needs of a registered list of patients, under a delegated capitated budget.

13. **Urgent and emergency care networks** would ensure patients get the right care, at the right time, in the right place. This could involve evening & weekend access to GPs or nurses working from community bases equipped to provide a greater range of tests & treatments as well as empowering ambulance services and better utilisation of community pharmacy. Networks of linked hospitals would provide specialist emergency centres & mental health crisis services would be funded & integrated.

14. A model for **viable smaller hospitals** is also proposed, recognising the issues around funding, staffing and management to maintain smaller acute hospitals.

15. The Forward View recognises a model for **specialised care**, for example to provide world class facilities for cancer surgery and radiotherapy while chemotherapy, support and follow up could be offered in local facilities.

16. The document also proposes a model for **modern maternity services** to provide women with more choice, including midwife led facilities.

17. The Forward View also recognises the need for **enhanced health in care homes**. It suggests that the NHS will work in partnership with local authorities and the care homes sector to develop new shared models of in-reach support to include medical reviews, medication reviews and rehabilitation services.

18. It is proposed that the NHS will work with local communities and leaders to identify the changes required in local and national organisations to work together. It would enable a joint approach to developing detailed prototyping of each model, a shared method of assessing local need to inform the preferred local model and there will also be national and regional support to implement changes in care model rapidly and at scale.

19. Following the publication of the 'NHS Five Year Forward View', NHS England also published 'Next Steps towards primary care co-commissioning'. The proposed models of care within the Forward View will require a change to the commissioning arrangements for primary care.

20. There are a number of options described in 'Next Steps' to primary care co-commissioning:

- Greater involvement of CCGs in decision making
- Joint commissioning arrangements for primary care between CCGs and Area Teams
- Delegated primary commissioning arrangements to CCGs

21. These options have previously been presented but 'Next Steps' has significant differences in simplifying the approvals process for joint or delegated co-commissioning, limiting controls for Area Teams over delegated commissioning and more practical assistance for CCGs in issues such as governance.

22. The options for co-commissioning would include general practice services including contractual GP performance management, budget management and complaints management but it would not include any functions relating to individual GP performance. It would include an opportunity to design local incentive schemes, an ability to establish new GP practices and approve practice mergers and also to make discretionary payments.

23. CCGs have been invited to consider their intentions for co-commissioning in January 2015.

24. Locally any changes would require cooperation between CCGs to establish and maintain a commissioning support function, which would not be viable for each CCG individually. This would also support the implementation of the MCP or PACS models of care locally.

25. The 'Forward View' also offers NHS backing to pilot a limited number of models of joint commissioning between the NHS and local government, potentially to allow full joint management of social and health care commissioning. The 'Forward View' suggests that in the long term this may be achieved under the leadership of Health and Wellbeing Boards.

26. The 'Forward View' also offers a commitment to deliver the transformation by providing national leadership for the transformation process, supporting a modern workforce, exploiting the information revolution, accelerating health innovation and driving efficiency and productive investment by looking at demand efficiency and funding.

27. Many of the themes within the NHS Five Year Forward View are not new and are broadly accepted but the new models of care and the associated changes to primary care commissioning could change the landscape of health and social care provision in Nottinghamshire. If successful they could enable the seamless, integrated care which has long been an ambition.

28. There are potential longer term implications for the Health and Wellbeing Board within this new landscape but the immediate changes will be within the health services, particularly within primary care where CCGs will be required to change their constitutions according to their preferred model for co-commissioning.

Statutory and Policy Implications

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

RECOMMENDATION

1) That the report be noted.

Dr Steve Kell
Clinical Lead NHS Bassetlaw Clinical Commissioning Group

For any enquiries about this report please contact:
Nicola Lane, Public Health Manager. Tel: 0115 977 2130. Email: nicola.lane@nottscc.gov.uk

Constitutional Comments (SB 14/01/2015)

30. As this report is for noting only constitutional comments are not required.

Financial Comments (KAS 19/01/15)

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

Background Papers and Published Documents

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

- The NHS Five Year Forward View
  October 2014

- Next Steps towards primary care co-commissioning
  NHS England
  November 2014

Electoral Divisions and Members Affected

- All

Nottinghamshire County Council

Report to the Health and Wellbeing Board

04 February 2015

Agenda Item: 6

REPORT OF CLINICAL LEAD FOR THE SOUTH NOTTINGHAMSHIRE TRANSFORMATION PROGRAMME AND SOUTH NOTTINGHAMSHIRE DIRECTOR OF TRANSFORMATION

SOUTH NOTTINGHAMSHIRE TRANSFORMATION PROGRAMME PARTNERSHIP COMPACT

Purpose of the Report

1. Partners from twelve statutory health and social care organisations across South Nottinghamshire, including Nottinghamshire County Council, have agreed to establish a 'Compact' that sets out their commitment to partnership working to deliver improved health and wellbeing for the citizens they serve through the reshaping of the health and social care system.

2. This Compact is being presented to partner organisation boards or equivalent, for organisational endorsement. To date, within Nottinghamshire County Council the Compact has been presented to the Adult Social Care, Health and Public Protection (ASCH&PP) Transformation Board and gained support.

3. The Health and Wellbeing Board is asked to endorse the Compact which sets out the ambition to create a sustainable and high quality health and social care system for the population of South Nottinghamshire.

Information and Advice

4. Overall, the citizens of South Nottinghamshire receive effective health and social care however services are not consistently coming together to provide joined up, quality and sustainable systems of service provision for the population served. Going forward it is increasingly unlikely that single organisations will be able to achieve sustainable services whilst working within their own boundaries.

5. Twelve partner organisations (commissioners and providers from health and social care) in South Nottinghamshire have come together developing a Compact which outlines a commitment to work in collaboration for the successful achievement of a sustainable and high quality health and social care system that supports improved health and wellbeing for the population served.

6. The Compact outlines the context for change, the principles of working together, and responsibilities of the South Nottinghamshire Transformation Programme which is the vehicle through which the partners are coming together to take forward the whole system change needed.

7. The Compact then goes beyond the principles and responsibilities in outlining the initial joint programme of work focusing on:

   i. Developing effective collaborative working arrangements.
   ii. Developing a new system based on an accountable care philosophy;
   iii. Optimising and improving the current system.

8. The Compact confirms the intention to develop shared system wide measures of success and outlines the means of keeping the Compact alive together with the process of signing up which is based on:

   - Support for the overall strategic direction;
   - Agreement to the principles;
   - Agreement to the shared work programme, including commitment to provide leadership and participation to secure success;
   - Agreement to employ high level system measures and to report them quarterly to public Boards or equivalent using a shared single report. These measures will form the basis of a public commitment to action.

9. The Compact includes the Terms of Reference for the South Nottinghamshire Transformation Board which is the overarching, strategic governing group for the South Nottinghamshire Transformation Programme. As a non-statutory body the Programme/Partnership operates on the basis of developing robust recommendations and ensuring that they align with decision making at statutory body level including Local Authority political approval processes.

Other Options Considered

10. None

Reasons for Recommendations

11. The Health and Wellbeing Board is asked to endorse the South Nottinghamshire Transformation Programme Compact on the understanding that this Programme is a non-statutory body developing robust recommendations and ensuring that they align with decision making at statutory body level including Local Authority political approval processes.

12. In endorsing the Compact, the Health and Wellbeing Board will be confirming support for the Programme to develop a shared single report of high level system measures that are reported to the partner public Boards or equivalent on a quarterly basis, with these measures forming the basis of a public commitment to action.

Statutory and Policy Implications

13. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are

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

Financial Implications

14. There are no financial implications of signing up to and endorsing the Compact. Any financial implications arising from the partners' joint programme of work will be outlined in recommendations for decision making at statutory body level including Local Authority political approval processes.

Implications in relation to the NHS Constitution

15. The Compact supports the delivery of the NHS Constitution.

Public Sector Equality Duty implications

16. Equality impact assessments are planned to be undertaken on the joint transformation projects and programmes of work where service change proposals might have an impact on equality'. These assessments will be outlined in recommendations for decision making at statutory body level including Local Authority political approval processes.

Safeguarding of Children and Vulnerable Adults Implications

17. None.

Implications for Service Users

18. The South Nottinghamshire Transformation Programme is committed to ensuring citizens are fully included in all aspects of service design and change. A Citizens Advisory Group has been established for the Programme, with citizen representation from each partner organisation's citizen/service user group, which acts as a critical friend in ensuring effective user involvement and engagement.

Implications for Sustainability and the Environment

19. The Programme aims to achieve a sustainable and high quality health and social care system for the population served.

Ways of Working Implications

20. Any implications for ways of working arising from the partners' joint programme of work will be outlined in recommendations for decision making at statutory body level including Local Authority political approval processes.

RECOMMENDATION

1) The Health and Wellbeing Board is asked to endorse the South Nottinghamshire Transformation Programme Partnership Compact.

Report author:
Rebecca Larder
South Nottinghamshire Director of Transformation

For any enquiries about this report please contact:
Rebecca Larder
South Nottinghamshire Director of Transformation
r.larder@nhs.net

Financial Comments (KAS 19/01/15)

21. There are no financial implications arising from this report.

Constitutional Comments (SMG 19/01/2015)

22. The proposals in this report fall within the remit of the Health and Wellbeing Board.

Background Papers and Published Documents

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

- The South Nottinghamshire Transformation Programme Partnership Compact

Electoral Divisions and Members Affected

- Rushcliffe, Broxtowe and Gedling. South Nottinghamshire Transformation also covers the unitary authority of Nottingham City.

Transforming Health & Social Care in South Nottinghamshire

THE SOUTH NOTTINGHAMSHIRE TRANSFORMATION PROGRAMME

PARTNERSHIP COMPACT

PARTNERS TO AGREEMENT

South Nottinghamshire Transformation Board Membership	
Clinical Commissioning Groups	
NHS Nottingham City	
NHS Nottingham North and East	
NHS Nottingham West	
NHS Rushcliffe	
NHS England	
NHS England Nottinghamshire and Derbyshire Area Team	
Local Authorities	
Nottingham City Council	
Nottinghamshire County Council	
Providers	
Circle Partners	
East Midlands Ambulance NHS Trust	
Nottingham CityCare Partners	
Nottinghamshire Healthcare NHS Trust	
Nottingham University Hospitals NHS Trust	

1. INTRODUCTION

Partners, from twelve statutory health and social care organisations across South Nottinghamshire have agreed to establish a 'Compact' that sets out their commitment to partnership working to deliver improved health and wellbeing for the citizens they serve.

This Compact sets out some principles and ways of working which all organisations have agreed to sign up to. It then goes beyond principles to establishing a shared programme of work that is dependent on the practical application of these principles. The Compact is about action and living the principles rather than simply espousing them.

Whilst to an important extent the improvement of all health services and social care depends on partnerships, the Compact is deliberately focussed on an agreed Programme of Transformation where all organisations involved are agreed that without partnership working we will fall drastically short of our objectives and in so doing undermine the continuation of sustainable health and social care services into the future.

The Compact has been developed at a time when there are major constraints on the availability of public funding and where the NHS is being asked to manage all improvements in quality and capacity within existing resources and local government is being asked to manage with significantly reduced funding. We are agreed that this can only be managed if all parties work in collaboration to find better ways of using the resources that are entrusted to us in combination.

2. THE STRATEGIC CONTEXT

We will create a sustainable, high quality health and social care system for everyone through new ways of working together, improving communication and using our resources better

Overall, the citizens of South Nottinghamshire receive effective health and social care however services are not consistently coming together to provide joined up, quality and sustainable[1] systems of service provision for the population served. By 2018/2019 a £100-140 million financial gap is forecast based on current models of health and social care service provision.

At the instigation of the four South Nottinghamshire Clinical Commissioning Groups[2], partners from twelve statutory organisations have responded to a 'Call to Action'[3] working in collaboration with citizens to develop a five year strategy aimed at reshaping the health and social care system towards the ambition of a desired future state focused on:

- Care organised around individuals, not institutions;
- The removal of organisational barriers enabling teams to work together;
- Resources shifted to preventive, proactive and care based closer to people's homes;

[1] Sustainable is taken to mean clinically, operationally and financially maintainable.
[2] The four Clinical Commissioning Groups are NHS Nottingham City, NHS Nottingham North and East, NHS Nottingham West and NHS Rushcliffe which have united in a 'Unit of Planning.'
[3] In 2013, NHS England launched a 'Call to Action' requiring CCGs to come together in Units of Planning working with partners (including Social Care) on the development of 5 year strategies for quality and sustainability

- Hospitals, residential and nursing homes only for people who need to be in these care settings;
- High quality, accessible, sustainable services based on real needs of the population.

We have a shared understanding of the ways in which this strategic vision and desired future state is intended to change the landscape in health and social care in South Nottinghamshire.

We have committed to the establishment of a South Nottinghamshire Transformation Programme with the purpose of: bringing together partners across South Nottinghamshire, with citizen involvement, to deliver a programme of transformational change to achieve the future desired state outlined in the five year strategy.

The South Nottinghamshire Transformation Programme aims to achieve the ambition through the optimisation of the current system and a programme of large scale strategic change aimed at fundamentally reshaping the health and social care system.

In moving to the future state, both approaches will be enabled by a new 'accountable care philosophy' centred on:

- Increased accountability to service users and the citizens of South Nottinghamshire;
- Improved user and citizen experience;
- Maintenance and improvement of population health and outcomes;
- Increased value (defined as health and social care outcomes achieved over the cost of achieving those outcomes);
- Integrated systems of care;
- Sustainability of service provision.

3. PRINCIPLES OF WORKING AND ORGANISATIONAL CULTURE

The operating principles **WE WILL** espouse:

a. Engage and consult carers, patients, citizens and staff in setting and refreshing our vision and strategy;
b. Act as one community promoting the health and wellbeing of the citizens of South Nottinghamshire;
c. Achieve mutual respect and understanding through building a culture of trust at all levels of our community;
d. Be open and transparent with each other;
e. Tackle obstacles to promoting the health and wellbeing of our citizens overcoming current climate and constraints within which the individual organisations function;
f. Be ambitious and courageous, accepting and managing risk together;
g. Be honest about success and failure, learning together;
h. Commit the necessary effort to deliver the changes needed and agreed;
i. Avoid duplication and waste by improving connections between our services;
j. Use common information and reporting.

WE WILL promote a culture of:

- Full citizen involvement in all aspects and activities of the Transformation Programme.
- Shared purpose, sovereignty, narrative (including common language) and information;
- System leadership, ensuring people are empowered to make decisions on behalf of the collective South Nottinghamshire;
- 'Holding to account' both on an individual and collective basis for delivery of the five year strategy and agreed measures of system success;
- Achieving better ways of using the resources entrusted to partners in combination;
- Promoting collective pride in moving the overall system in South Nottinghamshire towards the agreed vision for the local population.

4. THE RESPONSIBILITIES OF THE TRANSFORMATION PROGRAMME

We have agreed the South Nottinghamshire Transformation Programme will:

a) Develop, and refresh as needed, a five year strategy leading to a quality and sustainable system of care in South Nottinghamshire;

b) Develop and deliver a whole-system programme of large scale strategic change in support of the achievement of the five year strategy;

c) Ensure the five year strategy, and supporting programme of transformational change, is coherent with Joint Strategic Needs Assessments, Health and Wellbeing Strategies and aligned with Better Care Funds.

d) Ensure effective communication about the initiatives that are local to individual organisations, but make a contribution to the delivery of the five year strategy; and based on evidence, agree the initiatives arising from individual organisations that need rolling out across the system at scale and pace;

e) Ensure mechanisms are in place to assure delivery of the strategy both the whole-system programme of change and improvements/transformations local to individual organisations;

f) Put frameworks in place to share the benefits and risks (including finances) of initiating agreed system-wide strategic changes;

g) Implement systematic risk management processes to identify, assess and manage risks associated with the delivery of the five year strategy;

h) Ensure a co-ordinated approach to citizen, staff, organisation, and wider stakeholder engagement in the delivery of the five year strategy;

i) Ensure transparency by publishing the outputs and outcomes of the Transformation Programme's activities;

j) Meet all best practice and statutory requirements in progressing service and system change e.g. undertaking equality and health impact assessments.

5. GOVERNANCE ARRANGEMENTS

We have committed to the establishment and maintenance of robust accountability and governance arrangements for our Transformation Programme. This includes our coming together as a 'network of leaders' in a South Nottinghamshire Transformation Board (SNTB), which will be the overarching strategic governing group for our Programme (SNTB Terms of Reference outlined in Appendix 1).

We will lead the Programme through a 'network of leaders' with each partner organisation confirming their representatives (named leads and deputies), for the South Nottinghamshire Transformation Board and, over time, the underpinning governance structure. Partner representatives will be of sufficient seniority to fully engage in developing robust recommendations and ensuring that they align with decision making at statutory body level including Local Authority political approval processes.

6. THE PROGRAMME OF JOINT WORK

Shared leadership**:** we have brought together the leaders – clinical and managerial – from commissioners and providers across the health and social care system to make bold decisions about driving through new models of commissioning and service provision at scale and pace.

We will establish a rolling programme of work that we believe requires collaborative working to achieve the big outcomes that we all agree that shared commitment is necessary for that work to succeed. Clearly how the work programme develops over time will depend on our experience of how successful we are in being partners.

The initial work programme, which will be added to over time, by agreement, to embrace other top priorities:

i. Developing effective collaborative working arrangements.

ii. Developing a new system based on the accountable care philosophy;

iii. Optimising and improving the current system;

7. THE MEASURES OF SUCCESS

We have agreed that as part of furthering our commitment to joint working on transformation of South Nottinghamshire health and social care system (underpinned by this "Compact") that we should identify the measures that we can use to track our joint success. These measures must track quality and resource and be meaningful across all partners in the health and social care system. We intend these to form the basis of a public commitment to action and also be the basis for regular reports to each constituent board or equivalent – with a common report being used by us all to do that.

The idea isn't to create comprehensive balanced scorecards for the economy or to use the full range of measures and dimensions that are available. Instead we are looking at a few high level measures which are most impacted on by the interactions within a whole system (i.e. where we can only succeed together) and which have good proxy power (i.e. doing well on this implies doing well on a range of other things that are dependent on partnership working).

8. KEEPING THE COMPACT ALIVE

For the Partnership Compact to be a living force we need to be prepared to hold ourselves and each other to account for abiding by the principles and specific commitments to the work programmes set out. We agree that where any party to the South Nottinghamshire health and social care system believes that elements of this compact are not being honoured then in the first instance, the relevant accountable officers should attempt to resolve the issue bilaterally, if necessary with the mediation of:

- The Lay Chair of the South Nottinghamshire Transformation Board;
- The South Nottinghamshire Transformation Programme Critical Friend; and/or
- The Chairs of the Nottingham City and / or Nottinghamshire County Health and Wellbeing Boards.

In circumstances where agreement cannot be reached a Board to Board meeting will be held to seek resolution with an agreed independent chair.

The Partnership Compact will be governed by the South Nottinghamshire Transformation Board. We all commit to maintain the Transformation Board, over the course of the five year strategy, through any changes to organisational structures and jointly agree whatever organising and leadership arrangements as appropriate for this.

Finally, we will commit to the continuation of a programme of development activities including the regular sharing and testing of the strategies and plans of individual constituent organisations. We will respect the right and need for individual organisations to pursue their own objectives along-side our whole-system objectives. Working within relevant national frameworks, we respect the need for constructive competition in service provision to allow citizen choice or to achieve best value and, at times, this might mean that some information has to be retained for the sole use of one organisation. However all efforts will be made to minimise the risks from this of major negative unintended consequences for other partners across the system and to avoid any major “surprises.”

9. SIGNING UP

All parties have agreed a process whereby the Compact is signed up to by Boards or equivalent.

Signing the Compact is agreed to signify the following:

- Support for the overall strategic direction as set out in section 2, recognition of the consequences and acceptance that they will be incorporated in plans;

- Agreement to the principles by which we work together and the culture that we will promote across the South Nottinghamshire health and social care system;

- Agreement to the shared work programme and a commitment to provide the agreed leadership and participation from each organisation necessary to secure success;

- Agreement to employ a set of high level system measures and to report them quarterly to public Boards or equivalent using a shared single report.

APPENDIX 1
South Nottinghamshire Transformation Board
TERMS OF REFERENCE

1. Purpose

The South Nottinghamshire Transformation Board will be the overarching, strategic governing group for the South Nottinghamshire Transformation Programme. It is recognised that such a Programme of change may not always favour all partner organisations and that, at times, members of the Board will need to ensure some sacrifice in the common good.

2. Objectives of the Board

- Act as a network of leaders ensuring the citizen is at the heart of all activities of the Transformation Programme;
- Oversee the ongoing development of the South Notts 5 year strategy, Transformation Programme and associated collective work-plan;
- Provide collective leadership to maintain focus on the South Notts 5 year strategy, Transformation Programme and collective work-plan;
- Oversee the operational delivery of the Transformation Programme agreed work-plan and achievement of benefits realisation;
- Oversee the establishment and implementation of robust accountability and governance arrangements, testing and challenging timely delivery where required;
- Receive project documentation and respond to actions requested by the work-streams / sub-groups of the Transformation Board;
- Approve key documentation for the Transformation Programme;
- Ensure the critical dependences of the Programme are effectively managed;
- Ensure a co-ordinated approach to citizen, staff, organisation, and wider stakeholder engagement in the delivery of the five year strategy;
- Lead productive relationships and dialogue between senior leaders in the health and social care system. This will include working closely with:
    - Elected Councillors ensuring decisions are taken through Local Authority due processes;
    - Local MPs to ensure they are well-briefed and understand and support, wherever possible, the need for major service and system change, together with the consequences of these for the residents they serve;
- Ensure partner organisation plans are aligned to the South Notts 5 year strategy and Transformation Programme, recognising the right of individual partners to pursue their own objectives whilst making efforts to minimise the risks of major unintended consequences for other partners across the system and to avoid any major 'surprises';
- Ensure risks associated with the Transformation Programme are identified, assessed and managed;
- Act as ambassadors for the Transformation Programme taking collective pride in disseminating information to key stakeholders.

3. Responsibilities

It will be for the South Nottinghamshire Clinical Commissioning Group named leads or deputies to approve:

- The South Notts 5 year strategy;
- The allocation of Programme resource.

4. Membership

ORGANISATION	NAMED LEAD	NAMED DEPUTY
Chair	Sheila Hyde	Mike Wilkins
Citizen Representation	Mike Wilkins	Trish Cargill
South Notts Transformation Programme	Rebecca Larder	Jane Laughton
NHS Nottingham City CCG	Dawn Smith	Hugh Porter
NHS Nottingham North and East CCG	Sam Walters	Paul Oliver
NHS Nottingham West CCG	Guy Mansford	Oli Newbould
NHS Rushcliffe CCG	Stephen Shortt	Vicky Bailey
NHS England	Dawn Atkinson	Rhiannon Pepper
Circle Partners	Nicola Parry	Helen Tait
East Midlands Ambulance NHS Trust	Tim Loveridge	
Nottinghamshire Healthcare NHS Trust	Angela Potter	
Nottingham University Hospitals NHS Trust	Peter Homa	Rupert Egginton
Nottingham CitCare Partners	Lyn Bacon	Karen Franklin
Nottingham City Council	Colin Monckton	
Nottinghamshire County Council	Caroline Baria	
Primary Care	Tbc	
IN ATTENDANCE		
Administration support to the Board	Carly Ball	
Communications	Sarah Hewitt	
Erewash CCG	Lyn Wilmott-Shepherd	
HealthWatch	Claire Grainger	

Cumulative attendance of each partner will be reported in the minutes.

5. Accountability

Clinical Commissioning Group named leads and deputies will be of sufficient seniority to have authority to approve the 5 year strategy Programme resources to ensure delivery in a timely manner.

All named leads and deputies with be of sufficient seniority to fully engage in developing robust recommendations and ensuring that they align with decision making at statutory body level including Local Authority political approval processes.

6. Quorum

The meeting will be quorate when 70% of members are present.

7. Frequency of meetings

The Board will meet formally on a monthly basis to conduct its business. In addition a programme of Board development sessions for named leads and agreed deputies will be progressed.

8. Meeting preparation

- All partners will contribute items for the agenda, to be sent to the Director of Transformation, with the relevant paperwork, up to 10 working days before each meeting;

- The Chair and Director of Transformation will discuss the items for consideration, agreeing the final agenda;
- Papers will be circulated 5 working days before each meeting;
- Additional items for the agenda will be taken by exception with the knowledge and agreement of the Chair in advance of the meeting commencing;
- The draft minutes of each meeting will be circulated within 10 working days of the meeting being held and will be approved at the following meeting.

9. Declarations of interest

At the commencement of each meeting, the Chair will ask all members to declare interests. Where an interest is declared, the Chair will determine how this is to be managed including for example excluding the partner from the meeting for the relevant agenda item.

10. Communications

A common report of the Transformation Programme and the Board's activities will form the basis of regular communication to partner Board's or equivalent and the Health and Wellbeing Boards.

11. Review

These Terms of Reference will be reviewed on annual basis to ensure fitness for purpose.

September 2014

APPENDIX 2 - JOINT PROGRAMME OF WORK

Developing effective collaborative working arrangements

Overall, the citizens of South Nottinghamshire receive effective health and social care however services are not consistently coming together to provide joined up, quality and sustainable systems of service provision for the population served. It is increasingly unlikely that single health and social care organisations will be able to deliver quality and sustainable services whilst working within its own boundaries going forward. The evidence has identified six core aspects to successful collaborative working:

Establishment of core shared purpose: including addressing different organisational objectives and vague interpretations	**Understanding of where services should compete or are planned locally:** making application of national policy clear locally
Shared mechanisms for managing financial risk and benefit: payment mechanisms that are fit for purpose – 'my apple falls in your orchard.' Fixed points in system	**Shared agreement of ultimate arbitration:** when you can't agree, whom arbitrates?
Shared agreement of care / clinical basis for transformation: anything you do is based on evidence, owned locally. What this means for estates, workforce etc.	**Strong interpersonal relationships:** Fault lines will appear, e.g. a call from SofS. Are the relationships strong enough to weather them?

We - the named leads and our deputies - of the South Nottinghamshire Transformation Board will come together, building on initial work supported by a Critical Friend, actively engaging in a programme of successful collaborative working based on the above model, having responsibility for ensuring a culture of collaboration pervades throughout the system for the achievement of quality and sustainable care. This will include providing leadership to specific projects including work on the values, attitudes and behaviours required of all our South Nottinghamshire health and social care staff for a quality and sustainable urgent care system.

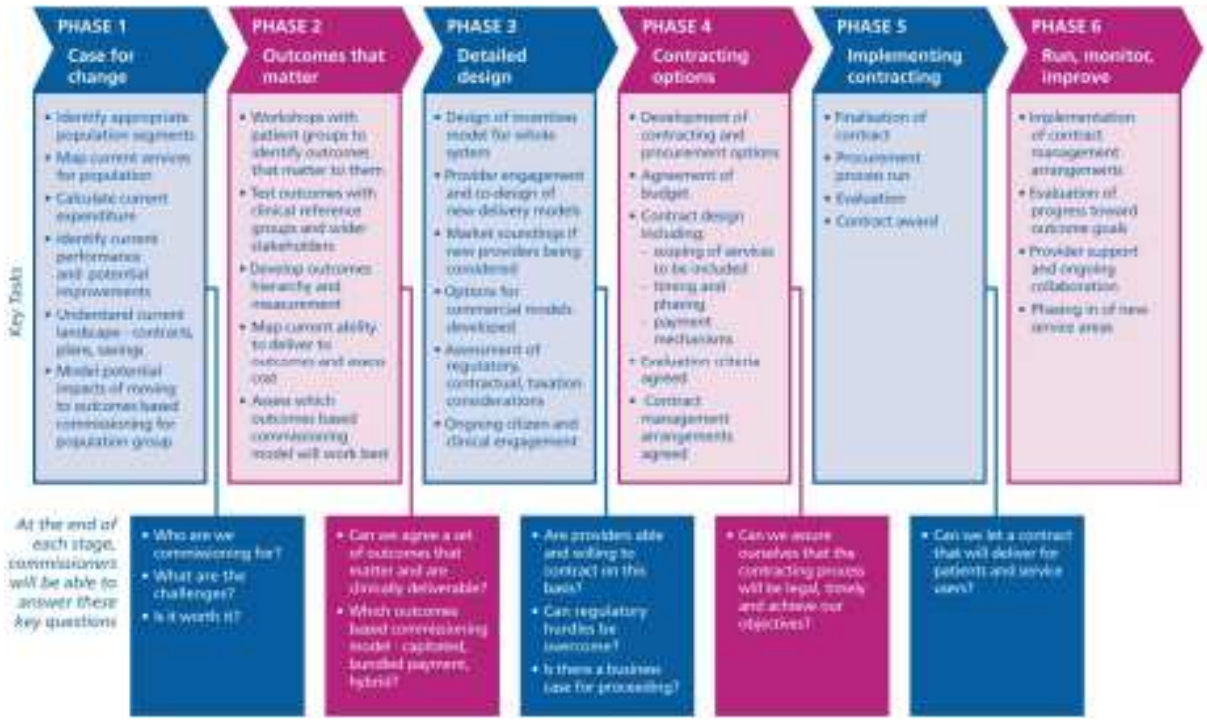
Developing a new system based on the accountable care philosophy

Clinicians / professionals need to be increasingly engaged and empowered to work together across organisational boundaries removing the divisions of responsibility; supporting greater communication and sharing of information; increasing the collective ability to solve problems and adapt or change services; agreeing and implementing new improved pathways focusing as much on wellness as on responding to illness; collaborating on care and the outcomes that matter to citizens but also holding themselves responsible for the total cost of service provision; supported not constrained by payment mechanisms and contracts.

The programme of transformation will be based on the accountable care philosophy and potentially enabled by new mechanisms aimed at liberating the scale of change required, including outcomes based contracting. Outcomes based contracting allows commissioners to come together to contract with a system of providers (for example through a prime contractor or system integrator model) agreeing a long-term financial envelope that creates the circumstances and incentives that enable the provider system to innovate and profit from success provided they manage the outcomes that matter to citizens and the associated costs. National and international studies demonstrate the benefits of this contracting approach as being: improved outcomes, significantly reduced acute activity, reduced rates of

institutionalism and improved citizen experience. Studies that also evidenced overall financial impacts have reported between 5-29% savings.

The case for change, in moving to outcomes based contracting, for the adult population will be determined between October and December 2014; and for children and young people between April and June 2015. Our approach to outcomes based contracting – if progressed - will be based on the process below, which we will adapt to our local circumstance developing both the commissioner and provider system, with the latter based on learning from a review of the characteristics of leading edge international health and social care systems that show evidence of effectiveness and efficiency.



Optimising and improving the current system

If we adopt an outcome based contracting approach, overtime responsibility and accountability for service transformation will sit with the provider system, making delivery a reality for the population / population group(s) covered by the contract.

Over the coming months, as we develop the new commissioning and provider system, we will come together agreeing and implementing a programme of improvement interventions aimed at optimising and improving the current system, ensuring these interventions align with our accountable care philosophy. These improvements will focus on service work-streams such as primary care, urgent care and elective care as well as enabling work-streams including information management and technology and workforce.

Improvement focus will be proportionate to the quality and sustainability challenge. Within the service work-stream, priority will be given to the development of a medium to longer-term service strategy for urgent care, which will be ready for implementation from April 2015. This strategy will build on the transformation activities being delivered through the resilience plan.

We will ensure citizens are engaged in and influencing all aspects of the Transformation Programme, enabling decisions to be made as close as possible to the people they affect, with the local population having as much say in decisions as possible. We will also invest in wider workforce and stakeholder engagement as a priority for success in achieving a quality and sustainable health and social care system for everyone.

Nottinghamshire County Council

Report to the Health and Wellbeing Board
4 February 2015

Agenda item 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LOCAL AUTHORITY COMMISSIONING OF COMPREHENSIVE SEXUAL HEALTH SERVICES FROM APRIL 2016

Purpose of the Report

1. The purpose of this report is to advise the Board of:

   a. the health needs and contractual arrangements related to the Council's responsibility for commissioning mandatory comprehensive sexual health services
   b. the extent to which the recently agreed Health and Wellbeing priority for sexual health is dependent on these services
   c. the potential implications and consequential costs of possible reductions in funding which will be determined by the Public Health Committee

Information and Advice

Public health significance of good sexual health

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

3. The burden of poor sexual health falls most heavily on disadvantaged groups. There is a clear association between sexual ill health, poverty and social exclusion in Nottinghamshire County. The immediate impact of poor sexual health falls on individuals, but its consequential costs are borne by society through increased burdens on public services.

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

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

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

c. **People presenting with HIV at a late stage of diagnosis** (Domain 3, Health Protection): in the most recent 3-year reporting period, 32 people in Nottinghamshire County were diagnosed with HIV at a late stage of the disease. As a proportion of the population, this is not different to the England average[ii]. Nevertheless, each of these individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed early. In addition to the avoidable, poor health outcomes for the individuals concerned, late diagnosis also yields significant treatment, clinical and social care costs.

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

6. Investment in sexual health services delivers a good return on investment. For example, evidence shows that the economic impact of investment in contraceptive services delivers £11 of benefit to public service budgets for every £1 invested[iii]. NICE guidance relating to various sexual health interventions provide summaries demonstrating their cost effectiveness.

7. Appendix 1 outlines the benefits of investment in effective SH services.

Commissioning responsibilities & interdependencies

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

9. Local Authorities Regulations[iv] mandate that unitary and upper tier local authorities commission confidential, open access services for STIs and contraception, as well as reasonable access to all methods of contraception. Appendix 2 provides a summary of the system wide commissioning responsibilities for sexual health, reproductive health and HIV services.

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

11. Appendix 3 provides insight into three service users' sexual health "journey" and demonstrates the interdependencies and collaborative commissioning arrangements required to ensure seamless access to appropriate services.

12. The consequential costs of poor access to timely testing for STIs, prompt treatment and a full range of contraception are borne by CCGs, NHSE, Nottinghamshire County Council, neighbouring local authorities and other public service budgets. Some of these costs are considerable. For example, national data indicates that the lifetime cost of treatment and social care of the 30 people in Nottinghamshire County diagnosed with HIV in 2010-11 is estimated to be in excess of £8 million[v]. Costs of HIV treatment and care are approximately

double for people who receive late diagnosis. Implications for the local system are that arrangements should be in place to promote and secure early diagnosis, with pathways into treatment which are smooth and seamless for patients (irrespective of the underlying commissioning responsibilities).

13. There are also close dependencies between sexual health and other local authority agendas. For example, the availability and accessibility of "young person friendly" sexual health and reproductive health services makes a critical contribution to Nottinghamshire's ambition to continue to lower teenage conceptions across the whole county and to a greater degree in more deprived areas[vi]. Similarly there are close dependencies with Sex and Relationships Education (SRE) and the Child Sexual Exploitation (CSE) agenda. Good CSE practice is a key priority of the Nottinghamshire Childrens' Safeguarding Board and is being embedded in local sexual health services.

14. Within our current and future commissioning arrangements, there is a need to be mindful that NHS providers (within specialist areas such as sexual health) are key contributors to medical and clinical workforce development and training. In other words, a failure to commission this workforce training represents a threat to the sustainability and future delivery of sexual health services in Nottinghamshire County.

Health needs assessment

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

16. Work is under way to update and refine this assessment of need. Amongst other things, this is likely to confirm the need to address:

    a. integration of sexual health services so that, within a single appointment visit, service users are able to access STI testing and relevant contraceptive advice and provision

    b. sexual health promotion to young people (especially in teenage hot spot areas across the county), to other people who have higher sexual health risks (including men who have sex with men and sex workers) and people at greatest risk of late diagnosis of HIV.

17. In addition to these aforementioned needs and the imperative to tackle the underlying circumstances that *motivate* young people to want to, or to be led passively to become pregnant or young parents at a young age, the Teenage Pregnancy Strategy also highlights the need for all children and young people to have access to good quality Sex and Relationships Education (SRE), and "young person friendly" contraception and sexual health services including specialist services and primary care.

The Council's current sexual health contracts and related cost pressures

18. Notwithstanding the importance of the wider sexual health agenda (e.g. SRE, CSE) and the effective integration of pathways for which commissioning responsibility is split (e.g. HIV diagnosis and treatment), the primary focus of this paper is on the commissioning of confidential, open access services for STIs and contraception, and associated prevention.

19. The total annual cost of the Council's sexual health contracts falling within the scope of this paper is approximately £6.8 million. These contracts are summarised in Appendix 4.

20. In regard to the management of contracts which cover the south of the County, it is critical to work in close collaboration with Nottingham City Council who are also associate commissioners of Nottingham University Hospitals for Genito-urinary Medicine (GUM) and Contraception and Sexual Health (CaSH) services. Dependencies in Bassetlaw are with Doncaster Council whose services are provided by Doncaster & Bassetlaw Hospital.

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

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

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

24. As part of meeting its obligation to ensure access to a range of contraception, the Council also commissions Emergency Hormonal Contraception (EHC) from 144 Community Pharmacies, who also "signpost" service users to contraceptive and sexual health services and C-Card for young people.

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

Future commissioning & prospects

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

27. In considering the reprocurement of these services, current and potential providers are unlikely to agree to new arrangements based on block contracts which expose them to risk

of cost pressures if treatment activity increases. Work is under way to quantify the additional financial pressures for the Council of "unblocking" these contracts.

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

Likely consequences of reductions in funding for sexual health services

29. The portion of the Public Health Grant to be allocated to sexual health will not be determined by the Public Health Committee until May 2015.

30. Until that time, public health colleagues are seeking to develop service models which meet the Health and Wellbeing Board's objective to reduce rates of STIs and unplanned pregnancy, the Council's obligation to provide confidential open access sexual health services, and which accommodate the aforementioned cost pressures - and to secure this within a budget which the Public Health Committee may determine should be reduced from its current level.

31. To achieve this, attention will focus on the potential savings which can be realised by improving the service model itself and/or which may be secured through market competition. A planning assumption in this work is that this approach has the potential to offset some or all of the likely cost pressures and to deliver some overall savings. Soft market testing may provide observations by which to provisionally validate the potential scale of such efficiencies and the likelihood of achieving them.

32. Beyond this, greater certainty about the scale of any realisable savings is unlikely to be forthcoming until the end of the procurement process. Until that time, assessments of what savings may be achievable will simply be provisional estimates of how the market will evaluate the opportunity.

33. Depending on the size of the budget to be determined in May 2015 by the Public Health Committee, it may not be possible to identify an affordable service model which meets the objectives of the Health and Wellbeing Board or the needs of the population at the same level as that of current arrangements.

34. In this eventuality, the Board should be aware that evidence indicates that sexual health services with reduced effectiveness or accessibility are likely to result in adverse consequences for patients (unplanned pregnancies in teenagers and adults, onward transmission of untreated STIs, infertility arising from delay in or lack of treatment for Chlamydia infection, and additional complications or early death associated with delayed diagnosis of HIV), CCGs (additional demand for termination of pregnancy, ante- and perinatal services, treatment for infertility and other complications arising from delayed diagnosis and treatment), NHS England (additional costs associated with failure to secure early diagnosis of HIV) and the Council (increased demand for Early Years interventions such as Sure Start, and nursery provision).

35. Accurately quantifying what the scale or timing of these impacts would be in Nottinghamshire is problematic and sensitive to assumptions about the extent to which adverse impacts are mitigated by efficiencies in the model and its procurement. Recent

national level modelling available is subject to similar limitations[vii]. Nevertheless, it indicates that, alongside the impact on health outcomes, the consequential cumulative financial impact might be considerable and that, in part, the burden of this would probably fall on NHS partners, notably CCGs who would have to divert funds to meet the costs associated with additional care.

36. In the meantime, current efforts of the public health team remain focussed on identifying service models and procurement options to mitigate the likelihood and impact of such an eventuality.

Immediate next steps

37. The immediate next steps are for public health to complete the updated needs assessment, the development of options for a proposed future service model and a recommendation about the preferred procurement approach for securing this.

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

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

40. Engagement with CCGs on this agenda is through their participation in the Sexual Health Procurement Group, the Public Health directorate's CCG Engagement Group, and via the CCG Congress which will receive a paper at a forthcoming meeting.

41. As our recommendations develop, Public Health will undertake consultation with relevant stakeholders. This will take place in early 2015.

42. A paper will be taken to the Public Health Committee in May to recommend a procurement approach and to support their decision-making about the portion of the public health grant to be allocated to sexual health services.

Reason for Recommendations

43. Effective arrangements to secure the provision of comprehensive open access sexual health services will be critical to address the Health and Wellbeing priority recently agreed by the Board.

Statutory and Policy Implications

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

Financial Implications

45. None

RECOMMENDATION

1. The Board is asked to note the information shared in the paper about Nottinghamshire County Council's commissioning of sexual health services and its relevance to the Board's Health and Wellbeing priority to reduce rates of STIs and unplanned pregnancy.

Dr Chris Kenny
Director of Public Health

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

Constitutional Comments (SG 05/01/2015)

46. Because this report is for noting only no Constitutional Comments are required.

Financial Comments (KAS 12/01/15)

47. There are no financial implications contained within this report.

Background Papers and Published Documents

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

- None

Electoral Divisions and Members Affected

- All

Appendix 1 Benefits of investment in effective SH services (DH 2014)

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

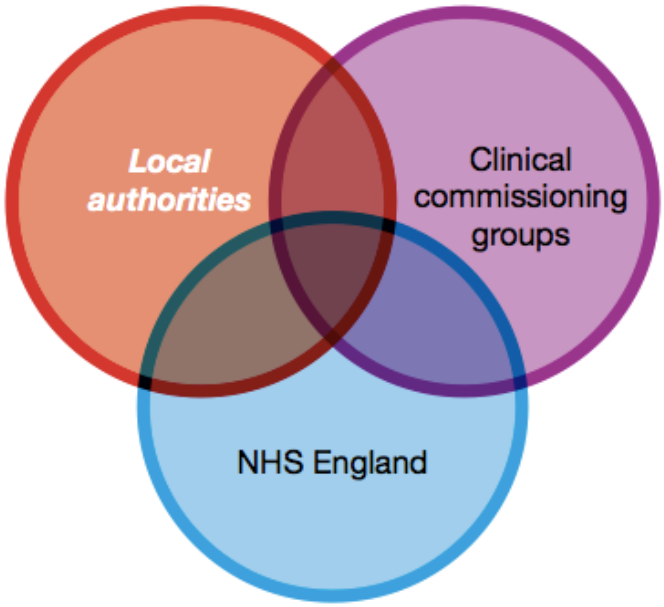
			health/prevention Las
Key objectives in 'A Framework for Sexual Health Improvement in England'	Benefits at the individual level	Benefits at the public health/population level	Other benefits (economic, health and social outcomes) =benefit for specified commissioner(s)
Objective: Reduce unintended pregnancies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

Appendix 2

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

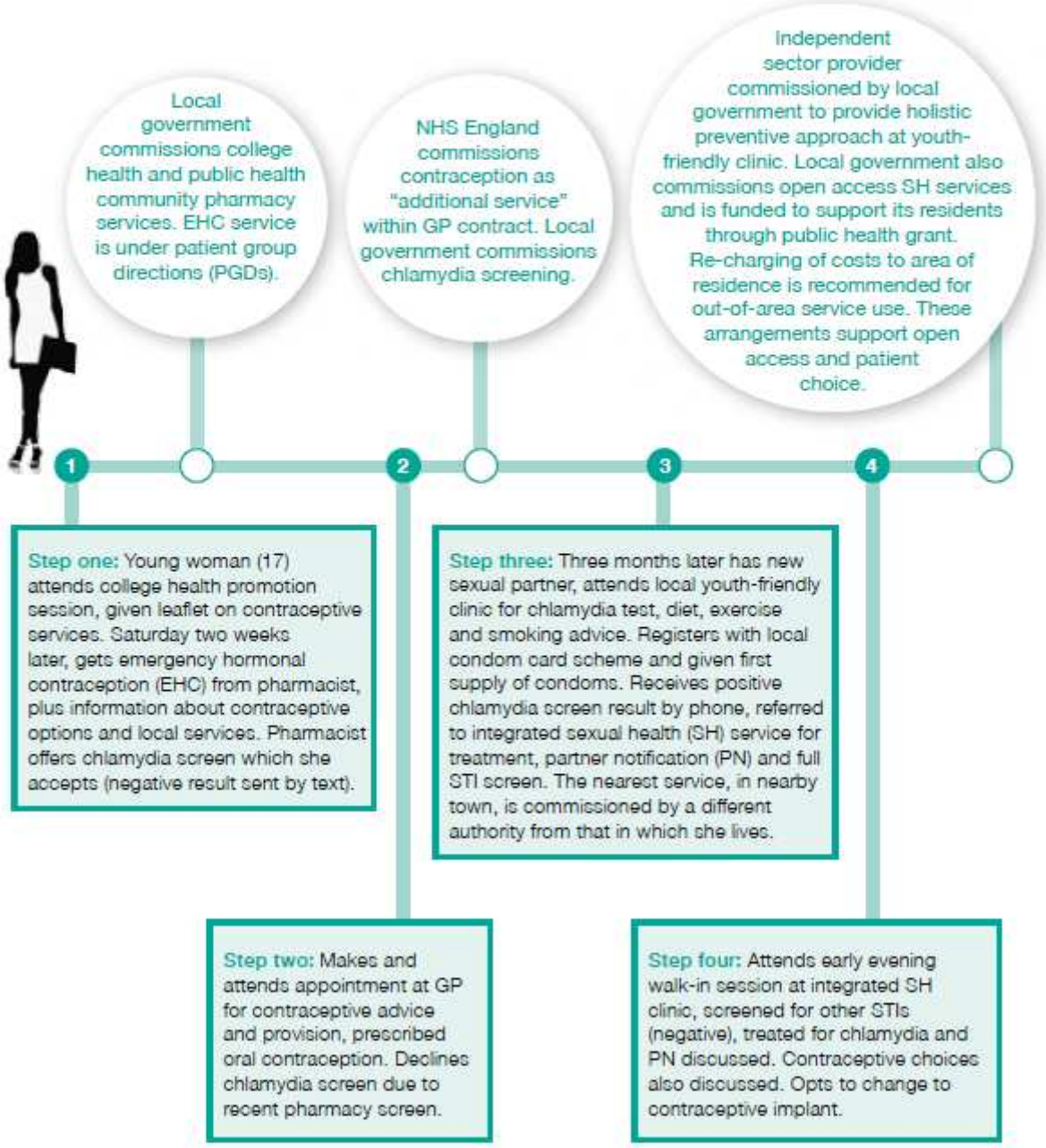
Local Authorities	CCGs	NHS England
• Contraception • STI testing and treatment • Chlamydia testing as part of the National Chlamydia Screening Programme • HIV testing • Sexual health aspects of psychosexual counselling • Sexual services including young people's sexual health, teenage pregnancy services,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

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



A young woman's journey

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



A woman's journey

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

Local government commissions open access integrated SH service.

CCG commissions abortion service.

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

1

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

2

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

3

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

4

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

A gay man's journey

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

Local government commissions integrated SH services including HIV testing.

NHS England commissions HIV treatment and care services. These are often provided at same site as local government-commissioned GUM or integrated SH services by same team of professionals.

Local government commissions social and peer support services, PN and STI screens for PLWH. NHS England commissions primary care for PLWH as part of "essential services" in GP contract.

1 2 3 4

Step one: Gay man (early 20s) attends integrated SH clinic. Gonorrhoea diagnosed, treated and managed, HIV test negative.

Step two: Returns to integrated SH clinic 18 months later with new gonorrhoea infection. Tests positive for HIV. Supported by GUM team, counselled by health adviser including issues of disclosure and PN. Urgent referral to specialist HIV outpatient clinic.

Step three: Seen at HIV outpatient clinic for assessment and evaluation, receives treatment information. Referred to voluntary organisation for peer and social support. Agrees HIV service can inform his GP of his HIV status and share details of his treatment and care.

Step four: Initial assessment, then ART initiated. With SH and HIV services delivered by same provider and co-located, PN undertaken, sexual history taken and full STI screen performed during same visit. Advised to return regularly for STI screening.

Appendix 4 Summary of current contracts for Sexual Health Services

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

Appendix 5

An excerpt from a draft of the updated sexual health needs assessment – to indicate some of the emerging themes

8 Unmet needs and service gaps

8.1 Unmet Needs

Nottinghamshire County is similar to the rest of the country when considering key sexual health outcomes. There is significant unmet need in terms of

- Sexually transmitted infections (STIs),
- access to and effective use of contraceptives and
- unplanned pregnancy, including teenage conceptions and terminations.

There is a clear evidence base, as laid out earlier in this document, for effective interventions to address population sexual health need. Actions to tackle the need identified in this section are included in the recommendations for commissioners.

In line with the national picture, there are increasing rates of STI diagnosis, with 3,840 diagnoses in Nottinghamshire County for the most common STIs in 2013. At least 60% of these occur in those aged 15 to 24 years. This indicates unmet need for effective SRE and health education/promotion initiatives to reduce risky sexual behaviour and increase correct, consistent use of condoms.

In addition, there is evidence of persistent risky sexual behaviour in Nottinghamshire County, as seen in rates of reinfection within a 12 month period from first clinic attendance. Re-infection rates in many districts are higher than the national average. The highest rates of reinfection are seen in those aged 15 to 19 years, with around 1 in 10 young people attending with an acute STI within a year of previous infection. Further investigation is needed to understand what is driving higher rates of reinfection and how behaviour change can be encouraged via sexual health services and health promotion routes.

Whilst those under 25 have the highest rates of STI diagnosis, and account for half of all GUM first attendances, it is important to remember that individuals may need sexual health services at any age, and this need may arise unpredictably throughout the life course. There is evidence from previous local analysis that a higher proportion of attendances at CaSH services are occurring in older women in central Nottinghamshire (Mansfield, Ashfield and Newark & Sherwood) as compared to the south. National evidence has also shown an increase in terminations of pregnancy in women aged over 25 (local comparative data unavailable). Effective sexual health services need to be flexible and responsive, taking an appropriate life course approach to provision.

In 2013, nearly 1 in 4 NHS funded terminations (22.8%) were carried out after 10 weeks gestation. Therefore, there is room for improvement in early access to both pregnancy testing and NHS services for termination of pregnancy.

There were 1,830 terminations of pregnancy carried out in Nottinghamshire County in 2013, of which 145 were carried out in those under the age of 18. In women aged under 25 attending for termination of pregnancy, just over 1 in 5 reported having a previous termination at any age. These figures are an indicator of lack of access to good quality contraception services and advice as well as problems with individual use of contraceptive method. Three months data from pharmacy emergency hormonal contraceptive (EHC) services show the key reasons for use of EHC were failed condom, unprotected sex and missed oral contraceptive pill. Previous use of EHC was recorded within the last year, for 38.8% of consultations. GP prescription rates for long acting reversible contraceptives (LARC) were 6.6 per 100 resident female population in 2013. In Nottinghamshire County LARC is provided by CaSH service providers (BHP, SFHFT and NUH) and also by GPs who have a contract with the council for delivery of LARC as a Locally Commissioned Public Health Service. The delivery outlets within CaSH and General Practice help increase access and choice for service users. Evidence has shown that LARC is much more effective in preventing pregnancy than other hormonal methods and condoms, and is also cost effective. In addition, provision of contraception,

particularly LARC methods, supplied or fitted by the termination provider can reduce repeat terminations. There is unmet need in Nottinghamshire County for accessible effective contraception and information about correct contraceptive use.

Poor sexual health outcomes within Nottinghamshire County are broadly associated with levels of deprivation. The more deprived areas have higher rates of diagnosed STIs and teenage conceptions. In particular Mansfield and Ashfield have a higher burden of poor sexual health outcomes than seen elsewhere in Nottinghamshire County. This includes overall rates of STI diagnosis, teenage conceptions, and rates of admission for pelvic inflammatory disease which are significantly higher than national averages in Mansfield and Ashfield. Reinfection rates for acute STIs are also higher than national averages in these areas.

In Nottinghamshire County, the proportion of 15 to 24 year olds screened for chlamydia is 19.5%, i.e. the lowest in the East Midlands and significantly lower than the England average (24.9%). Despite only 19.5% of this age group being screened, the chlamydia diagnoses rate in those aged 15 to 24 years is 2,207 per 100,000 population which is not significantly different from the England average. This could indicate that chlamydia testing carried out in Nottinghamshire is appropriately targeted, identifying those with chlamydia infection, despite screening a smaller proportion of the population. However it could also indicate that there is a high population prevalence of chlamydia infection compared to the England average in the 15 to 24 year old age group, with an asymptomatic proportion remaining undiagnosed.

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

Whilst rates of diagnosis for gonorrhoea remain significantly below the England average in Nottinghamshire County, the rate of increase in diagnosed gonorrhoea infection is greater than for any other county or unitary authority in the East Midlands, with the exception of Nottingham City. This increase is likely to reflect a change in testing patterns which has occurred across England in recent years. The use of more sensitive testing methods, the expansion of testing to include oral and rectal samples and the introduction of dual testing for chlamydia and gonorrhoea have been identified by various reports to be key drivers of increasing gonorrhoea diagnosis rates.[xi] Public Health England has noted that many local authority-commissioned sexual health services have been using dual testing inappropriately, which can result in increased levels of false positive results.[xii] Commissioners will need to assure themselves that PHE guidance on gonorrhoea testing is being appropriately followed by sexual health services and laboratories. Testing procedures which are not aligned with best practice will have an impact on cost effectiveness as well as leading to inappropriate treatment in the case of false positives.

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

A BBV Reference Tool was devised for use by local GP practices in identifying possible individuals with blood borne viruses, specifically HBV, HCV and HIV. This tool was originally devised in 2011 and further reviewed and refreshed in 2014. It now includes assessment for TB risk as well as BBV. The tool has been disseminated to all primary care practices in Nottinghamshire County via their CCGs. It takes an active case finding approach to earlier diagnosis of HIV. Case finding involves actively searching systematically for at risk people, rather than waiting for them to present with symptoms or signs of active disease. Promotion of the use of this tool provides one option for improving early diagnosis of HIV. Further effective strategies for early diagnosis in a low prevalence population need to be considered.

8.2 Service Gaps

As services are re-procured in the future, the commissioners' aim is to develop and commission an evidence-based, responsive, integrated sexual health service (ISHS) which delivers high quality, evidenced based services that are accessible and reflect value for money.

A number of the current services lack integration and there is some evidence of inequitable provision across the county.

An integrated approach to sexual health need and outcomes

Commissioning responsibilities for sexual health are now distributed across a number of organisations, introducing a risk of delivering a fragmented service to clients, which does not address sexual health needs in a coherent and comprehensive way. In particular patient pathways need to be reviewed, in light of new commissioning structures to ensure that they are holistic in meeting sexual health need. For example, incorporation of contraceptive provision and advice into GUM services, termination of pregnancy and maternity pathways.

We know that a significant number of Nottinghamshire County residents access their sexual health services in Nottingham City. So to effectively meet local need, an integrated approach also involves acknowledging close co-dependencies with Nottingham City sexual health services. There is need for close coordination between commissioners for county and city local authorities.

In line with a comprehensive approach to sexual health need, collaborative working across agendas is critical to achieving improvements in sexual health and avoiding consequential costs being displaced across the health and social care system. This includes work on interdependent priorities for child sexual exploitation, teenage pregnancy and sexual violence. This will recognise the opportunities to maximise outcomes for these vulnerable groups.

Implementing an integrated sexual health service model

An integrated sexual health service (ISHS) model aims to improve sexual health by providing easy access to services through open access 'one stop shops', where the majority of sexual health and contraceptive needs can be met at one site, usually by one health professional, in services with extended opening hours and in accessible locations.

An ISHS will need to support delivery against the three main PHOF measures

- Under 18 conceptions
- Chlamydia Diagnosis (15-24 year olds)
- People presenting with HIV at a late stage of infection

An ISHS will also support delivery to a number of local population based outcomes to improve sexual health, these include promoting:

- A culture of good sexual health across the population where individuals enjoy respectful and consensual sexual relationships
- The de-stigmatisation and normalisation of accessing sexual health services
- An increase in knowledge and awareness of issues around sex, relationships and sexual health in young people and those at highest risk of sexual ill health
- A high level of population knowledge about easy access to services providing contraception and sexual health advice for the whole population including information appropriate to all age groups and targeted at those at highest risk of sexual ill health
- Safer sexual behaviours (reduced sexual risk taking behaviours)
- A reduction in sexual health inequalities amongst key target groups including young people, young adults, BME groups, LGBT and those groups at highest risk of sexual ill health
- An increased uptake of effective methods of contraception, including rapid access to the full range of contraceptive methods including LARC (Long Acting Reversible Contraceptive) for all age groups

- A reduction in unintended pregnancies in all ages as evidenced by teenage conception and termination rates, including reduced numbers of repeat terminations
- Early diagnosis and effective management of sexually transmitted infections
- Low rates of sexually transmitted infections and a reduction in re-infection rates
- High uptake of HIV testing with particular emphasis on first time Service Users and repeat testing of those that remain at risk
- Improved wellbeing (social and emotional needs met) for those at highest risk of sexual ill-health

Delivering on Outcomes

Whilst providers will continue to submit activity based monitoring data, consideration needs to be given to requiring sexual health services to demonstrate impact on key outcomes, such as reinfection rates, teenage conceptions, uptake of LARC etc. Careful consideration needs to be given to how this can be effectively achieved without leading to unintended consequences.

Effective approaches to chlamydia screening

Subject to further investigation of the underlying reasons for particularly high rates of chlamydia infection and pelvic inflammatory disease in Mansfield and Ashfield, a review of the effectiveness of the local approach to chlamydia screening is needed. Current chlamydia testing occurs in GUM clinics based on symptomatic presentation, or opportunistically during a sexual health screen. The Department of Health Public Health Outcomes Framework 2013-2016 recommends that local areas aim to achieve a chlamydia diagnosis rate among 15 to 24 year olds of at least 2,300 per 100,000 population. Diagnosis rates in Mansfield, Ashfield and Gedling are currently above this threshold (2,641 and 2,998 per 100,000 respectively). Further work is needed locally to identify an effective evidence based option for chlamydia screening that would represent value for money in our local context.

Service quality

It is essential that the quality of services are assured in all contracts, with service user feedback seen as an essential mechanism that contributes to service developments and improvement. The quality of services are enhanced through the application of evidence-based practice and clinical leadership that is underpinned by professional guidelines, training and competency standards that set out the required training, skills and competencies of the sexual health workforce (for example BASHH and RSRH guidelines). There is a need to be mindful of the responsibilities of the health community to support training and development of the future workforce in the delivery of an integrated sexual health service.

At present not all sexual health providers in the county are meeting “You’re Welcome” standards, quality criteria for young people friendly services.

Child Sexual Exploitation

There is room for improvement in ensuring that all providers are appropriately referring children and young people to safeguarding services, in the event that child sexual exploitation is suspected. Service providers are expected to ensure all staff are appropriately trained and use the new national CSE assessment tool (Spotting The Signs).

Accessibility

Improving accessibility involves understanding the preferences of service users, and utilising mobile and web based communication technology to support engagement and reduce STIs, Teenage Conceptions and unplanned pregnancy. We need to consider how to build in regular awareness messages about sexual health sexual health

services into the county service model. In addition it is important to develop targeted approaches which ensure that services are promoted and are accessible for those at highest risk of sexual ill health.

Sexual Health Promotion

Sexual health promotion and prevention is central to the achievement of good sexual health outcomes. Sexual health promotion and prevention includes information, advice and guidance and training, relationship advice and targeted work with high risk groups in order to develop increased knowledge about healthy, equal and safe relationships and safer sex. The targeting of sexual health promotion messages to people who present as highest risk of sexual ill health remains an important priority.

We know that there are gaps in sexual health promotion in the south of the county and recent feedback from young people (focus group participants aged 15 -24) placed emphasis on their need for sexual health promotion (through a health education model) to address their fears and stigma when accessing sexual health services. Sexual health promotion is a priority for inclusion within an ISHS across the county.

Sex and Relationship Education

Sex and Relationships Education (SRE) is a gap for Nottinghamshire County. All secondary schools in the county are academies, which are not required to provide the council with information about their provision of SRE. So we have no way of knowing which schools offer comprehensive SRE packages. As Ofsted no longer check the quality of SRE many schools no longer prioritise it. We are looking to develop a new package for schools to bring together a range of health topics.

There is evidence that effective contraception and sexual health services in young people friendly settings is important if we want to reduce teenage conceptions.

There are particular groups who are at increased risk of poor sexual health outcomes and teenage pregnancy, including young offenders and those excluded from school. It makes sense to improve access to information and services for these young people. This approach has been re-affirmed through recent consultation work undertaken with young people in Nottinghamshire County

Work is underway to develop a new model of delivery for school health. This will need to address the inconsistency of provision of the sexual health element across Nottinghamshire.

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

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

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

[xi] Use of dual nucleic acid amplification tests for chlamydia and gonorrhoea on samples collected for the National Chlamydia Screening Programme: Results from a national survey of local authority commissioners, Public Health England.

[xii] Public Health England, Guidance for the detection of gonorrhoea in England.

Nottinghamshire County Council

Report to the Health and Wellbeing Board

4 February 2015

Agenda Item: 8

REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING BOARD

CHAIR'S REPORT

Purpose of the Report

1. To provide members with information on issues relevant to the Health and Wellbeing Board.

Information and Advice

Care Act

1. The Board had previously noted the increased burden resulting from the implementation of the Care Act and a letter was sent on behalf of the Board to Norman Lamb to highlight this.

   A response has been received from the Department of Health which recognises the scales of the challenge that the Act presents. It outlines plans to support Councils to understand the financial implications of the Act, how the Department of Health is exploring central funding allocations to cover the new burdens and potential support products which will be available shortly.

Urgent Care

2. There has been significant coverage of the pressures on urgent care both locally and nationally, with all the local acute trusts failing to meet the 4 hour target. Plans are in place to address this and are being monitored by system resilience groups (or equivalent forum) in Bassetlaw, Mid and South Nottinghamshire. Given the likely impact on all parties, it is proposed that the Board receive a report at the next meeting to outline the local position and actions.

Health and Wellbeing Board Peer Review

3. The Health & Wellbeing Board Peer Review is being held between 3-6 February 2015 to coincide with this meeting. Board members are invited to attend the initial feedback session on **Friday 6 February 2015** at 2pm in the Civic Suite at County Hall.

   For further information contact Nicola Lane, Public Health Manager, email: nicola.lane@nottscc.gov.uk tel: 0115 977 2130

Services for the deaf community

4. Nottinghamshire County Council has signed the British Sign language charter, making a public pledge to improve access to services for the deaf community.

   Signing the pledge commits the council to five key pledges aimed at improving the rights of deaf people including:

   - ensuring access for deaf people to information and services
   - promoting learning and high quality teaching of British Sign Language
   - supporting deaf children and families
   - ensuring staff working with deaf people can communicate effectively in British Sign Language
   - consulting with the local deaf community on a regular basis.

   In 2009/10 there were around 970 deaf adults in Nottinghamshire and from the 2011 census, approximately 300 county residents identified British Sign Language as their primary language.

   Board members are asked to consider raising the Charter within their own organisation to support an improvement in access to public services across the county.

   For further information please contact Nigel Walker, Commissioning Officer tel: 0115 977 4016 email: nigel.walker@nottscc.gov.uk

Integrated Care Pioneers

5. The Integrated Care Pioneer scheme is a NHS England programme with the aim of supporting health and social care services to work together to provide better support at home and earlier treatment in the community to prevent people needing urgent care in hospital or in care homes, with a focus on innovative and transformational approaches to care delivery. The Health and Wellbeing Board previously submitted an application to the first wave of integration pioneers in June 2013 but was unsuccessful.

   NHS England wrote to all Clinical Commissioning Groups (CCGs) in November requesting applications from areas interested in becoming Wave Two Integrated Pioneers, with up to ten areas joining the existing Wave One pioneers. The programme provides the opportunity to be at the forefront of delivering integrated care for the population using innovate models of commissioning and service delivery. Tailored support from among forty partner organisations to help deliver plans.

   An application setting out the Nottinghamshire County wide plans for integration was submitted on 10 December 2014, with final recommendations to be agreed by NHS England by 21 January 2015 and a formal announcement due on 27 January 2015. Five CCGs supported the Nottinghamshire application, covering the planning units of Mid and South Nottinghamshire, alongside Nottinghamshire County Council.

   For more information contact Sarah Fleming, Better Care Fund Programme Manager tel: 0115 9932564 email: sarah.fleming@mansfieldandashfieldccg.nhs.uk

Health and Wellbeing Board Meetings

6. The Health and Wellbeing Board has been operating since 2011. Since this time there has been an increasing remit for Health and Wellbeing Boards as a result of national policy. Alongside continued communication and engagement, this has resulted in an increased work programme for the Board, which has become more difficult to manage through bimonthly meetings. Members are all aware of the impact of this on the time available to look at agenda items as well as the length of the Board meetings.

   In order to better manage the agenda it is proposed that the Board moves to monthly meetings, rather than alternate formal meetings and workshops. If supported, this would be effective from June 2015. Stakeholder network events will still be held up to 5 times per year to provide development opportunities and partner engagement. Board members will be asked for their views on the proposed annual programme.

Health and Wellbeing Board Stakeholder Network

7. The Stakeholder Network event will take place on Tuesday 24 February 2015 between 6.30pm and 8.30pm at County Hall. It will focus on cancer. Invitations have been sent to Board members and wider stakeholders.

   For further information contact Nicola Lane, Public Health Manager, email: nicola.lane@nottscc.gov.uk tel: 0115 977 2130

Health & Wellbeing Board development (Lakeside Part 2)

8. Many members of the Board were involved in a session held last December 2013, to assist the development of the Better Care Fund at the Lakeside, Nottingham. This session explored issues beyond the Better Care Fund and highlighted the need to work together. It was extremely useful at promoting a common approach, allowing proper engagement with colleagues, especially from the Acute & Mental Health Hospital provider Trusts.

   It is proposed that a similar session be held in April 2015, to allow the Board an opportunity to consider its role and progress around the Better Care Fund. It will also allow the Board and its partners to consider the results of the forthcoming Peer Review and look at how we work together in a positive manner.

   The session is likely to be held on 29 April 2015. Board members are asked to hold this date in their diaries.

   For further information please contact Cathy Quinn, Associate Director of Public Health tel: 0115 977 2882 or email: cathy.quinn@nottscc.gov.uk

Health and Wellbeing Board logo

9. A logo for the Board has been devised and is attached as Appendix 1. The logo will be used on all appropriate business of the Health & Wellbeing Board following this meeting.

Update on policy and guidance

There have been a number of policies and guidance documents issued which are aimed at health and wellbeing boards. The following is a summary of those which may be of interest to Board members:

10. **Planning for the Better Care Fund**
    National Audit Office
    This report by the National Audit Office accounts how government departments devised, amended and assured planning for the Better Care Fund (BCF).

11. **Planning for the Better Care Fund**
    Local Government Information Unit Policy Briefing
    Briefing by the LGiU on the National Audit Office report on planning for the Better Care Fund attached as Appendix 2.

12. **Carers strategy: second national action plan 2014-16**
    This update to the national carers strategy provides an overview of achievements since the last update in 2010 and sets out key actions for the next two years. Major progress in identifying and supporting carers is being brought about by the Care Act and the Children and Families Act. The update encourages local areas to refresh their local carer strategies to ensure all partners are signed up to the latest developments.

13. **Integrated care: how to comply with Monitor's requirements**
    Monitor has updated previous guidance published in July 2014. It aims to assist providers and commissioners of healthcare services, and health and wellbeing boards to comply with their integrated care obligations. It also explains the relationship between these obligations and the other rules that Monitor enforces.

14. **Healthwatch survey: 2015 health and care issues**
    Results from a survey of local Healthwatch conducted during November and December 2014 have found that getting an appointment with a GP is the number one priority for the NHS to address over the next year. Other key issues were for a greater focus around discharge planning and ensuring people are properly engaged and involved in discussions around changes to local services.

15. **Manifesto for Community Pharmacy**
    Pharmacy Voice, Pharmaceutical Services Negotiating Committee (PSNC) and the Independent Pharmacy Federation (IPF).
    The Manifesto has been launched calling for politicians to champion community pharmacy and sign up to five key pledges.
    - Encourage patients to think 'pharmacy first', and use pharmacy to help relieve pressure on GPs and emergency departments
    - Improve patient choice and healthcare by making it easier to commission pharmacy services and backing more national services
    - Help improve the public's health, recognising the accessibility and support community pharmacy can provide
    - Enable patients, especially those with long term conditions, to get more from their medicines through better use of community pharmacy
    - Help pharmacies to get access to the records, information and support they need to provide more effective and safer care to patients.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) That the report be noted.

Councillor Joyce Bosnjak
Chairman of Health and Wellbeing Board

For any enquiries about this report please contact:

Nicola Lane, Public Health Manager. Tel: 0115 977 2130. Email: nicola.lane@nottscc.gov.uk

Constitutional Comments

14. This report is for noting only.

Financial Comments

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

Background Papers and Published Documents

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

- None

Electoral Divisions and Members Affected

- All

Nottinghamshire
Health & Wellbeing Board

POLICY BRIEFING

Planning for the Better Care Fund

Date: 25th November 2014

Author: Christine Heron LGiU associate

Summary

This report by the National Audit Office (NAO) gives a blow by blow account of how government departments devised, amended and assured planning for the Better Care Fund (BCF). In essence, while the NAO believes that the fund has potential, it is highly critical of how it has been managed, and doubts whether the programme will make the expected savings.

This is one of the most highly critical reports ever published by the NAO. Many of the points made, however, are consistent with the views of a range of health and care experts – the BCF is a good policy, but savings are too ambitious, timescales too tight, and revisions have taken it from its original local, preventative focus.

Despite all this, a huge amount of excellent work has gone into developing plans for integration, and the focus must now be on delivering the benefits to people who need health and care services.

This briefing will be of interest to councillors and officers in councils with adult social care responsibilities, and to those involved in health and wellbeing boards and health overview and scrutiny.

Briefing in full

The Better Care Fund timeline

This timeline traces the development of the BCF over the past eighteen months. It shows that much has happened in a relatively short space of time.

June 2013

The BCF was announced in the spending round. The aim was to pool £3.8 billion of existing funding, mainly from the NHS, into a single budget to provide integrated health and care to provide seamless services, reduce the need for hospital admission, and protect adult social care services. The spending round made an

assumption of savings of £1 billion from implementing the programme. The Department of Health (DH) and Department of Communities and Local Government (DCLG) developed the policy with NHS England and the LGA.

October 2013

Draft guidance was issued. The BCF was to be a local initiative led by councils and CCGs with a range of support from the LGA and NHS England available to local areas on a voluntary basis. The NAO indicates that there was no central programme team, limited risk management and no analysis of local planning capacity and capability. The guidance did not include the £1 billion savings requirement, or the need to show how savings would be achieved.

Feb 2014

Health and wellbeing boards, which had to approve plans, submitted first drafts.

April 2014

Health and wellbeing boards submitted their plans for approval. The total amount of savings they identified for 2015-16 was £731 million, but 53 health and wellbeing boards submitted plans identifying no savings. Areas were planning to pool £5.5 billion, and the additional £1.7 billion was seen as an endorsement of the fund's potential to improve services. The government allocated £200 million so local areas could start reforms, such as recruiting and training staff.

May 2014

NHS England estimated that only £55 million of the £731 million proposed savings were 'credible' and concluded that plans were overly optimistic. It found that local areas that had not engaged effectively with acute trusts estimated greater savings than those that had involved local hospitals. DH and DCLG also concluded that aspects of plans needed further development, and the approval process was halted.

The NAO does not mention this, but during this period many NHS bodies, particularly hospitals and their organisations, were waging a high profile campaign expressing concern about the impact of the BCF on their ability to provide services, and voicing suspicions that funding would be used to plug holes in local authority budgets, sometimes, literally, holes in roads.

May to July 2014

New guidance was issued, with significant changes. Part of the £1 billion element of the fund which was related to performance would now be paid solely on one indicator – a reduction in emergency admissions to hospital. Areas were asked to aim for at least a 3.5 percent reduction on 2014 levels, representing £300 million savings to NHS commissioners – or a smaller reduction if agreed by all local parties.

For example, areas are at different starting points for what has already been achieved in reducing unplanned admission.

The rest of the £1billion would have to be spent on NHS commissioned (or jointly commissioned) out of hospital services (rather than social care or prevention). Plans had to show how acute providers were involved, and providers supplied a commentary on the planned activity changes.

Government also tightened up the governance and programme management of the fund, with single NHS England 'responsible owner' – the National Director for Commissioning Operations. A programme director was established, and those involved in supporting the BCF were combined into a task force. A risk register was introduced, and £6.1 million extra funding to support and assure local plan development was allocated.

September 2014

Health and wellbeing boards submitted revised plans.

October 2014

Following independent assurance process, of plans submitted by the 151 health and wellbeing boards – six plans were approved outright, 91 needed a small amount of extra work, 49 were improved with conditions and five plans were not approved. Areas planned to pool £5.3 billion, 39 percent more than the minimum requirement of £3.8 billion but £0.2 billion less than April. The savings projection is £532 million, with emergency admissions forecast to fall by 3.1 percent. The assurers identified protection of social care services as the biggest risk, with 21 areas assessed as having material risks. In 20 percent of areas, providers gave heavily qualified support for the plan. NHS England required 12 areas to improve provider engagement.

January to March 2015

The first quarter when the level of reductions in emergency admissions will determine payment for performance.

April 2015

The first non-performance related payment for the Fund.

May 2015

CCGs will release the first of four in arrears payments for performance, based on reductions in admissions in January to March 2015 compared to January to March 2014 – provided this is achieved, or that the CCG considers this is the best way to address why the target has not been met.

NAO analysis

The NAO indicates that the BCF is innovative, with real potential to integrate health and social care. However, it was based on assumptions that integrated care would be effective in reducing emergency admissions on a sustainable basis, improving outcomes and saving money. The NAO believes that the evidence for this is 'tenuous', particularly when emergency admissions have been rising for many years and data is variable. Another dubious assumption was that this could be done without additional or transitional funding and within the same year. A further constraint were the financial stresses facing local authorities and, increasingly, the NHS.

The NAO believes that government departments and NHS England 'underestimated the complexity of bringing together the different health and social care organisations around a single local vision in a relatively short time'. Measures put in place during the July hiatus have 'much improved' the Fund's governance and programme management. However, the requirement to resubmit plans also meant areas lost time which should have been used for preparation. While the pause was the right thing to do, it also 'undermined the Fund's credibility with local bodies and increased the risks involved in implementing it'. The NAO concludes that expectations for savings 'are based on optimism rather than evidence'.

NAO recommendations

The NAO makes a series of recommendations for national government including:

- clarify the fund's long term vision, including expected patient benefits and financial savings
- clarify how the fund's performance management will work
- draw up a fund accountability system statement saying how the accounting officers will gain assurance on how local areas spend the fund
- agree financial and service expects with HM treasury and reflect these explicitly in progressive objectives and guidance.

Comment

Nobody could accuse the NAO of pulling its punches in this report; however, Health Service Journal (HSJ) understands that an earlier draft included the comment that the BCF was a 'case study in how not to manage a major cross-departmental programme'.

Local Government Chronicle (LGC) reports that the permanent secretaries of DCLG and DH have strongly objected to the report, and refused to follow a civil service procedure to approve the NAO's use of information. LCG understands that the permanent secretaries believe that the NAO report fails to understand that the programme was seeking to encourage local innovation and delivery.

In one way, the permanent secretaries have a point. Most of the NAO's recommendations are audit-centric, based solely on financial planning and risk management and as such tend towards bureaucratic central command and control.

However, if their recommendations miss the point, elements in their analysis have been echoed by many health and care stakeholders, such as the Kings Fund. Richard Humphries blog states that 'defying gravity would be easier' than reducing hospital admissions by 3.07 percent. Latterly, the HSJ and Serco Commission on Hospital Care for Frail Older People, chaired by University of Birmingham Foundation Trust Chief Executive Dame Julie Moore, supports integration and prevention but warns there is no evidence that these will lead to financial savings in the near future. The belief by politicians that health and social care integration is a 'silver bullet' to tackle NHS financial problems is a 'myth', while the Better Care Fund had been planned in a 'hokey cokey' fashion.

The BCF was greeted enthusiastically at first, particularly by local authorities, but CCGs were often also engaged. In many areas it brought local partners together to have useful conversations about how they could work better together in a formal way. Health and wellbeing boards were often energised by the prospect of overseeing a large-scale development.

However, growing concerns about the impact of pooling so much NHS funding and transferring it so quickly from acute care, with the danger of emergency health services folding and the associated media headlines, led to a swift change of political tack. While these dangers were probably real, it was the speed of implementation without transitional funding and with a requirement for large, same-year savings which made this so.

From a local government point of view, the changes to how the fund operates have been a severe disappointment. The NAO says:
'The LGA sees the Fund's core purpose as promoting locally led integrated care. The Association has stated publicly that the revisions undermine the Fund's core purpose, and reduce the resources available locally to protect social care and prevention initiatives. The delays and changes to the fund have eroded local goodwill and the Association told us that they revised policy and subsequent programme management arrangements had in their view moved the integration agenda backwards and not forwards.' (Paragraph 14.)

Nationally, the Government is said to be considering extending Better Care Fund approaches to public health and children's services; in contrast, in its Five Year Forward View NHS England urges that it should be evaluated before being rolled out further in health and care.

So, the BCF was conceived with good intentions, then hindered by financial worries, political concerns and an excess of enthusiasm rather than sound planning. But plans are now mainly approved and set for implementation. A huge amount of joint work has gone into the plans and it is essential that these should drive forward into

delivery. There is no doubt that in many areas the BCF is going to have a major positive impact on patient care and that some savings will be made. In most areas it is likely to result in many positive outcomes. It is important now that learning and good practice emerging from the work on the BCF are shared and adopted, rather than being blighted by criticisms of its processes.

Related policy briefings

NHS Five year forward view

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk

Nottinghamshire County Council

Report to Health and Wellbeing Board

4 February 2015

Agenda Item: 9

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

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

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To assist the Board in preparing its work programme.

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

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

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

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

Constitutional Comments (HD)

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

Financial Comments (NS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to the Board will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Health and Wellbeing Board & Workshop Work Programme

	Health & Wellbeing Board (HWB)	HWB Workshop (closed sessions)
4 February 2015	**Sexual Health** (Jonathan Gribbin) **NHS Five Year Forward View** (Steve Kell) **South Notts Transformation Compact** (Rebecca Larder) **NHS England restructuring** (Tracy Madge)[Presentation] **Chair's Report:** • Proposal for monthly meetings • Lakeside part 2 • British Sign Language Charter • Care Act Update report	
4 March 2015	**Adult Safeguarding Annual report** (Allan Breeton) **Breast Feeding** (Kate Allen) **Health & Wellbeing Strategy Update and Implementation Group report** (Anthony May/ Cathy Quinn) **Better Care Fund – progress around pooled budget** (Jon Wilson/Lucy Dadge)[deferred from February] **Approval of the Pharmaceutical Needs Assessment** (Cathy Quinn) **Learning Disabilities Self-assessment** (Cath Cameron Jones) **Autism Self-Assessment** (Cath Cameron Jones) TBC	

	Health Scrutiny, Healthwatch and the Health & Wellbeing Board *TBC* **Chair's Report:** • Report on Pharmacy Applications	
1 April 2015	***CCG Commissioning Plans – to be discussed with CCGs*** **Dental Public Health & Fluoridation** (Kate Allen) ***Public Health Committee Annual Summary*** *(TBC)* ***Annual Statement of Assurance for Health Protection*** *(Jonathan Gribbin) TBC* ***Follow up report on Healthy Child Programme and Public Health Nursing for Children and Young People*** *(Kate Allen) TBC* **Health & Wellbeing Strategy report** (Anthony May/ Cathy Quinn) **Chair's Report:** • **Adolescent Health Strategy** **Update on Leaving Hospital Policy** (6 month update requested at HWB 1.10.14)	
May 2015	***No Meeting due to elections***	
3 June 2015	**Excess Winter Deaths** (Mary Corcoran) **Better Care Fund report** (Jon Wilson)	
July TBC		
September TBC		
November TBC		
January 2016 TBC		
March 2016 TBC		