Nottinghamshire County Council

Health and Wellbeing Board (Shadow)

Wednesday, 06 March 2013 at 14:00

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

AGENDA

Notes

(1) 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

(2) 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.

minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday, 16 January 2013 (commencing at 2.00pm)

membership
Persons absent are marked with `A'

COUNCILLORS

Reg Adair
Mrs Kay Cutts
Martin Suthers OBE (Chair)
Alan Rhodes
A Stan Heptinstall MBE

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

Dr Steve Kell	-	Bassetlaw Clinical Commissioning Group
Dr Raian Sheikh	-	Mansfield and Ashfield Clinical Commissioning Group
Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
A Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group
Dr Tony Marsh	-	Nottingham North & East Clinical Commissioning Group

LOCAL HEALTH WATCH

A Jane Stubbings	-	Nottinghamshire County LINk

NHS COMMISSIONING BOARD

A	Helen Pledger	-	Local Area Team, NHS Commissioning Board

OTHER COUNCILLOR IN ATTENDANCE

Councillor Joyce Bosnjak

OFFICERS IN ATTENDANCE

Barbara Brady	-	Public Health
Paul Davies	-	Democratic Services
Cathy Quinn	-	Public Health
Nick Romilly	-	Public Health
Dr Barbara Stuttle CBE	-	Local Area Team, NHS Commissioning Board
Dr Helen Walsh	-	Rushcliffe Clinical Commissioning Group

MINUTES

The minutes of the last meeting held on 7 November 2012 having been previously circulated were confirmed and signed by the Chairman, subject to the amendment of the penultimate line of page 4 to read "That the use of social media in health promotion be explored…"

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Heptinstall, Dr Griffiths, Jane Stubbings and Helen Plegder.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

Dr Jefford declared an interest in behalf of the CCG representatives in the items on Domestic Violence and Carers' Funding Allocation.

DEVELOPING VIABLE OPTIONS FOR SHERWOOD FOREST HOSPITALS AND SURROUNDING HEALTH ECONOMY THROUGH A PARTNERSHIP TRANSFORMATIONAL APPROACH

Dr Jefford introduced the report which updated the Board following the presentation about Sherwood Forest Hospitals Trust to the previous meeting. Reports on the Trust's finances and governance would go to the Trust's Board and then to Monitor. The report also outlined the role and composition of the Mid-Nottinghamshire Integrated Care Transformation Board.

RESOLVED: 2013/001

(1) That the progress under way to secure a vision for sustainable hospital and community based services in mid Nottinghamshire be noted.

(2) That update reports be presented to each meeting of the Health and Wellbeing Board.

TACKLING DOMESTIC VIOLENCE IN NOTTINGHAMSHIRE

Barbara Brady and Nick Romilly gave a presentation on the health and wellbeing dimension to domestic violence. They drew attention to current work by agencies to prevent or respond to domestic violence and identified gaps in current services and the challenges which still had to be met. They responded to questions and comments.

- Cases identified as medium risk could also result in death. This made dealing with the challenges identified in the report all the more important.

- Partnership working should include work with perpetrators. The proposed changes for Probation should be taken into account.

- Training on domestic violence should be widely spread, and include housing workers, for example.

- How was the capacity of services assessed? Was there sufficient administrative support? Could district councils help? - District councils were quite actively engaged. However the NHS could engage more, through its domestic violence representatives.

- The action plan in recommendation (2) should be costed. - Chris Kenny assured the Board that this would be the case.

- Intervention should be at the time of disclosure, not by way of communication back to the victim's GP. - Action would be taken at the time of disclosure. However the GP was seen as having a holistic view of the patient. A high risk case would be referred to MARAC (Multi Agency Risk Assessment Conference). For medium risk cases, there were more gaps in service.

- The role of voluntary organisations should be recognised. - Providing contact details for voluntary organisations could be one of the actions taken.

- The table on page 7 of the report showed a great variation in the numbers disclosing domestic violence. - This reflected the areas served by Sherwood Forest Hospitals midwifery service. The purpose of the table was to show the extent to which domestic violence was under-reported.

- Work should also take place with perpetrators to break the cycle of domestic violence. - This was acknowledged. Probation worked with some perpetrators, but not all.

- Victims included people over 60, where their children might be the perpetrator, and male victims, who did not receive the same level of support as females. - This showed the challenge of measuring the real scale of the problem. If support was tailored to the victim, their gender should not be an issue.

- Another consequence was the impact on children of witnessing domestic violence against a parent. - Services existed to deal with this.

- It was important to share information, and this could over-ride confidentiality issues.

- The MASH (Multi Agency Safeguarding Hub) was an opportunity to link actions together. Agencies were encouraged to report disclosures to MASH, which covered both adults and children, and could help agencies access an appropriate response.

- It was important to develop a proper business case for filling the gaps in service, including the costs to the NHS of domestic violence, and whether funds could be diverted from less effective activities.

- The contract for health visitors and district nurses required that they be trained in domestic violence.

- Serial victims of domestic violence existed, and had low self-esteem. - Specialised support should reduce the risk of repeated violent relationships.

- Low self esteem could be deep-rooted. Children's Centres worked with parents to develop self esteem, by for example encouraging people to return to work.

- Obvious actions should be taken without delay.

RESOLVED 2013/002

(1) That the report be noted.

(2) That approval be given for the Domestic Violence Strategy Group to develop a costed plan of action to address the challenges identified in the report, and present a follow-up report to the Health and Wellbeing Implementation Group in three months time.

EXPENDITURE OF CARERS FUNDING ALLOCATION - PROPOSED PLANS OF NOTTINGHAMSHIRE CCGs

David Pearson introduced the report, which advised the Board that £1.5m was to be allocated from Health to the County Council to be spent on support for carers. The report outlined to proposed uses for the funding, and governance arrangements to ensure its correct use. Mr Pearson observed that the 2011 census had identified 91,000 carers in Nottinghamshire, of whom 23,000 provided more than 20 hours of care per week.

RESOLVED: 2013/003

(1) That the report be noted and the recommendations for the proposed expenditure of the additional £1.5m funding be supported.

(2) That a further report be presented in April 2013 updating on the Carers Strategy and how the additional funding will be used across Health and Social Care.

HEALTH AND WELLBEING IMPLEMENTATION GROUP REPORT

The report summarised progress made by the Health and Wellbeing Implementation Group and the integrated commissioning groups. David Pearson invited the Board's views on how this information should be presented in future. Board members acknowledged the importance of knowing how their recommendations were being pursued. A "you said - we did" layout was suggested, with the Board's recommendations as a starting point. A further suggestion was to link progress to outcomes rather than processes. It was stated that frameworks and output measures were being developed, and indicated that the next report on the Tobacco Alliance would have output measures.

It was observed that Appendix 4 to the report, about tobacco control, did not identify action against illegal and contraband tobacco. The City Council was understood to have two officers dealing with this. Tobacco could be "cut" with dangerous substances. In response, it was pointed out that the County Council also did work against illegal tobacco, and the report did not cover every action being undertaken.

David Pearson observed that overall, considerable progress was being made.

In relation to the establishment of local HealthWatch, it was reported that the County Council's Policy Committee on 16 January 2013 had approved the direct appointment of a chairman and implementer for the HealthWatch board.

RESOLVED 2013/004

That the progress being made to support the work of the Board and the delivery of the Health and Wellbeing Strategy be noted.

ROLE OF DISTRICT COUNCILS IN IMPROVING HEALTH AND WELLBEING

Councillor Hollingsworth introduced the report, which summarised district council activities in support of the Health and Wellbeing Strategy. She indicated that each district council was preparing its own implementation plan, and suggested a stronger recommendation to the Board, as set out below.

Councillor Roberts also supported a stronger recommendation. He stated that the Board could also audit what each district council was doing to meet its area's needs.

David Pearson expressed the Board's thanks to Councillor Hollingsworth, John Robinson and Ruth Marlow for their work. He added that the report was a summary and information for each district was available on request.

In reply to a question about whether any funding went from the county to district councils, Chris Kenny indicated that some of the Public Health Grant was passed to district councils.

The Chairman asked whether district councils were satisfied with the way in which they related to the Board. Councillor Hollingsworth replied that she and Councillor Roberts worked hard to gather all district councils' views. All district councils were invited to the pre-meeting a few days before the Board

met. There had been no complaints, although she was aware that some district councils had asked for their own seat on the Board.

It was agreed to accept the revised recommendation, and therefore it was -

RESOLVED 2013/005

That the Health and Wellbeing Implementation Group be tasked to look at future commissioning models between district councils, CCGs and Public Health to support the Health and Wellbeing Strategy.

AMBITION AND OPERATING PRINCIPLES FOR THE HEALTH AND WELLBEING BOARD

The report summarised discussions at the workshop on 28 November 2012 and proposed an ambition statement and operating principles for the Board. Points made during discussion about the report included:

- The Board had important decisions to take and should wherever possible take its decisions in public.

- The Code of Conduct did not adequately reflect the position of the non-councillors on the Board. It was understood that regulations which were due shortly would address this. There would be a further report to the Board about this.

- CCGs were themselves representative organisations with a large membership. They were not in a position to consult their membership on every issue.

- The role of the Board could be enhanced, given that it was the only setting with this membership, to promote joint working with CCGs and local authorities and ensure that Public Health outcomes were delivered.

- There would be a report to the next meeting about an outcomes framework.

RESOLVED: 2013/006

That the ambition statement and supporting principles be agreed for the time being, and subject to review in the light of the forthcoming regulations.

COMMUNICATIONS AND ENGAGEMENT PLAN

The report proposed a communication and engagement plan for the Board, Joint Strategic Needs Assessment and Health and Wellbeing Strategy. It was suggested that large local employers be included among the collaborators and providers, that the Local Area Team of the NHS Commissioning Board also be included in the plan, and that the plan be reviewed after the Board became fully operational on 1 April 2013.

RESOLVED: 2013/007

(1) That Communication and Engagement Plan proposed in Appendix 1 to the report be accepted.

(2) That a national management trainee or similar project worker provide short-term dedicated support to undertake this work and to provide a presence on behalf of the Board at local events.

(3) That early work be undertaken to coordinate communications and engagement activity across the County Council and with key partners under the overarching plan.

(4) That the Communications and Engagement Plan be initiated by a refresh of the Health and Wellbeing Board website to include more detail about the Board and its members, their remit and work programme.

(5) That the Communications and Engagement Plan be reviewed after 1 April 2013.

PUBLIC HEALTH GRANT AND BUDGET PLANNING UPDATE

Chris Kenny reported that since the report had been written, the Government had announced that the allocation to the County Council for Public Health would be £35.1m in 2013/14 and £36.1m in 2014/15. Options would be reported to the Public Health Sub-Committee in February and the Board in March. He did not anticipate many changes in how the budget was spent in 2013/14, as existing contracts would be carried forward. However there were opportunities to change how the budget was spent in 2014/15. The Board was well placed to consider the options. In reply to a question about linking spending to targets, Dr Kenny referred to the outcomes framework to be reported to the next meeting.

RESOLVED: 2013/008

(1) That the 2012/13 Public Health Budgets in place be noted, and the services that the budget is used to commission, to address the health needs across Nottinghamshire County.

(2) That the information on the planning work undertaken to date be received.

(3) That it be noted that the preferred option for setting budgets for 2013/14 is Option 1 (fund all current pre-commitments only and use the non-recurrent monies to meet in-year cost pressures and financial risks).

The meeting closed at 4.30 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health and Wellbeing Board

6th March 2013

Agenda Item: 4

REPORT OF INDEPENDENT CHAIR OF NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Purpose of the Report

1. The purpose of this report is to inform the Health and Wellbeing Board of the work of the Nottinghamshire Safeguarding Adults Board and to provide a summary of the NSAB annual report 2011/12.

Information and Advice

Introduction

2. The Nottinghamshire Safeguarding Adults Board is the multi-agency group of senior managers from key organisations responsible for developing and implementing processes to safeguard vulnerable adults. 'Safeguarding Adults' encompasses work undertaken to help individuals who may need community care services to retain independence, wellbeing and choice and to help maintain their human right to live a life that is free from abuse and neglect. The Board was established in April 2008 and has built upon the seminal work undertaken by its predecessor, the Nottinghamshire Committee for the Protection of Vulnerable Adults (NCPVA). Allan Breeton was appointed as independent chair for NSAB in the autumn of 2009.

3. The Board has been implementing the recommendations in the Department of Health (2000) "No Secrets" report which has been key in providing much of the early impetus for the safeguarding adults' agenda. It provided guidance to local agencies that have a responsibility to investigate and take action when a vulnerable adult is believed to have been subject to abuse. It offers a structure and content for the development of local inter-agency policies, procedures and joint protocols which draw on good practice nationally and locally. The much quoted sentence from No Secrets "There can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults", remains at the heart of all safeguarding adults' work.

4. This guidance has more recently, in 2005, been supplemented by the ADASS document "Safeguarding Adults: A National Framework of Standards and outcomes in adult protection work"

5. Our vision for Nottinghamshire with regard to safeguarding adults is of a county where all adults can live a life free from any form of abuse or neglect. The aim of the board is **'to safeguard vulnerable adults from harm and abuse by effectively working together'.** The Board has produced a coordinated multi agency policy which ensures a consistent approach to safeguarding is applied across the county. It has developed a culture of cooperation and critical review which has led to improvements in practice and outcomes for those adults at most risk of abuse.

The Sub Groups

6. There are four sub groups which sit under the Nottinghamshire Safeguarding Adults' Board with representatives of each of the statutory agencies. These sub groups; Quality Assurance, Serious Case Review, Training and Communications, deliver the strategy and actions arising from the Board.

Quality Assurance

7. The Board monitors the quality of its safeguarding response via the Quality Assurance (QA) sub group. The Quality Assurance sub-group is chaired by the Group Manager within the Council who has lead responsibility for Safeguarding Adults. Regular audits of safeguarding assessments are undertaken and learning fed back to individual practitioners and wider audiences as relevant. The key functions of the QA sub group are to:

    - Provide NSAB with information on issues of quality, performance and audit.
    - Ensure service user/carer involvement and participation and feedback.
    - Assure the safeguarding adult process and practice across the County.
    - Assure the quality of the NSAB policy and procedures
    - Monitor organisational action plans
    - Audit the functions and process of the safeguarding board
    - Assure Inter-organisational arrangements are effective
    - Assure intra-organisational governance arrangements are in place
    - Develop recommendations for future Quality Assurance systematic annual Board audit

8. The sub group has recently developed a "Thresholds and Pathways" document which supports the multi-agency procedures and provides further advice and guidance on the referral process. This document is now being used by relevant statutory agencies and by independent sector providers and voluntary sector agencies.

Serious Case Review

9. At the present time the sub group is chaired by the Chief Officer of Newark and Sherwood, and of Ashfield and Mansfield Clinical Commissioning Groups, who is also the Director of Nursing and Integrated Governance for NHS Nottinghamshire County. The group has representation from health, social care and the police. The sub group ensures that cases of death or serious harm that involve abuse or neglect are thoroughly investigated. Its aim is find out why things went wrong and then to ensure that lessons are learned and shared across agencies. A Serious Case Review is commissioned where there has been multi-agency involvement and where there may have been factors of multi-agency working which may need to be improved to prevent the situation arising again in the future.

10. Serious case reviews have been undertaken under national guidance since 2007. During that time NSAB has commissioned five serious case reviews within Nottinghamshire; three in 2009, one in 2010, one in 2011 and the most recent review was commissioned in February 2012. The executive summaries and recommendations relating to each of these Serious Case Reviews are published on the Council's internet site. In each of these cases the Independent Author made a series of recommendations (which are available on Nottinghamshire County Council's website) to ensure that lessons are learned by the relevant agencies so that similar circumstances are, wherever possible, avoided in the future. Recent serious case reviews involving adults with pressure ulcers have led to improved monitoring, documentation, recording, and treatment for adults with pressure ulcers and a more coordinated multi agency response.

Training

11. The Board continues to oversee the delivery of both individual and multi-agency training via the training sub group. The sub group is chaired by the Multi-Agency Training Coordinator with the Safeguarding Adults Strategic Team. The sub group is made up of managers who hold key roles within the learning and development functions within their agencies. The sub group seeks to ensure that appropriate levels of training are provided across the County and that this is accessible to statutory, independent and voluntary organisations.

12. This comprises of the regular and ongoing training which is provided for Safeguarding Referrers, Investigating Officers, Safeguarding Managers and Training for Trainers. In addition, the Board hosted a "one off" training event which considered the criminal offence introduced by Section 44 of the Mental Capacity Act (2005) – "Wilful neglect or ill treatment of a person who lacks capacity". This event brought together a range of police, health and social care practitioners to explore the issues connected with this relatively new piece of legislation and to find ways of overcoming barriers to its appropriate use.

Communications

13. The Communications sub group is chaired by one of the County Council's Senior Audience and Communications Officers. This group has two important roles, the first of which is to raise awareness about safeguarding adults with front line staff including social workers, police officers, and with care workers including those who work within the independent sector, so they understand how to recognise adult abuse, how to report concerns and what processes are involved.

14. The second role is to raise awareness with the general public so they know what adult abuse is, who might be affected and how they can report it. The "good neighbour campaign" was launched by the communications sub group in June 2012 as one part of the Board's wider communication strategy. This campaign aims to raise awareness of what we can do to "look out" for those who may be more at risk in our communities.

The Multi Agency Partnership

15. The Nottinghamshire Safeguarding Adults Partnership is a broad group of organisations drawn from across Nottinghamshire consisting of agencies from the public, private and voluntary sector that have an interest in Adult Safeguarding. The Partnership meets twice yearly and provides for a two way flow of information between NSAB and those organisations which are able to contribute to the safeguarding agenda. We have forged strong links with the Nottinghamshire Coroner who gave a presentation at a recent Partnership event which was extremely well received. In May this year the half day event focused on raising awareness of the Mental Capacity Act. It included presentations and case studies and allowed those present to consider what further work is needed to fully embed the Act within their organisations.

16. Much of the work of the Partnership is focused on raising awareness of safeguarding and ensuring all agencies and their staff are able to identify safeguarding concerns and are familiar with the process to follow to make a "referral". Our work in this area has contributed to the high number of safeguarding referrals which Nottinghamshire historically has in comparison to neighbouring Council areas.

Safeguarding Adults' Peer Challenge

17. In November 2011 NSAB commissioned a peer review into all aspects of safeguarding adults in the County to provide independent scrutiny and quality assurance of its safeguarding processes. This was conducted in accordance with the Local Government Group Safeguarding Adults Peer Challenge Group methodology which had originally been developed by the Improvement and Development Agency (IDeA). The Association of Directors of Adult Social Services (ADASS), the Social Care Institute for Excellence (SCIE) and the NHS confederation have endorsed the standards used. These standards focus on identifying opportunities for improvement and learning in 8 main areas:

    - Outcomes
    - People's experience of safeguarding
    - Leadership
    - Strategy
    - Commissioning
    - Service delivery and effective practice
    - Performance and resource management
    - Local Safeguarding Adults Board

18. The Peer Challenge was chaired by an independent person, Mr Mike Evans, who is a former Director of Social Services in Leeds and who is currently the Independent Chair of Cumbria's Safeguarding Adults' Board. The findings of the peer challenge team were that safeguarding adults practice and procedures in Nottinghamshire are basically "sound". A detailed report was produced with a number of recommendations and associated action plan. The Board is currently overseeing the implementation of this.

19. Key work streams arising from the peer challenge include the introduction of the "National Capability Framework" for safeguarding adults, the development of a service user engagement strategy, a review of performance data provided to the Board and a review of the multi-agency policy, procedures and practice guidance.

Multi Agency Safeguarding Hub (MASH)

20. NSAB has fully supported and contributed to the development of the MASH which recently went "live" for adults on Monday 28th January 2013. The MASH provides agencies with a single point of contact for all adult safeguarding referrals. This will ensure that Safeguarding Adults is able to reap the full benefits of closer inter agency working at the point of referral and throughout the safeguarding process.

Annual Report 2011/12 – Key Facts and Figures

21. The Board produces an annual report which contains both statistical and qualitative information on its performance and that of adult safeguarding in the preceding year. Our more recent annual reports reflect feedback and are shorter with less statistics, user friendly, focused on outcomes and how the Board has "made a difference".

22. After a slight fall last year, this year has seen the continued upward trend in the number of safeguarding referrals made to Nottinghamshire County Council from 880 in 2007/8 (when Nottinghamshire commenced recording safeguarding data as a single Local Authority) to a total of 2,939 referrals being received in 2011/12. The more recent increase in referrals is due to increased awareness of adult safeguarding due to effective local communication initiatives and as a result of greater national publicity following high profile reports and media stories such as that at Winterbourne View.

23. NSAB also collates data in relation to the number of referrals by service user group and age band. As we might expect the figures for 2011/12 show high numbers of referrals relating to elderly people with significant numbers in the 75-84 and 85+ categories. The other area of high numbers of referrals is within learning disabilities.

24. A comparison of the last 2 years' figures showing the number of referrals by service user group and age band shows a significant increase in the number of referrals in the Learning Disability (455 to 679) and Mental Health (253 to 336) categories and this coincides with the BBC Panorama programme screened in May 2011 highlighting abuse at Winterbourne View, Bristol, an independent hospital which provided services for adults with Learning Disabilities. The publicity generated by this, combined with the rigorous analysis of the issues in the subsequent serious case review, has led to a considerable amount of safeguarding activity involving a number of agencies including the Care Quality Commission, commissioners of services and the independent sector. Additionally, the independent sector has accessed the multi-agency training programme provided by the Board thus increasing their knowledge and awareness of the safeguarding agenda. This is likely to account for some of the increase in referrals in this category.

25. Recent benchmarking data from comparator local authorities has indicated that the numbers of referrals that lead on to a safeguarding assessment are broadly similar in number to those of other authorities. The data showed that the numbers of safeguarding assessments in Nottinghamshire are in the middle ranges when compared to those of other comparator local authorities.

26. The statistical returns provided to central government concentrate on those referrals which led to a safeguarding assessment. In Nottinghamshire, 1,137 of the 2,939 referrals received in 2011/12 went on to assessment. Guidance has been produced in terms of a "Thresholds and Pathways" document which compliments the multi-agency procedures and provides

practical examples of circumstances which require a safeguarding referral. It is anticipated that once this guidance is embedded into practice we will see a reduction in the percentage of referrals which don't subsequently go on to require a full safeguarding assessment.

27. Additionally, it is anticipated that the work undertaken by staff at the MASH and the advice they provide to the people who make referrals will ensure that only the appropriate referrals are progressed on to safeguarding assessments. Where the referrals do not warrant a safeguarding assessment, the referrers will be notified of the process under which their referral will be addressed – in some instances this will trigger the need for a self-direct support assessment to determine social care needs. The work undertaken by staff at the MASH will enable greater consistency of decision making in terms of those referrals which require a full assessment.

Legislative Changes and Next Steps

28. On 11th July 2012 the Government published its response to the Law Commission report on Social Care - "reforming the law for adult care and support: the Government's response to the Law Commission". In it the Government pledged to:

- create a new statutory framework for adult safeguarding, to clarify the roles and responsibilities of local authorities and other organisations
- ensure there is a Safeguarding Adults Boards in every local authority area, as the vehicle for co-ordinating partners activity on safeguarding
- consult on whether to introduce new powers for local authorities to enable them in their safeguarding enquiries

29. There has been much debate recently over the issue of terminology and the Law Commission favoured a move away from the term "vulnerable adult" and to the term "adult at risk". However, the Government's view is that the use of any particular descriptive term in the legislation will be problematic and unlikely to be future proof or suitable for a modern care and support statute. The Government also dismisses the proposal to set definitive criteria for who would be considered to be at risk of harm. The Government's "preference would be to define the scope of safeguarding in law with clearer reference to concepts of "abuse" and "neglect". This is where the core work of adult safeguarding should sit, "where adults in vulnerable situation are hurt because of actions (or lack of action) of others".

30. The clear message from Government is that it will place adult safeguarding on a statutory framework and that "adult safeguarding activity should be focused on cases where a person is at risk as a result of the act or omission of another".

31. Whilst the current arrangements for safeguarding adults are not set in legislation, there are already well established and strong partnership arrangements in place within Nottinghamshire with both relevant statutory agencies and voluntary sector agencies contributing to the work of the Board. As such, NSAB is already well positioned to undertake any statutory responsibilities which the forthcoming legislation may bring. Any changes to adult safeguarding resulting from Government legislation will be reflected in future reviews of the multi-agency procedures.

Conclusions

32. The work undertaken by NSAB continues to develop and the Board, through its sub groups, ensures that agencies are ensuring that the multi-agency policies and procedures are being implemented effectively throughout their relevant organisations. The Board will continue to ensure that health and social care services help to reduce the risk of harm and that where harm has been known to have taken place, that effective processes are in place to prevent individuals from further harm.

Statutory and Policy Implications

33. 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) It is recommended that the Health and Wellbeing Board note the contents of this report.

ALLAN BREETON
Independent Chair of Nottinghamshire Adults' Safeguarding Board

For any enquiries about this report please contact:
Allan Breeton
Independent Chair of Nottinghamshire Adults' Safeguarding Board

Constitutional Comments (NAB 25.02.13)

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

Financial Comments (CLK 25.02.13)

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

Background Papers

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

a. Peer Challenge Report

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Health and Wellbeing Board

6th March 2013

Agenda Item: 6

REPORT OF DIRECTOR OF PUBLIC HEALTH

SEXUAL HEALTH IN NOTTINGHAMSHIRE COUNTY

Purpose of the Report

1. This report provides an overview of Sexual Health and Wellbeing in Nottinghamshire County. It provides estimates of prevalence of sexual ill health across the county, information on national and local policy drivers and a summary of the services in place to meet assessed need and improve population sexual health. It also highlights future commissioning options in line with priorities and the new organisational roles and responsibilities.

Information and Advice

2. The World Health Organisation defines Sexual health as:

   "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006a)

3. Sexual Health includes a number of key elements:

   - Prevention and treatment of Sexually Transmitted Infections (STIs)
   - Prevention of unintended pregnancy
   - Early access to Termination of Pregnancy services
   - Infertility help and advice
   - Sexual well-being services, including advice on and access to contraception services
   - Safeguarding of young people and vulnerable adults
   - Aspects of mental health related to sexual dysfunction
   - Addressing risk taking behaviour associated with substance misuse and insufficient resilience

4. Sexual health is an important issue for Nottinghamshire County for a number of reasons:

- Many STIs have long-term effects on health.
- Some Genital Wart infections and Chlamydia are associated with cervical cancer.
- Untreated, between 10 and 20% of Chlamydia cases result in infertility due to pelvic inflammatory disease (Land et al 2010). Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection and over 186,000 new cases were diagnosed in England in 2011 (HPA website).
- Genital warts are caused by the Human Papilloma Virus (HPV) and these do not usually have any long term effects on health. However, other strains of HPV which are also sexually transmitted are associated with cervical cancer.
- Syphilis can mimic a range of conditions and the long term consequences, which may occur many years later, can affect the cardiovascular and neurological systems. Untreated it can lead to serious complications and even death. In pregnancy it can lead to miscarriage or stillbirth and can be passed on to the baby.
- The natural progression of the Human Immunodeficiency Virus (HIV) is to develop profound immunosuppression, which can lead on to the Acquired Immunodeficiency Syndrome (AIDS) and may possibly lead to death.
- In 2011, 6,280 people were newly diagnosed with HIV in the UK, compared with 7,914 in 2005, when the number was at its highest (BASHH 2011).
- The proportion of heterosexuals who acquired their infection in the UK continues to increase (BASHH 2011).
- There are at least 20,000 people unaware of their infection, around half of whom are heterosexual (BASHH 2011).
- There has been a slow but significant decline in the proportion of people diagnosed late (CD4<350 cells/mm^3) over the past decade. Nevertheless, the proportion of late diagnoses remained high in 2010 (50%). These individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed promptly (HPA 2012).
- More than 2.1 million HIV tests were performed in England in 2010; most were within the STI clinic and antenatal settings. The coverage of HIV testing among all attendees in these settings was 69% and 96%, respectively (HPA 2012).
- If the 3,640 UK-acquired HIV diagnoses made in 2010 had been prevented, between £1.0 and £1.3 billion lifetime treatment and clinical care costs would have been saved (NICE 2011)

5. There is evidence of an increase in risky sexual behaviour, with continued lack of knowledge about the possible consequences:

    - The average (median) age which people start having sex is now 16; forty years ago it was 21.
    - Between a third and a half of teenagers do not use contraception at first intercourse. 43% of young people (age 15-24) had unprotected sex with a new partner in Great Britain in 2010. Of those surveyed 15%, compared to 36% in 2009 (Bayer 2010) gave the reason as getting drunk or forgetting contraception.
    - Young adults (15-24 years old) make up only 25% of the sexually active population, but represent almost 50% of all new acquired sexually transmitted diseases (Ros et al 2008).
    - 15% of young adults between the ages of 18 and 26 have had a sexually transmitted disease in the past year (Wildsmith 2010)
    - Nationally there were 32,552 under age 18 conceptions in 2010 compared to 40,336 in 2007. Across Nottinghamshire in 2010 there were 461 compared to 524 in 2007. 43% lead to abortion.
    - Half of all conceptions in those aged under 18 occur in the 20% most deprived wards. Teenage pregnancy can affect long-term health and social outcomes of both parents and children. Babies of teenage mothers have a 60% higher risk of dying in the first year of life and have a significantly increased risk of living in poverty, achieving less at school and being unemployed in later life.
    - The National Survey of Sexual Attitudes and Lifestyles (NATSAL) in 2000 identified that the East Midlands had the highest percentage of women aged 16-29 that had had 2 or more partners in the last year and did not use a condom.

Health inequalities

6. The highest burden of sexually related ill-health is borne by women, gay men, teenagers, young adults, black and minority ethnic groups and more deprived communities.

7. Children born to teenage parents are less likely to be breastfed, more likely to live in poverty and more likely to become teenage parents themselves (Botting et al. 1998 cited in NICE 2007).

8. 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 (Hofferth et al 2002).

Resource Implications

9. Preventative services both promote well-being and positively impact upon financial costs. It has been estimated that that the prevention of unplanned pregnancy by the National Health Service (NHS) contraception services saves the NHS over £2.5 billion a year, and through activities such as Chlamydia screening there is the potential to dramatically reduce costs associated with preventable infertility and pelvic inflammatory disease.

10. Every £1 invested in contraception saves the UK NHS £11 plus additional welfare costs, which is a powerful economic argument for maintaining contraceptive services (Teenage Pregnancy Independent Advisory Group 2010).

11. Overall, the cost to the NHS alone of teenage pregnancy is estimated to be £69m annually (Teenage Pregnancy Independent Advisory Group 2008 http://publicpolicyexchange.co.uk/docs/8J02-PPE_4_Gill_Frances.pdf).

12. In October 2006 NICE guidelines on Long Acting Reversible Contraception (LARC) suggested that an 8% shift from oral contraceptive to LARC methods would result in a net saving to the NHS of over £102 million.

National and Local Drivers

National Drivers

13. The National Strategy for Sexual Health and HIV (DH 2001) highlighted significant inequalities in sexual health and set out a blue print for the development of sexual health services. Subsequently, improving sexual health was identified as one of the key national priorities in the White Paper, Choosing health (2004) The White Paper 'Our Health, Our Care, Our Say (Department of Health 2006)[3] and associated consultation paper 'Commissioning Framework for Health and Well Being' 2007 prioritises sexual health, adopting the themes and principles of person centred services, better understanding of the needs of populations and individuals, preventative services that emphasise healthy living and well-being and more effective joint planning and service delivery. It also builds on principles within the National Strategy for Sexual Health and HIV (Department of Health 2001) and Effective Commissioning of Sexual Health and HIV Services (DH 2003). These include improved health and social care for people with HIV and AIDS, reducing health inequalities within sexual health, reducing stigma and involving service users in plans and developments.

14. The following documents also shape the focus for Sexual Health service provision:

- Public Health Outcomes Framework for England (2012).
- Service Standards for Sexual Health and Reproductive Healthcare (2011).
- Teenage Pregnancy Independent Advisory Group Final Report (2010).
- Moving forward: Progress and priorities – working together for high-quality sexual health (2009) Department of Health.
- High Quality Care for All (Darzi) Review (2008).
- Evaluation of One-Stop Shop Models of Sexual Health Provision (2007).

- Home Office. Tackling sexual violence: Guidance for local partnerships (2006) The Government is committed to taking a partnership approach to improving both justice and health outcomes for victims of sexual violence. Sexual Assault Referral Centres (SARC) have a role to play in the delivery of several government agendas, including safeguarding, sexual health, mental health, public health, reducing crime and the fear of crime, increasing victim and witness satisfaction and bringing offenders to justice.
- National Institute for Health and Clinical Excellence guidance on Long Acting Reversible Contraception (LARC 2005).
- Prevention of sexually transmitted infections: a review of reviews into the effectiveness of non- clinical interventions. Health Development Agency (2004).
- HIV Prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission. Evidence briefing Health Development Agency (2003).
- The National Sexual Health and HIV Strategy (2001).

Local Drivers

15. The Joint Strategic Needs Assessment (JSNA) has identified Sexual Health (including Teenage Pregnancy) as important to the Health and Wellbeing of people living in Nottinghamshire County. It reinforced that poor sexual health is closely linked to social patterns and deprivation. The JSNA highlighted significant variation across the county in both the prevalence of STIs and the number of teenage conceptions. Addressing sexual ill health and promoting sexual wellbeing is a key step to reducing overall health inequalities.

16. In 2010/11 the NHS Operating Framework instructed Primary Care Trusts to divest themselves of provider services by April 2011 as part of the Transforming Community Services Programme. As a result responsibility for the delivery of Sexual Health services for Nottinghamshire County Southern Boroughs transferred to Nottingham University Hospital (NUH), Nottinghamshire Northern Districts to Sherwood Forest Hospital Trust and Bassetlaw to Bassetlaw Health Partnership (which is part of the Nottinghamshire Mental Health Trust).

Targets and Performance

17. **Targets and indicators** – currently key priority indicators for teenage pregnancy, Chlamydia screening, Genitourinary Medicine (GUM) and abortions include the following targets:

    - A 50% reduction in the under 18 conception rate by 2010 (from the 1998 baseline of 46.4 per 1,000). Nottinghamshire County has extended this to continue to achieve a downward trend.

    - A Chlamydia screening diagnostic target of 2,400 diagnoses per 100,000 15-24 year olds (until 2012 this was a coverage target which measured the proportion of 15-24 year olds screened for Chlamydia as a proxy for Chlamydia prevalence)

    - 100% of patients attending GUM services are offered an appointment to be seen within 48hrs

18. The Public Health Outcomes Framework, which comes into effect from April 2013, includes three sexual health specific outcomes in two of the four domains.

Targets from April 2013

Domain	Indicator
Domain 2 Health Improvement	Under 18 conceptions
Domain 3 Health Protection	Chlamydia diagnoses (15-24 year olds)
Domain 3 Health Protection	People presenting with HIV at a late stage of diagnosis

Epidemiology of Sexual Health in Nottinghamshire

19. Please see Appendix A for a comprehensive description of health needs, service analysis and gaps in service delivery.

Future Commissioning of Sexual Health Services Post April 2013

20. Local Authorities will be mandated to commission needs led sexual health services for its population from April 2013. The commissioning responsibilities will involve commissioning comprehensive sexual health services, the core functions which include: comprehensive needs assessment , strategy development linking in with the new national sexual health strategy (due imminently), sexual health promotion and education, particularly high risk groups who experience disproportionally poor sexual health outcomes: provision of partner notification: targeted services, including outreach for high risk groups: procuring high quality accessible integrated sexual health services and monitoring sexual health outcomes.

21. Responsibility for commissioning some aspects of sexual healthcare currently discharged by PCTs will not transfer to Local Authorities. Abortion services will be the responsibilities of Clinical Commissioning Groups. HIV treatment and care services, which are low volume / high cost services, will be commissioned by the NHS Commissioning Board.

22. Sexual Health Referral Centres which provide crisis response and coordinate forensic medical care for victims of sexual violence will be commissioned by the NHSCB, as a devolved Public Health function. As such Health and Wellbeing Boards will be required to maintain a line of sight in the commissioning of their local service.

Responsibilities for commissioning sexual health services from April 2013

Service	NHS Commissioning Board	Clinical Commissioning Groups	Local Authority
Comprehensive Sexual Health Services (including contraception, STI testing and treatment, HIV testing but not treatment, EHC in primary care settings)			✓
Termination of Pregnancy		✓	

HIV treatment (but not testing) and Care Outpatients/ Inpatients	✓		
Sexual Assault Referral Centres	✓		
Psychosexual services (Sexual Health aspects)			✓
Sex Relationship Education			✓

Further Actions Required

23. Reducing sexual ill health:

- Commission Sexual Health services that meet the need of the target population, are cost effective and easy to access.
- Ensure engagement of all key stakeholders at Sexual Health Strategic Commissioning Group to ensure seamless care pathways
- Strengthen sexual health prevention services and initiatives to prevent infection, re-infection and unintended pregnancies across key population groups and settings.
- Ensure high quality sex and relationship education is available and accessible in schools and other settings
- Ensure that Emergency Hormonal Contraception is easily available through Community Pharmacies
- Increase accessibility to long acting reversible contraception through training programmes to the relevant health professionals
- Develop a local programme to increase earlier diagnoses of HIV infections consistent with identified needs.
- Further integrate as standard practice opportunistic Chlamydia screening in core clinical services
- Explore with target at risk groups effective methods to communicate Sexual Health messages effectively and implement these.
- Strengthen links with targeted Youth support to increase exposure to sexual health promotion and more effectively address young people's sexual health needs

24. All these actions will be taken forward via a Health and Wellbeing Board workshop, which will focus on the actions required to develop the overall specification for sexual health services and commissioning action plan. The specifications will then form the basis of the contracts between the local authority and sexual health providers. This process will be

coordinated by the sexual health strategy group (chaired by the Director of Public Health) which will ensure a joined up approach between the local authority, NHS commissioning board and CCGs in their commissioning roles.

25. Agreement of the detailed action plan and progress made against the plan will be monitored through the Health & Wellbeing Implementation Group.

Summary and Key Points

26. The responsibility and resource for commissioning Comprehensive Sexual Health Services move to the Local Authority in April 2013.

27. The responsibilities for commissioning Termination services moves to the CCGs in April 2013

28. The responsibility for commissioning SARC, elements of contraception within the GP contracts and HIV treatment and care moves to the NCB form April 2013

29. Public Health will retain responsibility to provide public health advice to all commissioners of the Sexual Health Services

30. The Local Authority is well placed to have a significant impact on improving sexual health outcomes for its residents and to effectively address the wider determinants of health and wellbeing which influence sexual health.

31. The Health and Wellbeing Board in collaboration with its stakeholders will agree the key priorities for improving sexual health

Statutory and Policy Implications

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

RECOMMENDATION/S

The Health and Wellbeing Board is asked to:

1) Note and endorse the content of the report.

2) Note the roles and responsibilities for Local Authorities for commissioning to support comprehensive sexual health services from April 2013.

3) Support the list of further actions required as described in paragraph 23

4) Support the development of a detailed action plan using a forthcoming Health & Wellbeing Board workshop.

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Director of Public Health

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Constitutional Comments (NAB 25.02.13)

33. The Health and Wellbeing Board has authority to consider and support the matters set out in this report by virtue of its terms and reference.

Financial Comments (CLK 25.02.13)

34. The financial implications are contained in paragraph 24 of the report.

Background Papers

References used in the development of the report

Electoral Division(s) and Member(s) Affected

All

Appendix A

Summary of health needs, service provision locally and gaps in services

Sexually transmitted infections (STIs) in Nottinghamshire County

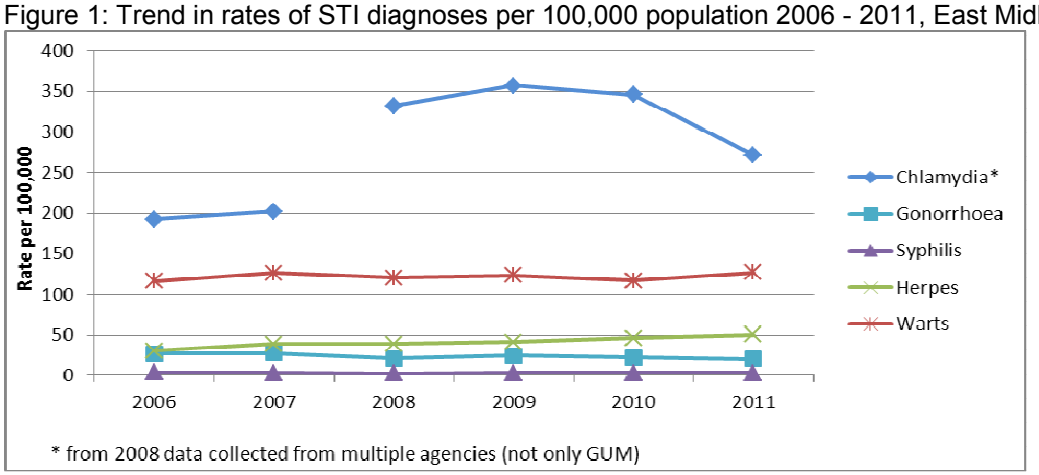
The main STIs are Chlamydia, Gonorrhoea, Syphilis, Human Immunodeficiency Virus (HIV), Genital Herpes and Genital Warts. HIV and other STIs are a major concern in the UK. In 2009, it is estimated 86,500 people were living with diagnosed HIV infection representing a threefold increase since 1999. A quarter of these people were unaware of their infection. Of the newly diagnosed HIV cases in 2009, 1,130 probably acquired their infection heterosexually within the UK; accounting for a third of heterosexuals diagnosed. Uptake of HIV testing was 77% among STI clinic attendees in England and the East Midlands.
The East Midlands rates for the main STIs have continued to be lower than the national rates and have followed a similar pattern for the last three years.

Who is at Risk?

There is a clear relationship between sexual ill health, poverty and social exclusion. Groups who are most at risk of poor sexual health and may experience barriers to accessing services include women; young people; asylum seekers and refugees; black and minority ethnic groups; single homeless people; gay and bisexual men; sex workers; looked after young people; drug injecting users; people with learning difficulties; people in prisons and youth offending institutions; young people not in education, training or employment.

Figure 1 shows the rates of new diagnosis of the most common STIs at a regional level. These changes are reflected at a national level where rates of Chlamydia, have notably increased over the last 4 years. This is also due to the increased testing that has taken place nationally and locally. However, rates of STIs in the East Midlands are generally lower than in England. Across England, in both men and women Chlamydia is the commonest STI diagnosed followed by Genital Warts, and then Herpes.

Figure 1: Trend in rates of STI diagnoses per 100,000 population 2006 - 2011, East Midlands



Source HPA:GUMCAD

Figure 2a highlights which districts within Nottinghamshire County are within the highest 25% nationally for diagnosis of Sexually Transmitted diseases. For Genital Warts Mansfield and Bassetlaw are within the top 25% nationally for diagnosis, for diagnosis of Herpes Bassetlaw, Gedling, Ashfield and Mansfield are in the top 25% nationally for diagnosis and for Gonorrhoea Ashfield , Mansfield and Gedling are in the top 25% nationally.

From 2008-2011 the trend in rates of STI diagnosis across Nottinghamshire County have remained fairly static. Chlamydia diagnosis has reduced in line with a decrease in testing and therefore should be interpreted with caution (Figure 2b).

Figure 2a: Rates of STI diagnosis per 100,000 population by local authority 2010

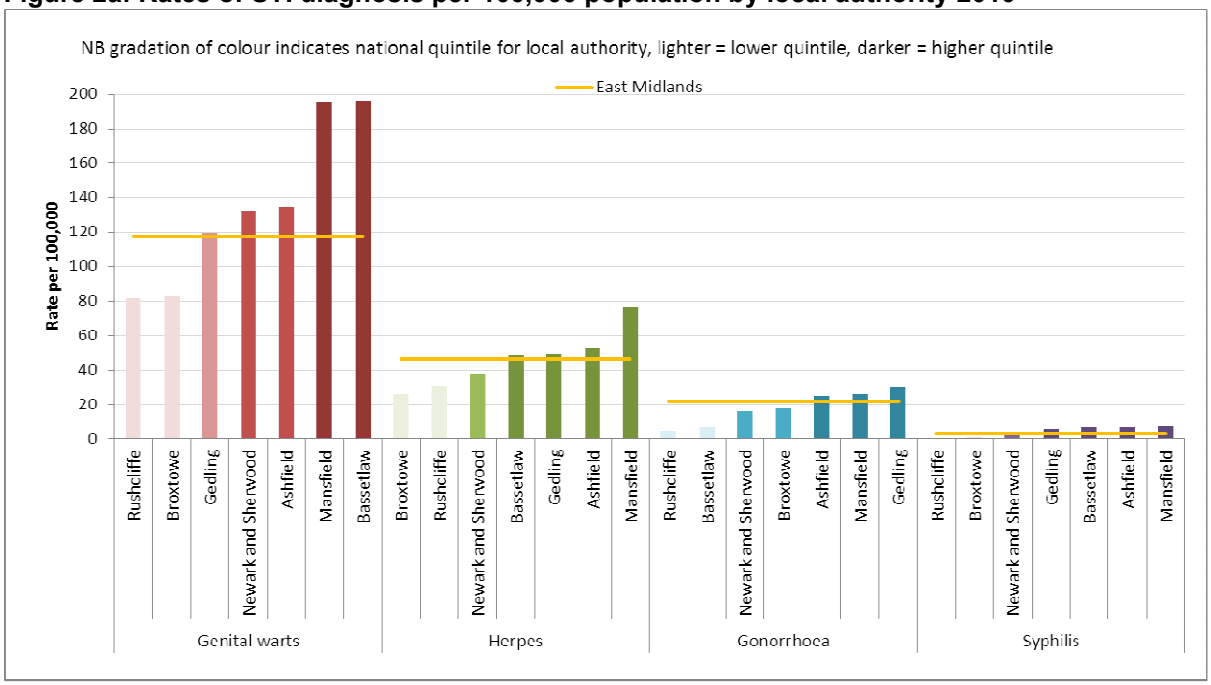
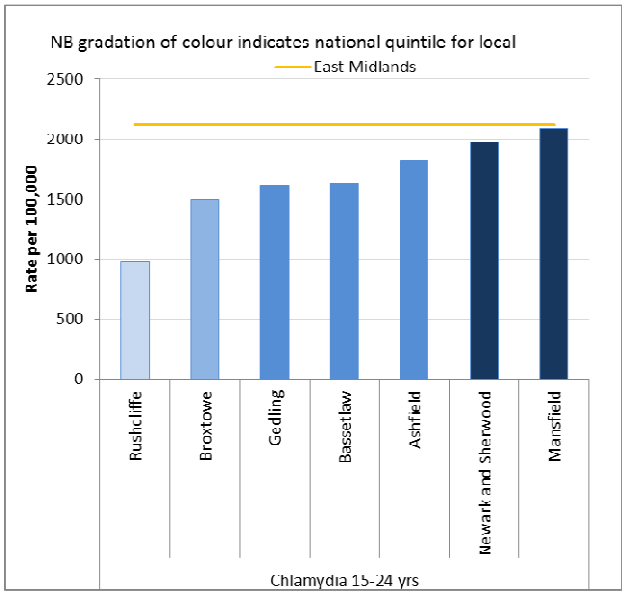


Figure 2b Rates of Chlamydia diagnosis per 1,000 population by local authority



Source: Health Protection Agency

Chlamydia

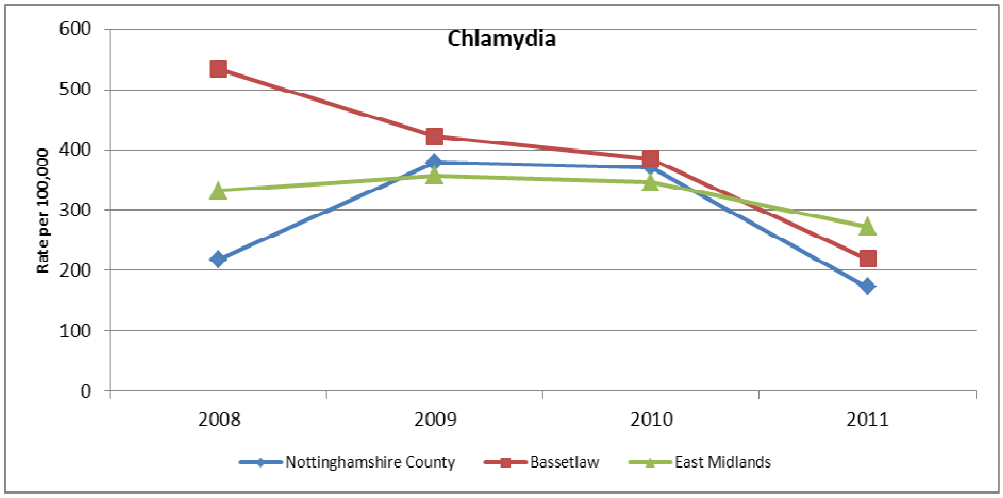
Of the five main STIs, the incidence of Chlamydia is the highest amongst men and women nationally and regionally, affecting approximately one in ten of sexually active young people, with rates rising:

- It is asymptomatic in 75% of women and 50% of men
- Untreated infection can lead to serious health problems, particularly for women

- It may cause pelvic inflammatory disease (PID), ectopic pregnancy and infertility
- In men it can cause Urethritis, Epididymitis and Reiter's Syndrome (arthritis)

Figure 3 shows the trends in the rate of chlamydia diagnosis over time. Both Nottinghamshire County and Bassetlaw overall have rates lower than the East Midlands rate, however this masks the rates at district level which can be seen in Figure 4.

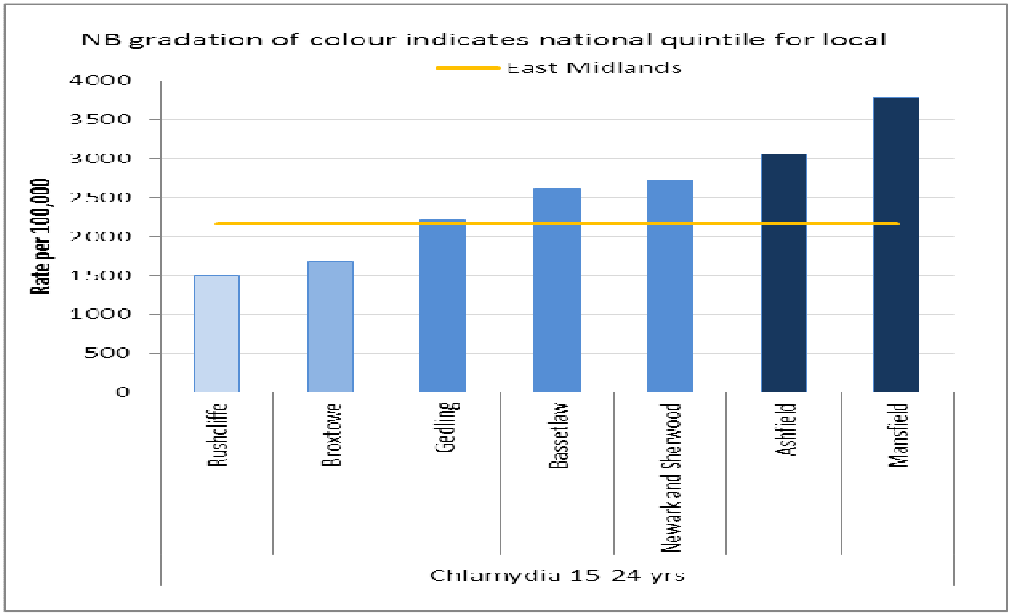
Figure 3 Trend in rates of STI diagnoses per 100,000 population 2008 – 2011, Chlamydia



Source HPA:GUMCAD

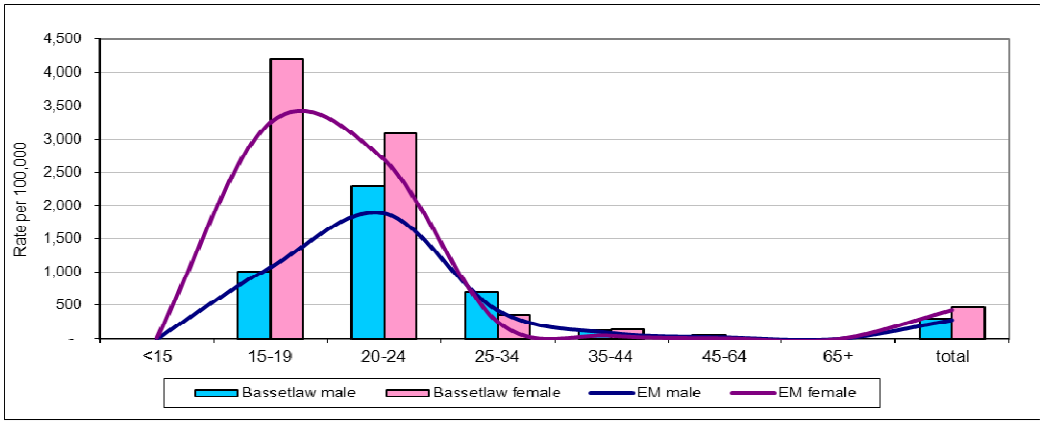
Figure 4 shows Mansfield, Ashfield, Newark and Sherwood, Bassetlaw and Gedling all have rates of Chlamydia diagnoses per 100,000 in the 15-24 year age group higher than the East Midlands with Mansfield and Ashfield districts significantly higher rates per 100,000 population in the 15-24 year olds. The prevalence is highest in young sexually active adults especially women aged 15-19 years and men 20-24 years in both Nottinghamshire County and Bassetlaw (Figure 5 and 6).

Figure 4: Rates of Chlamydia diagnosis per 100,000 population by local authority in 2010



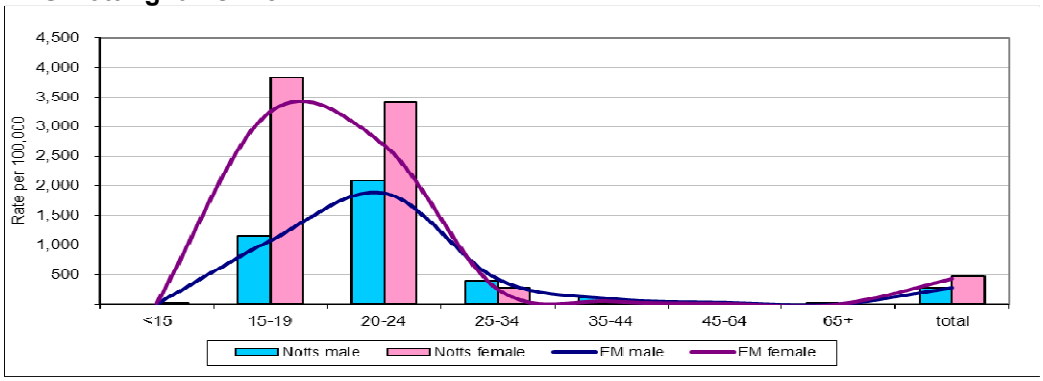
Source: Health Protection Agency

Figure 5 Rates of STI diagnoses per 100,000 population by age and gender 2011, Chlamydia – NHS **Bassetlaw**



Source HPA:GUMCAD

Figure 6 Rates of STI diagnoses per 100,000 population by age and gender 2011, Chlamydia - NHS Nottinghamshire PCT

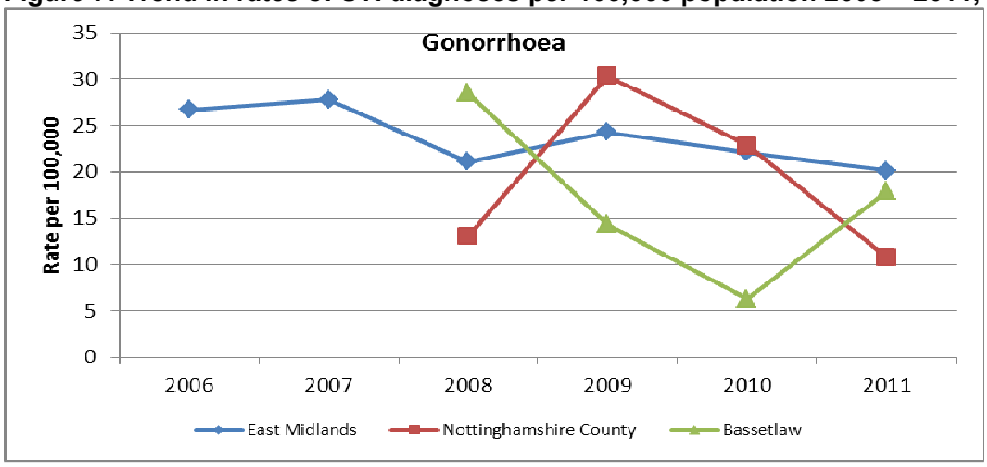


Source HPA:GUMCAD

Gonorrhoea

Nationally, Gonococcus infection has a highly unequal distribution within the population. It is concentrated in urban areas, among young people, men who sleep with men and minority ethnic groups, the Black/Black British ethnic group in particular. Figure 7 demonstrates that Bassetlaw and Nottinghamshire County have rates lower than the East Midlands for Gonorrhoea infection.

Figure 7: Trend in rates of STI diagnoses per 100,000 population 2008 – 2011, Gonorrhoea

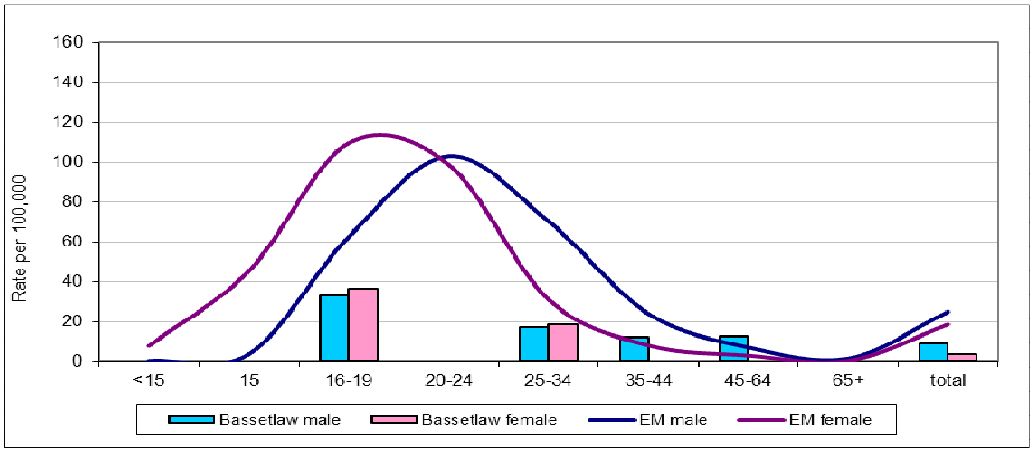


Source HPA:GUMCAD

Figure 8 and 9 show the peak age group nationally for Nottinghamshire County and Bassetlaw is 20-24 and 25-34 year old males and 15-19 year olds and 20-24 year old females

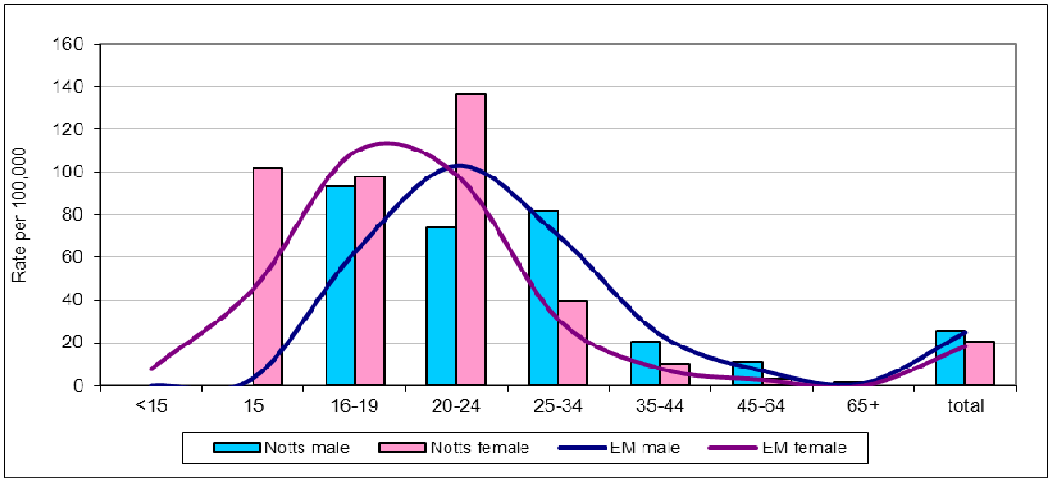
Figure 8 Rates of STI diagnoses per 100,000 population 2011 by Age and Gender,

Gonorrhoea Bassetlaw PCT



Source HPA:GUMCAD

Figure 9 Rates of STI diagnoses per 100,000 population 2011 by Age and Gender, Gonorrhoea NHS Nottinghamshire PCT

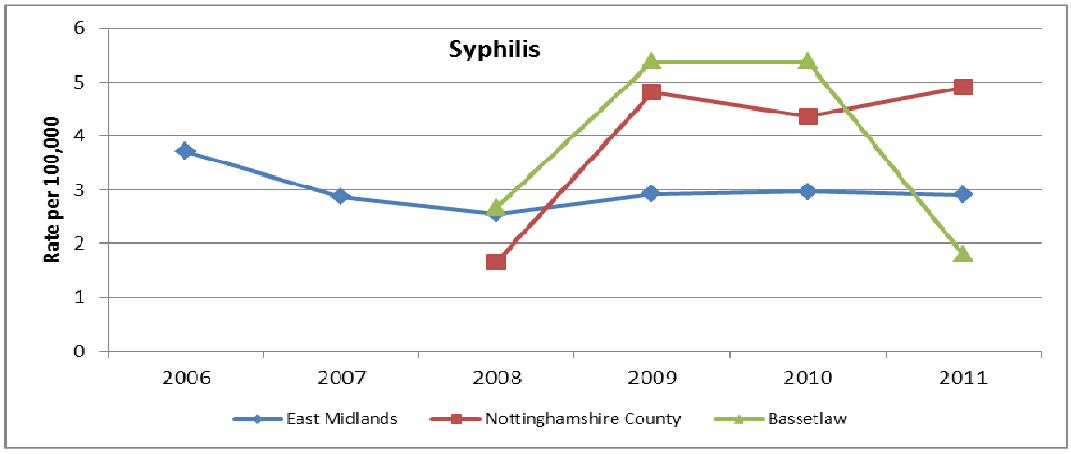


Source HPA:GUMCAD

Syphilis

The rate of increase over the last ten years in the new diagnosis of Syphilis has been high, with the East Midlands having a higher than national rate of change. However whilst the rate of change has been large, the total numbers are small with Syphilis only representing 2% of all new diagnosis of all the main STIs (Figure 10).

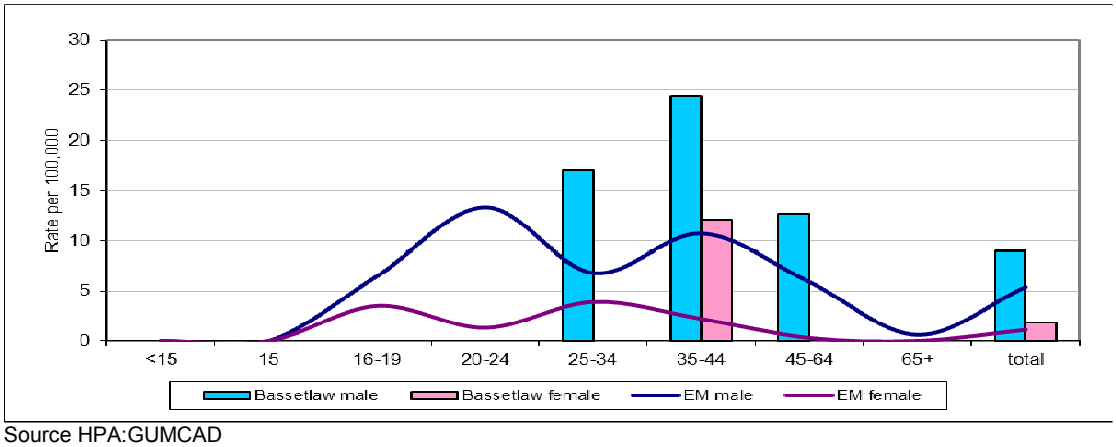
Figure 10: Trend in rates of STI diagnoses per 100,000 population 2008 – 2011, Syphilis



Source HPA:GUMCAD

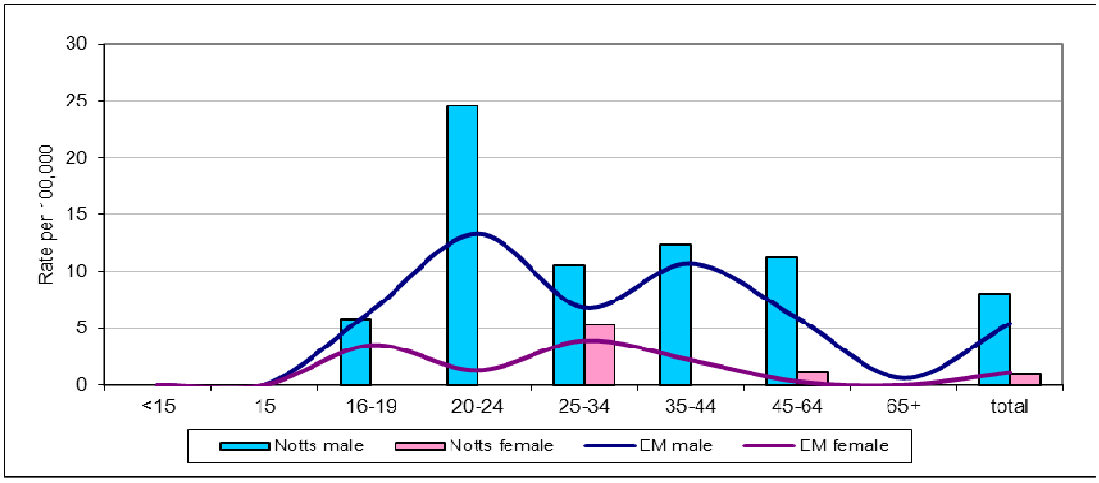
In 2011 the Syphilis was the highest in men, which is mirrored across the East Midlands, particularly the within the subgroup of men who have sex with men. This is a particular vulnerable group and usually relates to sexual practices. Figure 11 and 12 shows the gender and age groups most affected.

Figure 11 Rates of STI diagnoses per 100,000 population by Age and Gender 2011, Syphilis Bassetlaw PCT



Source HPA:GUMCAD

Figure 12 Rates of STI diagnoses per 100,000 population by Age and Gender 2011, Syphilis NHS Nottinghamshire County

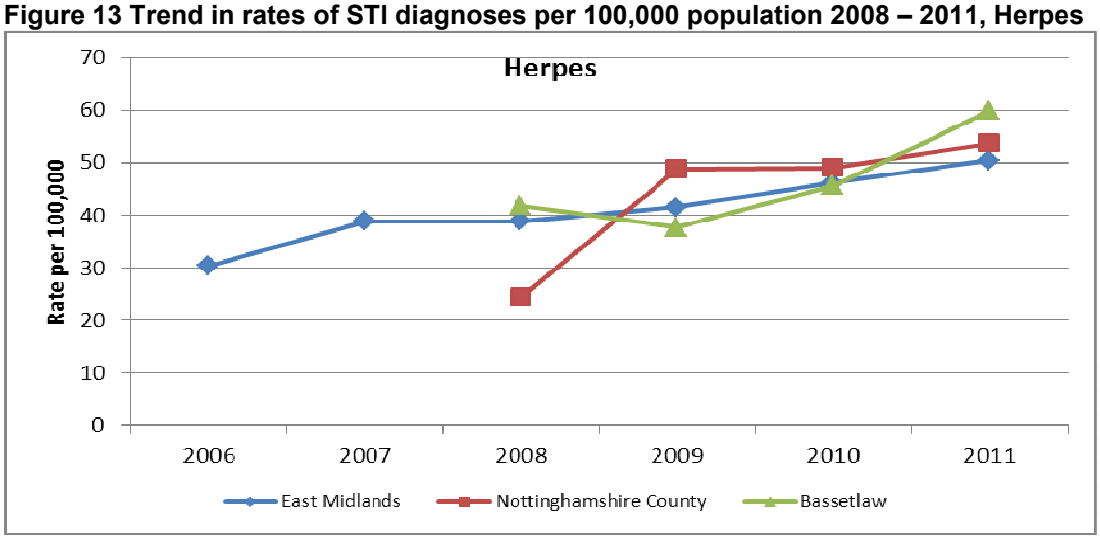


Source HPA:GUMCAD

Herpes

Figure 13 shows that Herpes diagnosis in Bassetlaw and Nottinghamshire County has steadily increase over the last 5 years, however although the rates are increasing steadily the numbers are relatively low. The same picture can also be seen nationally.

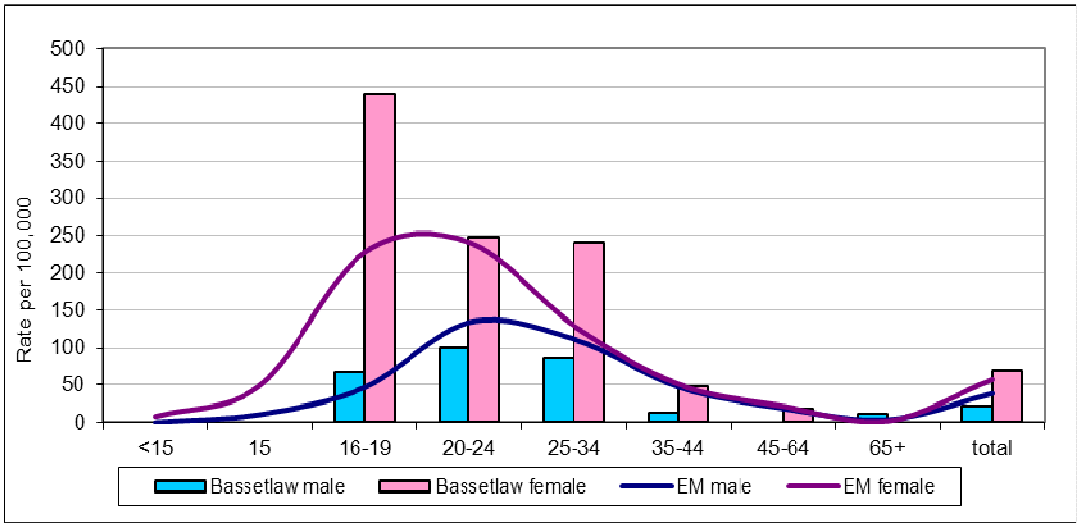
Figure 13 Trend in rates of STI diagnoses per 100,000 population 2008 – 2011, Herpes



Source HPA:GUMCAD

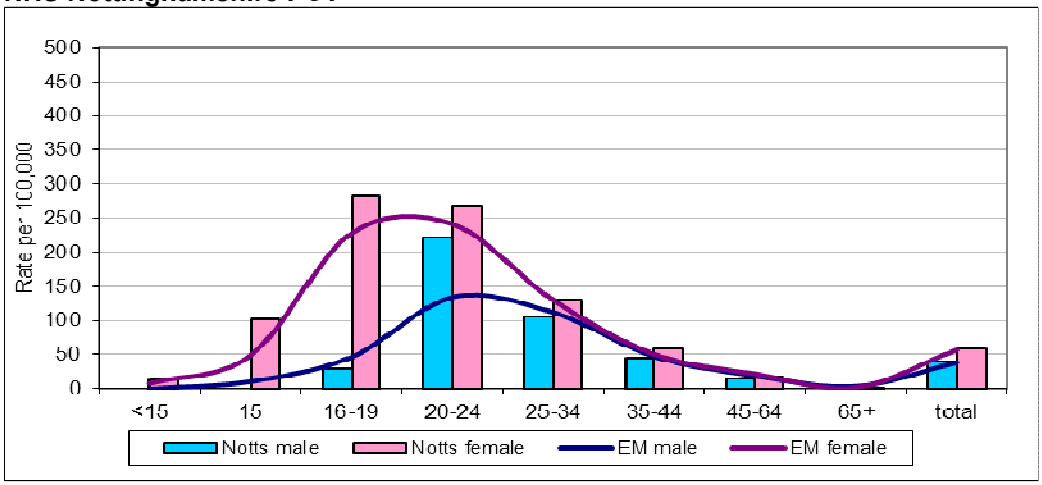
The highest rates in males occur in the 20-24 year olds, the pattern in females is more variable with higher rates being divided between the 16-19 years and 20-24 years (Figure 14 add 15). Heterosexual are the group most at risk. The rate in females in Bassetlaw in 16-19 is nearly double that for the 20-24 and 25-34, this may be due to those accessing services.

Figure 14 Rates of STI diagnoses per 100,000 population by Age and Gender 2011, Herpes Bassetlaw PCT



Source HPA:GUMCAD

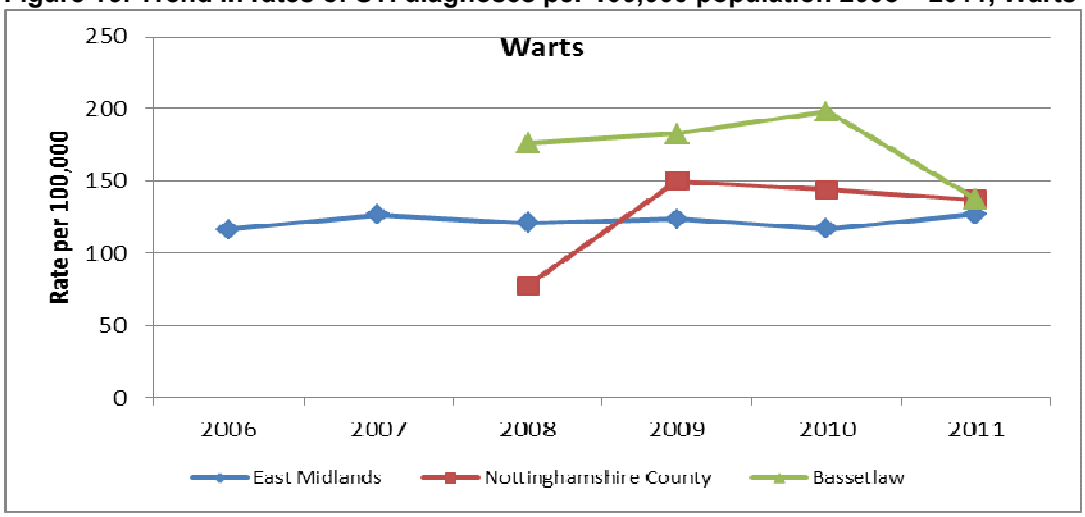
Figure 15 Rates of STI diagnoses per 100,000 population by Age and Gender 2011, Herpes NHS Nottinghamshire PCT



Source HPA:GUMCAD

WartsThe number of new infections for Genital Warts within Nottinghamshire County has remained static. Bassetlaw in 2011 saw a reduction in the rate of Warts diagnosed (Figure 16). The highest proportion of occurs in heterosexuals, however it must be noted that not all clients disclose their sexual orientation.

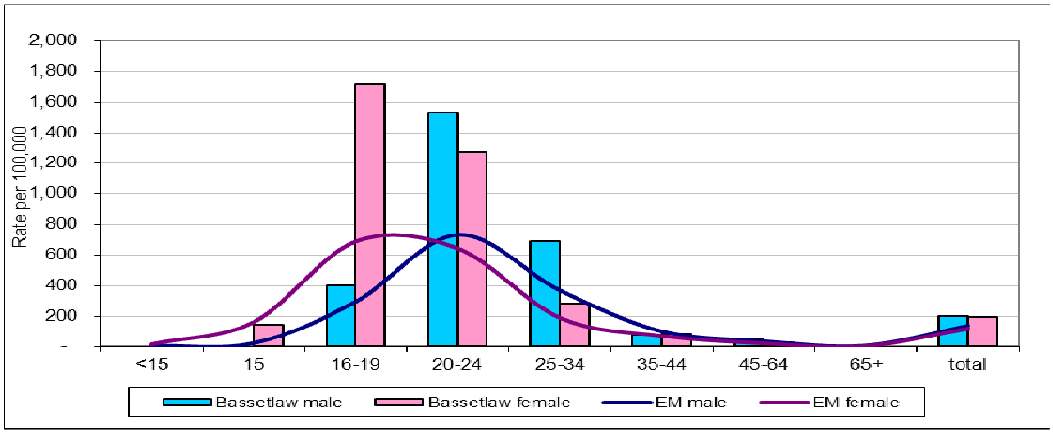
Figure 16: Trend in rates of STI diagnoses per 100,000 population 2008 – 2011, Warts



Source HPA:GUMCAD

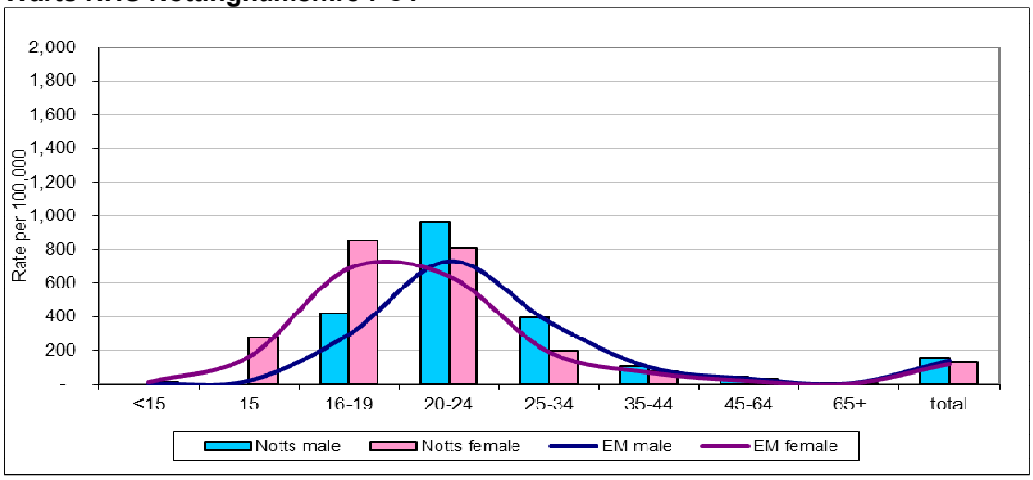
Figure 17 and 18 demonstrate that rates in Bassetlaw are highest for Genital Warts in females in 16-24 year olds but for males the rate is much higher in the 20-24 year olds. The picture in Nottinghamshire is similar but rates are much lower

Figure 17 Rates of STI diagnoses per 100,000 population 2011 by Age and Gender, Warts Bassetlaw PCT



Source HPA:GUMCAD

Figure 18 Rates of STI diagnoses per 100,000 population 2011 by Age and Gender, Warts NHS Nottinghamshire PCT



Source HPA:GUMCAD

Discussion on Sexually Transmitted Infections (STI) and summary

There is a strong positive correlation between the rates of STI's and socio-economic deprivation and this is evident in Nottinghamshire. . Mansfield is the most deprived district in Nottinghamshire County and it has the highest number of diagnosed acute STIs a rate of 870.2 per 100,000 residents. In contrast, Rushcliffe which is the least deprived district in Nottinghamshire County also has the lowest rates of STI diagnosis. There are a number of factors which may influence the relationship between STIs and deprivation including access to and uptake of sexual health services, education, life skills, sexual health awareness, and sexual attitudes and behaviour.

Preventing the reinfection of STI's continues to be a priority. Nationally in 2011, 7.1% of women and 9.1% of men presenting with an acute STI at a GUM clinic became re-infected with an acute STI within twelve months. An estimated 3.8% of women and 6.7% of men presenting with gonorrhoea became re-infected with gonorrhoea within twelve months. Within Nottinghamshire County, Mansfield has the highest re-infection rates, an estimated 8.2% of women and 9.7% of men presenting with an acute STI at a GUM clinic during the three year period from 2009 to 2011 became re-infected with an acute STI within twelve months. An estimated 2.2% of women and 6.3% of men presenting with gonorrhoea became re-infected with gonorrhoea within twelve months. Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Mansfield, an estimated 8.8% of 16 to 19 year old women and 15% of 16 to 19 year old men presenting with an acute STI at a GUM clinic during the three year period from 2009 to 2011 became re-infected with an STI within twelve months. Teenagers may be at risk of re-infection because they lack the skills and confidence to negotiate safer sex.

Easy access to services, that are timely and welcoming are vital to ensure clients feel able to access services that historically, and remain, with a high stigma of having or have had a sexually transmitted infection. Areas across the county with high diagnosis rates are those that are densely populated as well as some rural parts. Sexual Health services are open access services, which is imperative to ensure clients feel confident to be able to access these services.

Areas with higher rates of STI diagnosis also have pockets of higher rates. We have data to inform where these pockets of higher rates of STI diagnosis are within our populations across Nottinghamshire County but due to the sensitivity of the data cannot be made

publically available. This data will be used to shape and inform the more detailed Health Needs Assessment due late 2013.

Human Immunodeficiency Virus

Human Immunodeficiency Virus (HIV) continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost if the client presents late. Each year, many thousands of individuals are diagnosed with HIV for the first time. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK. The HIV annual report estimates that across England between 19% and 30% of those with HIV are unaware (undiagnosed) (HPA 2012), for Nottinghamshire this equates to between 73 and 115 people. Since 1999 the number of new HIV diagnoses acquired heterosexually has been higher than the number of people diagnosed through sex between men.

Data presented in this section is for diagnosed patients only, which are those patients accessing care. Across Nottinghamshire 310 people were diagnosed with HIV in 2011.

There has been an increase in prevalence over the past four years for Nottinghamshire County compared with the East Midlands and England. Nottinghamshire County's prevalence rate of 0.68 per 100,000 population aged 15-59 is below the East Midlands and England and falls outside of the 2 per 1000 threshold where extended routine testing is required (NICE 2010).

In 2011, 310 people diagnosed with HIV who are resident in Nottinghamshire accessed HIV related care, compared to 279 in 2010. The increase in the number of people diagnosed with HIV and seen in 2011 could be due to an increase in the number of newly diagnosed people (data not available), migration of people into Nottinghamshire, uptake of treatment from those not previously known to services or a decrease in the numbers dying.

The diagnosed prevalence varies across Nottinghamshire in 2010. . The geographical spread of the 279 people diagnosed with HIV infection across Nottinghamshire shows 45% of people are resident in South Nottinghamshire, a further 43 % are resident in Central Nottinghamshire and the remaining 12% of people accessing care are in Bassetlaw. Gedling district has the highest numbers within Nottinghamshire, although remains lower than the England average.

The main route of infection in both males and females is sexual contact. For males, the main route of infection is via sex between men (66%), whereas for women the main route of infection is via sex between men and women (86%).

The demographic profile (age, gender, ethnicity, deprivation) of patients diagnosed with HIV has not changed notably over the past five years. The demographic profile (age, gender, ethnicity, deprivation) of patients diagnosed with HIV has not changed notably over the past five years. The majority of people diagnosed with HIV infection who are resident in Nottinghamshire are aged between 25 -55 years. There has been a slight increase in the age group 55+years. This could be due to more effective treatment. The majority of people diagnosed with HIV infection who are resident in Nottinghamshire categorise their ethnic origin as white 73% with a further 22% categorised as black African.

Those diagnosed with HIV are more likely to live in deprived areas compared with the overall population of Nottinghamshire aged 25-65years.

Teenage conception and termination of pregnancy in Nottinghamshire

Teenage pregnancy is a well-established and evidence based indicator of inequality. The UK has one of the highest rates of teenage pregnancy in Western Europe. In practice, this is

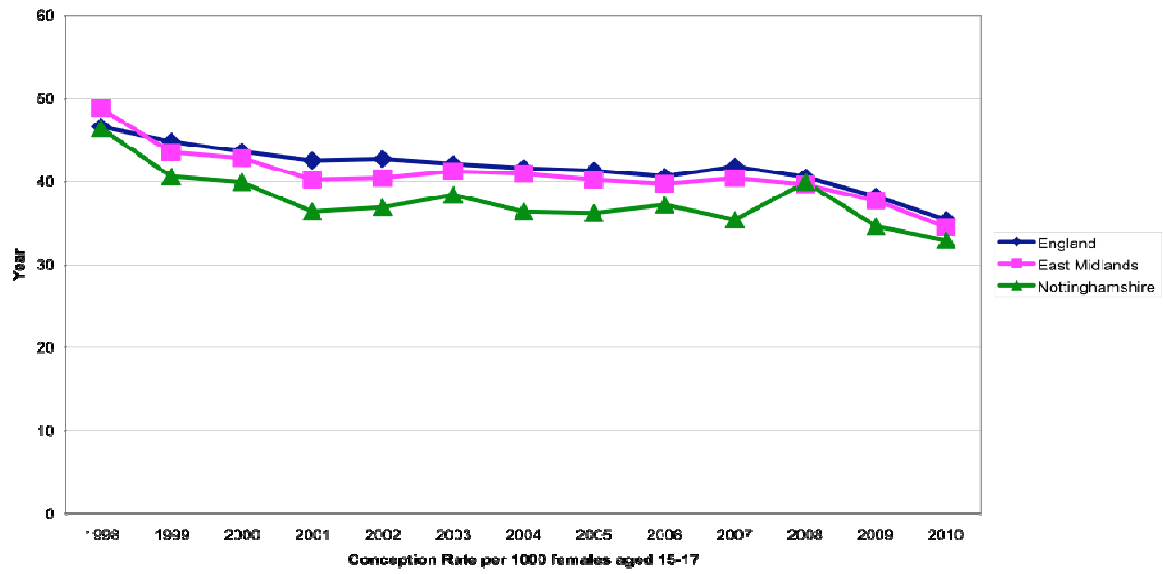
normally measured as a conception rate as some conceptions will result in a birth, others will end with a termination of pregnancy or abortion.

- Teenage mothers are prone to poorer antenatal health and the health of their children is worse than their peers.
- Teenage parents are also less likely to finish their education, less likely to find a good job and more likely to end up as a single parent bringing up children in poverty.
- The risk of teenage parenthood is greatest for young people who have grown up in poverty and disadvantage, and those with poor educational attainment, and the children of teenage mothers have a much higher chance of becoming teenage mothers themselves.
- The infant mortality rates for babies born to teenage mothers is 60% higher than for babies born to older mothers
- Teenage mothers have three times the rate of post natal depression of older mothers and a higher risk of poor mental health for three years after the birth.

The 2010 under 18 conception rate for Nottinghamshire was 32.9 per 1000 females aged 15-17 – a decrease of 4.9% from the 2009 rate of 34.6, and a decrease of 29.1% since the 1998 baseline year. The number of under 18 conceptions in 2010 was 461, a reduction of 153 from the 1998 baseline number of 614.

In 2010, Nottinghamshire continues to have a lower under 18 conception rate (32.9) than both the England average (35.4) and the East Midlands average (34.5). Currently Nottinghamshire's overall reduction of 29.1% against the 1998 base rate compares favourably with a national reduction of 24.0% and the East Midlands reduction of 29.3% (Figure 21)

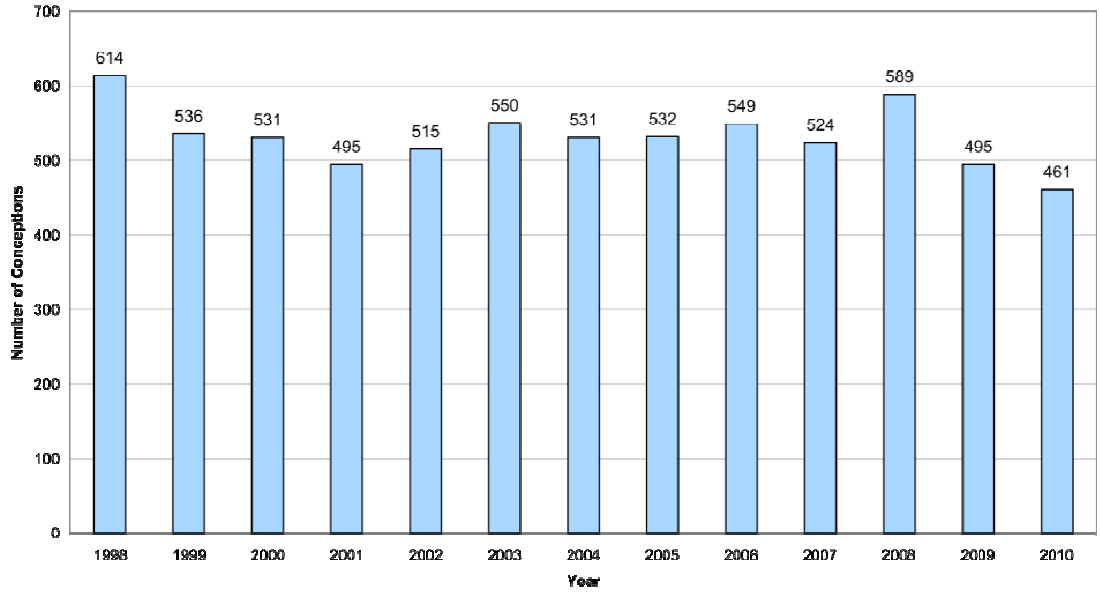
Figure 21: Teenage Conception Rates 1998-2010 for Nottinghamshire



Source: ONS 2012

It is however useful to see how the numbers of conceptions rather than just the rate, the graph below shows the reduction in the numbers of conceptions from the 1998 baseline year to 2010, reducing the numbers of teenage conceptions by 153 conceptions. (Figure 22)

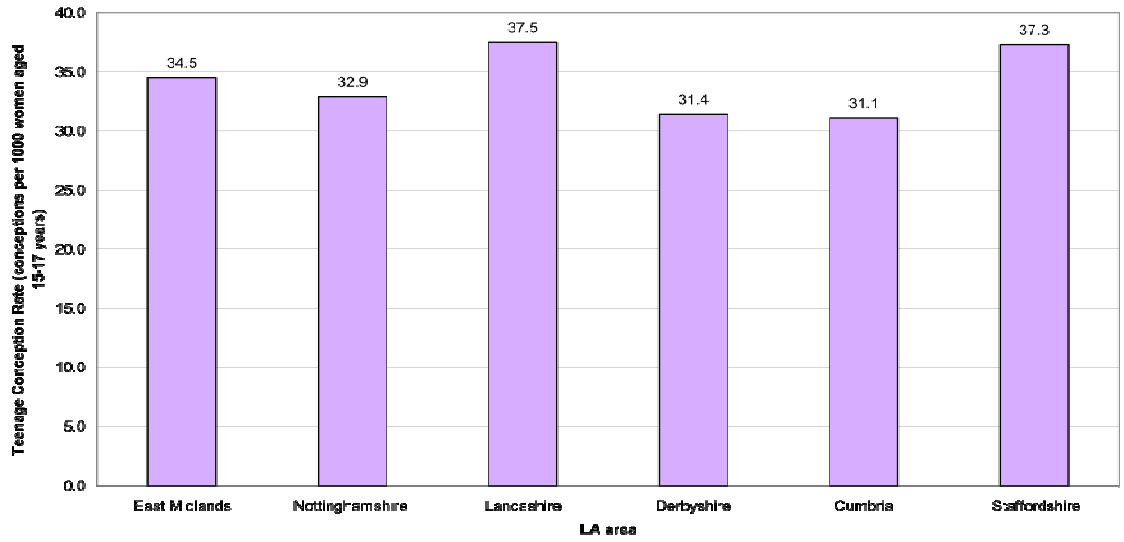
Figure 22: Numbers of teenage conceptions Nottinghamshire 1998-2010



Source: ONS 2012

Figure 23 below indicates that Nottinghamshire's 2010 teenage conception rates were similar to statistical neighbours and below the East Midlands average.

Figure 23: 2010 Teenage Conception Rates for Nottinghamshire and Statistical Neighbours



Source: ONS 2012

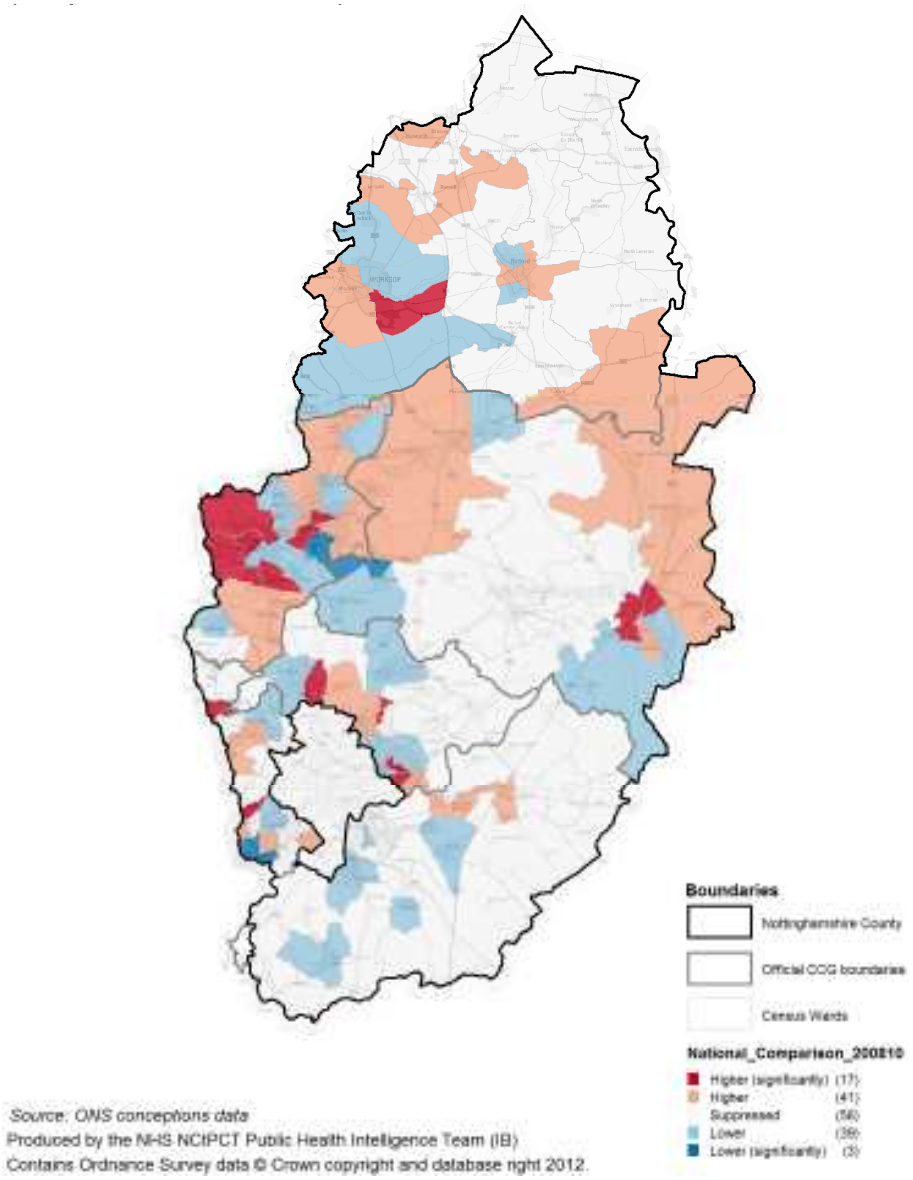
Within Nottinghamshire County, there is local variation between wards in the under 18 conception rates. Local variation has been considered by comparing the value for small geographical areas with the national value. All districts have seen a reduction in their teenage conception rates since the 1998 baseline year with the exception of Rushcliffe, although rates have fluctuated over the years.

The aim over time is that health inequalities are reduced by lowering teenage conceptions across the whole of Nottinghamshire but to a greater degree in more deprived wards. Teenage conceptions are strongly associated with levels of deprivation in the population.

Health inequalities are reducing , however, this is mainly due to teenage conception rates in the least deprived area increasing slightly or remaining static rather than because they are reducing in the most deprived areas within the County

Figure 24 demonstrates there are a number of areas that are statistically significantly higher than the national value. There are also some (but fewer) areas that are significantly lower than the national value. Some localised areas around the north of the City are increasing (in Gedling and in Broxtowe) as well as in Mansfield and Ashfield; these areas are also associated with levels of deprivation

Figure 24: Under 18 conceptions: 2008-10: Change in rates by locality: Nottinghamshire wards: statistical significance relative to England



Source: HSCIC (ONS, DfE)

Figure 25 The wards listed below are included in the 20% of wards in England with the highest teenage conception rates (at least 58.4 conceptions per 1,000 women aged 15-17). Please note that the population estimates used as the denominator in these rate calculations

are estimates of the population of 15-17 year old females by ward, aggregated over a 3 year period. Some wards have small populations of women in this age group: rates for these wards fluctuate from year to year and the area may not be one with a high incidence of teenage pregnancy.

Figure 25 Nottinghamshire Wards in top quintile for Under 18 conception rates 2008-2010

Ashfield	Hucknall East Kirkby in Ashfield East Kirkby in Ashfield West
Bassetlaw	Ranskill Worksop South East
Gedling	Carlton Killisick Netherfield and Colwick Valley
Mansfield	Eakring Portland Ravensdale Sherwood
Newark and Sherwood	Bridge Castle Devon
Broxtowe	Eastwood South Stapleford North

Termination of pregnancy: National and Regional picture

The level of abortions is often used as an indicator of the degree of failure to use contraception, or failure of the contraception itself. In England and Wales, the total number of abortions carried out in 2011 was 189,931, 0.2% more than in 2010 (189,574) and 7.7% more than in 2001 (176,364). The abortion rate in NHS Nottinghamshire County and NHS Bassetlaw was highest among women age 20-24 years which is consistent with the East Midlands and England and Wales. The National Strategy for Sexual Health and HIV highlighted that there were wide variations in access to abortion services and in method of termination. For those women who are legally entitled to access an abortion, it is important they can access the procedure as soon as possible. If a woman can access the service before she is nine weeks pregnant, she can have a choice of an early medical or surgical abortion. The earlier in pregnancy an abortion is performed, the lower the risk of complications. Delays in access to abortion services will seriously impact on pregnant teenagers who tend to seek professional advice later than older women.

The percentage of NHS funded abortions performed at under 10 weeks in NHS Nottinghamshire County (70%) is significantly improved on 2010 (61%) but remains lower than Bassetlaw (74%), with the East Midlands (68%) and England (78%). The age standardised abortion rate (ASR) was 17.5 per 1000 resident women aged 15 to 44 years, the same as in 2010, but 2.3% higher than in 2001 (17.1) and more than double the rate of 8.0 recorded in 1970. The abortion rate was highest among women age 20 years (33 per 1000) the same as in 2010 and 2001. The under 16 abortion rate was 3.4 per 1000 women and the under 18 rate was 15 per 1000 women, both lower than in 2010 (3.9 and 16.5 respectively). 78% of abortions were carried out at before 10 weeks gestation compared to 77% in 2010 and 58% in 2001.

Figure 26: 2011 legal abortion rates (number) by age

	Total number of abortions	Rate per 1,000 women resident aged 15 – 44 years ASR*	Crude rate (number) per 1000 women Age Group					
			Under 18	18-19	20-24	25-29	30-34	35+
England and Wales	189,931	17.5	15 (14,599)	28.8 (20,324)	30.1 (55,909)	22.9 (42,321)	17.2 (29,579)	6.9 (27,19
East Midlands	11,865	13.8	13 (1,039)	22 (1,336)	23 (3,588)	18 (2,475)	14 (1,731)	5 (1,696
NHS Bassetlaw	247	13.7	16 (33)	24 (32)	27 (77)	19 (52)	9 (26)	3 (27)
NHS Nottinghamshire County	1,644	13.7	13 (157)	23 (187)	25 (476)	18 (346)	12 (227)	5 (251)

- *ASR Age standardised abortion rate

Source: (DH Statistical Bulletin May 2012)

Figure 26 shows that for 2011, NHS Nottinghamshire County and NHS Bassetlaw both have slightly lower Abortion rates (13.7 per 1000 women aged 15-44 years) than the East Midlands (13.8 per 1000) and England and Wales (17.5 per 1000). There were 1,644 abortions in NHS Nottinghamshire County in 2011, almost half of which were in women aged under 25 years (820). There were 247 abortions in NHS Bassetlaw in 2011, 57% (142) of which were in women aged under 25 years.

Figure 27: Number and (rate) of legal abortions 2007-2011. Rate is per 1000 women resident aged 15-44 years ASR*

	2011	2010	2009	2008	2007
England and Wales	189,931 (17.5)	189,574 (17.5)	189,100 (17.5)	195,296 (18.2)	198,499 (18.6)
East Midlands	11,865 (13.8)	11,869 (13.9)	11,904 (14)	12,409 (15)	12,738 (15)
NHS Bassetlaw	247 (13.7)	244 (13.5)	279 (15)	265 (14)	285 (15)
NHS Nottinghamshire County	1,644 (13.7)	1545 (13)	1530 (13)	1587 (13)	1660 (14)

*ASR = age standardised abortion rate
Source: (DH Abortion Statistical Bulletins from 2007 to 2011)

Figure 27 shows that over the 5 year period from 2007 to 2011 the overall trend in the number (and rate) of abortions locally, regionally and nationally is downwards, NHS Nottinghamshire County and NHS Bassetlaw have consistently had a lower rate than England and Wales over the last 5 years. NHS Bassetlaw (13.3%) has experienced a much greater reduction in the number of abortions between 2007 and 2011 than England and Wales (4.5%) and the East Midlands (4.4%) against NHS Nottinghamshire County who experienced a 1% reduction.

Figure 28 shows that NHS Nottinghamshire County (41%) had a much lower proportion of abortions performed in NHS hospitals than in the East Midlands (67%), but slightly higher than that of England and Wales (35%). In contrast NHS Bassetlaw (76%) has a higher proportion of abortions performed than both East Midlands and England and Wales. The proportion of privately funded abortions within NHS Nottinghamshire County and NHS Bassetlaw (2%) are lower than those both regionally (3%) and nationally (4%).

Figure 28 2010 legal abortions by purchaser, gestation, sexual health indicator and repeat

	Purchaser (%)			Gestation weeks (%)			Sexual Health Indicator			Repeat Abortions	
	NHS Funded		Privately funded	3-9	10-12	13+	Total NHS funded abortions	NHS funded abortions at under 10 weeks	% of all NHS funded abortions under 10 weeks	% of previous abortions in women under 25	% of previ abortions women under 19
	NHS Hospital	Independent sector									
England and Wales	35	61	4	78	13	9	183,052	142,653	77.9	26.2	11 Engl only
East Midlands	67	30	3	68	22	9	11,501	7,816	68	23	8
NHS Bassetlaw	76	23	2	74	17	9	243	180	74	21	suppresse
NHS Nottinghamshire County	41	57	2	70	20	9	1,606	1,131	70	22	8

Gestation – % are rounded so may not add to 100

Source: (DH Statistical Bulletin May 2012)

Locally, regionally and nationally in 2011 the vast majority (between 90-91%) of abortions are performed at under 13 weeks. Nationally there has been a continuing increase in the proportion of abortions that are performed under 10 weeks since 2002. In 2011, 78% of abortions in England and Wales were performed under 10 weeks compared to 77% in 2010 and 58% in 2000. NHS Nottinghamshire County's proportion (70%) is slightly higher than the regional (68%) but remains below the national proportion of abortions taking place under 10 weeks but demonstrates an increase from 61% in 2010. The gestation times at which abortions are performed in NHS Bassetlaw is also slightly lower than that of England and Wales at 74% for those undertaken under 10 weeks and more abortions are performed earlier than in the East Midlands. The proportion (20%) of NHS Nottinghamshire County's

Nottinghamshire County	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
u18 conception numbers	614	536	531	495	515	559	531	532	549	524	588	495	461
% leading to abortion	40%	37%	38%	41%	42%	41%	40%	47%	48%	46%	48%	43%	43%

abortions performed at 10-12 weeks gestation, this is 10% lower than the proportion (30%) which has remained consistent nationally since 2002, reflecting the 9% increase in abortions performed in under 10 weeks. The trend, over the last 5 years, for abortions by gestation for England and Wales and NHS Nottinghamshire County illustrating that the proportion of abortions performed earlier is greater nationally and locally for NHS Nottinghamshire County. In 2011, slightly less women aged under 25 had a previous abortion in NHS Nottinghamshire County (22%) and NHS Bassetlaw (21%) compared with 23% in East Midlands and 26.2% in England and Wales. Additionally 8% (20) of the 247 abortions in women aged under 19 were repeat abortions consistent with the East Midlands and 11% for England (note this is not England and Wales). The data for the proportion of repeat abortions in NHS Bassetlaw for women aged under 19 years has been suppressed owing to the number being less than 10

Repeat Terminations

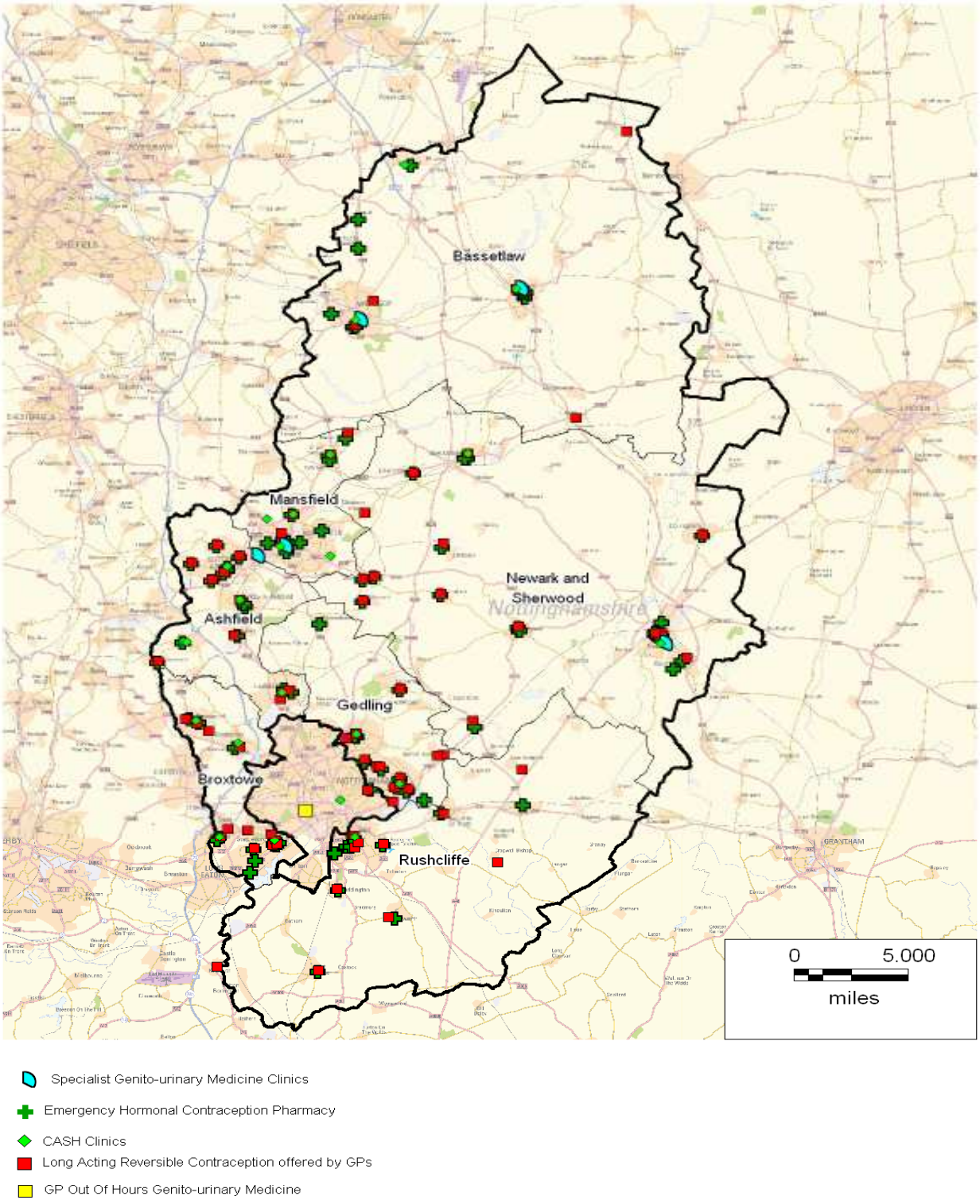
The percentage of under 18 conceptions leading to termination in 2010 was 43%, based on the 2010 population, this compares to 50.3% for England and 42.9% for the East Midlands. The proportion of young women accessing a termination will vary depending on a number of factors including, a young woman's aspirations, access and knowledge to appropriate services and early identification of pregnancy.

Over 25% of women under 25 nationally who had a Termination of pregnancy in 2011 had one or more previous terminations. Both Nottinghamshire County and Bassetlaw have less repeat abortions in the under 25s but are similar to the East Midlands. Trend over time shows Nottinghamshire County and the East Midlands have remained static where Bassetlaw have shown a small reduction

The number of terminations across the districts between 2001 and 2009 as a whole is similar to the East Midlands with Rushcliffe and Gedling having a larger proportion of teenage conceptions leading to abortion. Interestingly, the Mansfield district has the lowest percentage across the districts of teenage conceptions leading to termination.

Current Activity – Need / Use of Services Service Provision across Nottinghamshire County

Figure 29 Sexual Health Service provision across Nottinghamshire 2013



Sexual Health is a complex area that encompasses many different facets and service providers. It is important that all services irrespective of where they are commissioned from dovetail to ensure seamless care pathways are in place to provide the optimum care for clients irrespective of their sexual health needs. Figure 29 highlights the different provision of sexual health services across Nottinghamshire.

Genito Urinary Medicine (GUM) Clinics
There are 5 main GUM clinics in Nottinghamshire. Sherwood Forest Hospital Trust provides one at Sherwood Forest Hospital, Sutton-in-Ashfield and one at Newark Hospital. Doncaster and Bassetlaw Acute Trust provides a clinic at Retford Hospital. Nottingham University Hospital Provides a clinic at the City Hospital. Nottingham University Hospital also provides community GUM clinics across 6 sites within Nottingham City that county clients access.

Primary Care Services
There are 109 GP surgeries. All practices provide some elements of Sexual Health services as part of their core contract. There are 69 practices that provide coil fits through a locally enhanced service agreement with the PCT and 59 practices that provide contraceptive implants.

Community Contraceptive and Sexual Health Clinics
There are 54 different contraceptive clinics available to people of all ages, which provide the full range of contraceptive methods across the county. Majority provide screening for chlamydia and most will provide screening for gonorrhoea and other STIs if this is appropriate.

Community Contraceptive and Sexual Health Clinic specifically for Young People
There are 20 clinics specifically targeted at young people across the county. There are higher numbers of specific Children and Young People clinics in the Northern CCGs (Mansfield, Ashfield, Newark & Sherwood and Bassetlaw). Bassetlaw offer specific clinics for CYP onsite in 5 out of their 6 secondary schools and also provide specific small group work for those children with learning difficulties/ challenging behaviour.

Termination of Pregnancy Providers
There are numerous providers for termination of Pregnancy, however due to a newly commissioned model to meet the Royal College of Obstetrics and Gynaecologists guidelines for abortions (2010) there is one provider for Pre-termination Assessment and Early Medical Abortion within a Community setting across Nottinghamshire County excluding Bassetlaw. Other providers of medical and surgical terminations include Sherwood Forest Hospital Trust, Nottingham University Hospital, Nations, Doncaster and Bassetlaw Acute Trust, Marie Stoops, The British Pregnancy Advisory Service. Referrals are made by primary care and Sexual Health services and also by self-referral (excluding Bassetlaw).

Chlamydia Testing
Both Bassetlaw and Nottinghamshire County decommissioned a programme approach to opportunistic chlamydia testing. Opportunistic Chlamydia testing is available through core clinical provision. Within Bassetlaw this is currently being developed, in the rest of Nottinghamshire County core clinical services are undertaking opportunistic testing in a variety of settings. There is still work to be undertaken to increase testing through core service provision.

Non NHS and Multiagency Community Provision
A wide range of sexual health advice, information and support is provided by non-NHS organisations such as the Terrance Higgins Trust, Connexions services, Targeted Youth Support services and the C-Card scheme.

NHS Community Provision of Sexual Health services
There are 337 schools in Nottinghamshire of which 45 are secondary schools. Some school nurses can provide educational input into sex and relationships education into schools, and some provide pregnancy testing and provision of Emergency Hormonal Contraception. Health Visitors provide contraceptive advice to parents.

The Sexions service, a specialist service that provides SRE into schools within the Mansfield and Ashfield Districts provide across numerous age groups linking CYP into specialist sexual health services. The specialist Contraceptive and Sexual Health service provides this element within the Bassetlaw district.

Specialist NHS provision of Community Sexual Health services support
Specialist Nurses, such as Looked after Childrens Nurses work directly with young people in care. A large part of their role is to liaise with other agencies, for example school nurses, specialist sexual health staff, Child and Adolescent Mental Health Services (CAMHS) and foster carers.

Community Pharmacists
There are 143 Community Pharmacies within the whole of NHS Nottinghamshire County and 21 in Bassetlaw. To date 99 pharmacies (9 in Bassetlaw) provide Emergency Hormonal Contraception to all ages via a Local Enhanced service agreement.

Out of hour's provision
Nottinghamshire as Out of Hours provision 7 days per week for those clients requiring to see a medical practitioner outside of 'normal hours' and at weekends. These services are able to provide Emergency Hormonal contraception.

Psychosexual services
Nottingham University Hospital provides this service on behalf of Nottinghamshire County residents.

Sexual Assault Referral Centre (SARC)
SARC is a specialist medical and forensic service for anyone who has been raped or sexually assaulted. The aim of the centre is to be one-stop service, providing medical care, forensic examination, safe guarding and sexual health services following an assault/rape. It is provided to men, women and children over the age of 13. In Nottinghamshire the centre is jointly funded between the NHS City, County and Bassetlaw, the Police and both City and County Council. The service is provided by a partnership including specialist police officers, skilled health professionals, pediatricians, forensic medical examiners and the voluntary sector and is available 24/7 365 days a year. Research has shown that those individuals seen in a SARC were less likely to withdraw from investigations than those seen by police alone and hence increasing conviction rates. There is an expectation that this facility will assist in the collection of forensic evidence to support convictions, whilst improving the mental and physical health and wellbeing of victims.

C-card scheme
The C Card scheme started in 2006 to assist young people in getting access to condoms, lubricants and advice on sex, STIs and relationships. The scheme is available from a range of places including Health Centres, GP Practices, Youth Centres, Colleges and Schools. The advice is free and confidential, and is aimed at helping young people make the right choice about sexual health. The C Card scheme gives young people a chance to ask all those questions they may have about sex, health and relationships. 13,784 young people under 20 are registered onto the scheme; there are a larger proportion of young men accessing the

scheme than young women, which is a key target for the scheme. Over 60% of current users are male.

HIV Social Support for those with or Affected by HIV
There are a range of health services provided for people living with HIV/AIDS including testing and clinical services, hospital care, psychological therapy, alternative therapy and health promotion. Clinical services are reported by service users to be of a particularly high quality. Nottingham Positive Care team (NPCT) is a specialist team providing a service directly to people living with HIV/AIDS. They provide social support and care in the community to people living with HIV and are funded by the statutory sector (PCT and Local Authorities). The aim of the NPCT is to support people living with HIV to live safely and independently in the community. An important focus for the team is to help people avoid crisis by providing access to a range of health and social care services.
The HIV Support Service is commissioned by a funding partnership of Nottingham City Council, Nottinghamshire County Council, NHS Nottingham City and NHS Nottinghamshire County. The service is provided by Terence Higgins Trust.

Service usage / Need

Diagnosis of Sexually transmitted infections is used as a proxy indicator of the Sexual Health needs within the population. This informs us of the need in those accessing service provision; however there is a lack of information on undiagnosed STIs, and therefore the fuller picture of who is at risk within our population. Sexual Health services are 'open access' services, and therefore any person can access these services irrespective whether they are residents within that area. In 2011 91.5% those accessing GUM services, accessed locally commissioned GUM services. 8.5% of those accessing GUM services, accessed services outside of Nottinghamshire County (Figure 30). This figure is reflective for those clients the PCT have received a cross charge payment for, however there may be a percentage accessing other services that currently there has been no charge for under block contract arrangements. In order to treat infection and prevent the onward transmission of infection it is important services are open access, are easily accessible and normalise sexual health behaviours. The stigma attached to attending GUM services remains problematic and is a barrier to those needing to access services.

GUM Attendances

Figure 30 Number of Nottinghamshire County residents accessing GUM service 2011

In area	Number of Patients	% Patients
Nottingham City Hospital	5361	37.7%
King's Mill Hospital	5271	37.1%
Retford Hospital	2376	16.7%
Out of area	1209	8.5%
Grand Total	14217	100.0%

Source: HPA GUMCAD

Figure 31 Nottinghamshire County residents attending GUM services for the first time are predominantly in the 20-34 year old age group for both males and females. Nationally the age group for first attendees is slightly higher, 25-34 years. Of those accessing predominately they are heterosexuals and have been born in the United Kingdom and are white.

Figure 31 % of patients living in Nottinghamshire (incl. Bassetlaw) attending any GUM clinic for the first time, by age group and gender, 2011

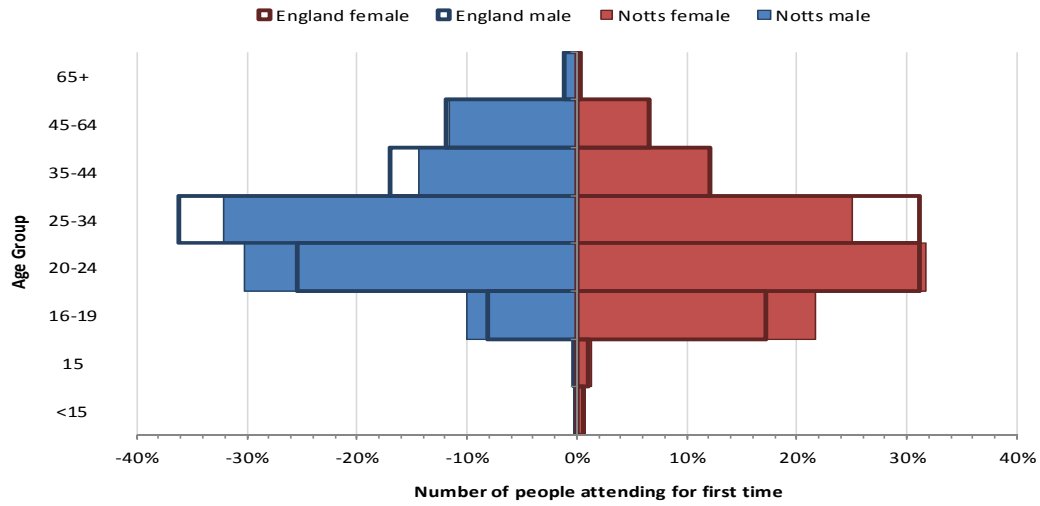
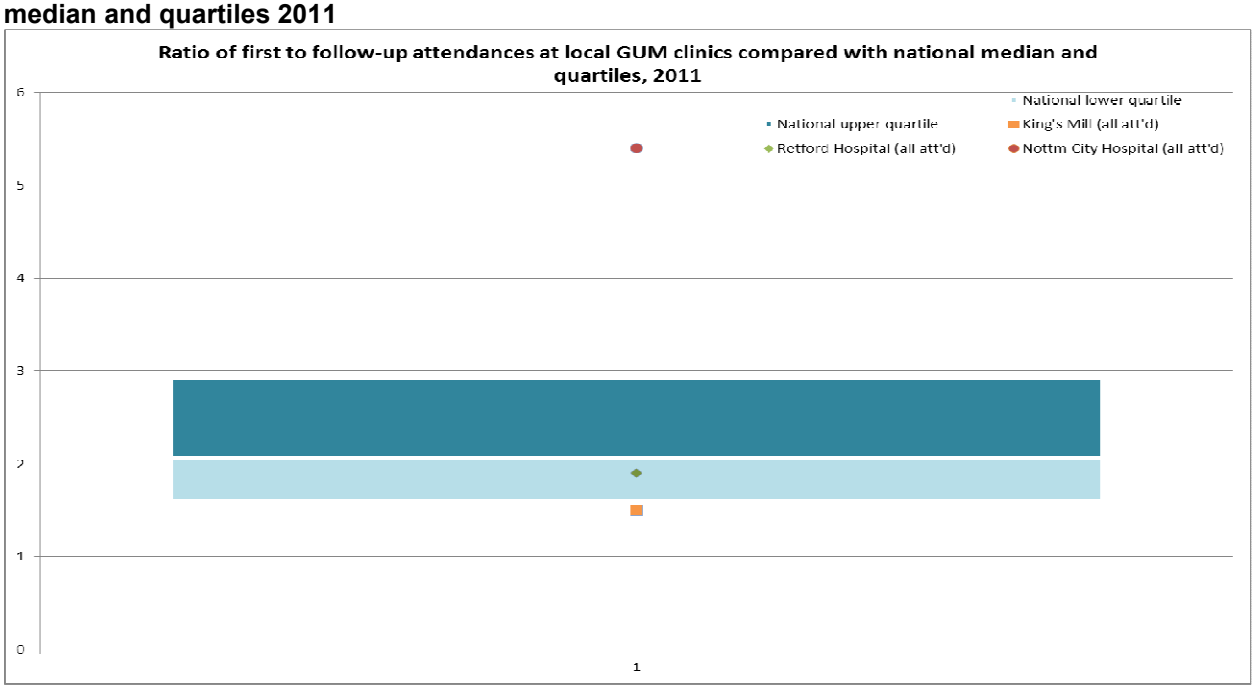


Figure 32 Ratio of first to follow up attendances at local GUM clinics compared with national median and quartiles 2011



Source: HPA GUMCAD

Figure 32 above shows that for those accessing GUM services across Nottinghamshire County there is a large variation. Those attending Nottingham City Hospital for GUM services the ratio of first to follow up appointments is double the amount accessing services at Sherwood Forest Hospitals and Bassetlaw Hospital (which are in line with the national average). It is unclear whether this is a data quality issue or if this is due to how services are being provided, further investigation is required.

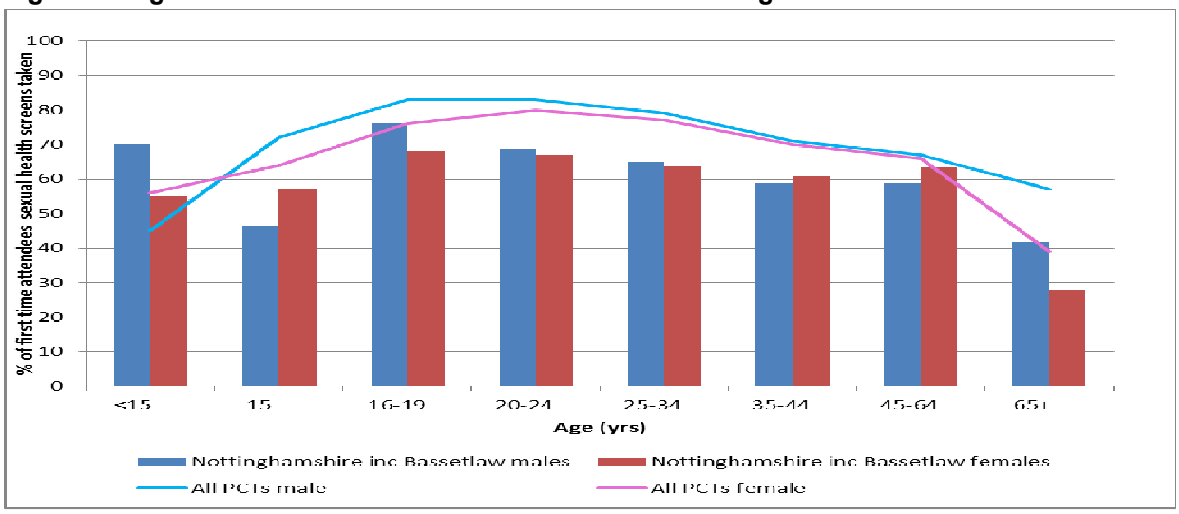
Sexual Health Screens

Figure 33 shows that of those first attenders who undertake a sexual health screen at GUM services within Nottinghamshire County the age profile mirrors that of the national profile, with approximately 60-70% across the age ranges of those attending accepting a sexual

health screen. Of those attending male homosexuals of Asian or Asian/British origin and mixed race bisexuals accept an offer of a sexual health screen.

Age Sex Breakdown

Figure 33 Age of first attenders to GUM services undertaking a sexual health screen



Source: HPA GUMCAD

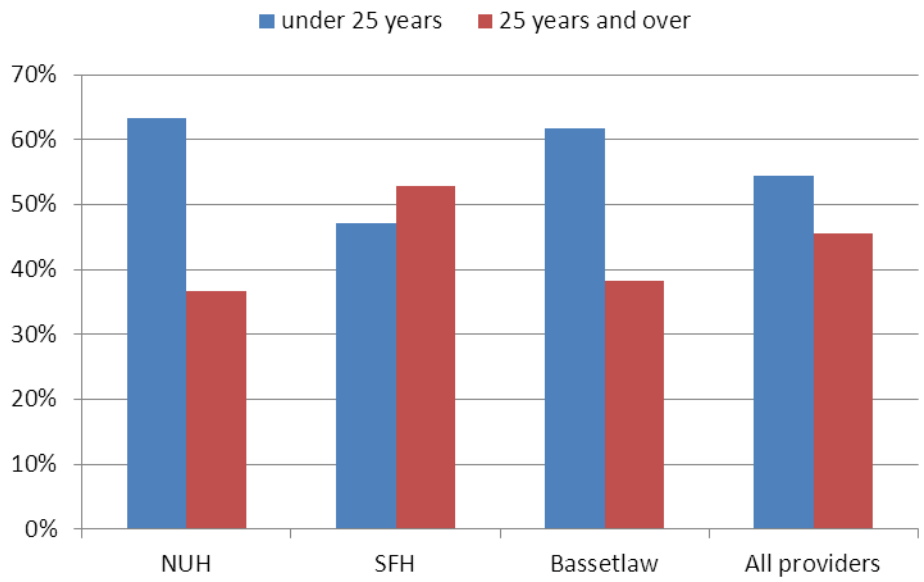
Contraception Services attendances

Provision of contraception

It is important that people have easy access to contraception and good quality family planning advice. It is also important that people have choice and access to a full range of methods that suit their needs. Contraception use is vital to improved sexual health and for a reduction in unintended pregnancy and STIs. Contraception can be accessed via Contraceptive and Sexual Health Services throughout the county and via General Practice. Basic Sexual Health provision (condoms, Emergency Hormonal Contraception and pregnancy testing) can also be accessed through some school nursing services and community pharmacies. It is important that people have easy access to contraception and good quality family planning advice. It is also important that people have choice and access to a full range of methods that suit their needs. National statistics show that 75% of women aged 16-49 use contraception and nearly half the women attending Contraceptive and Sexual Health Services England are aged 16-24.

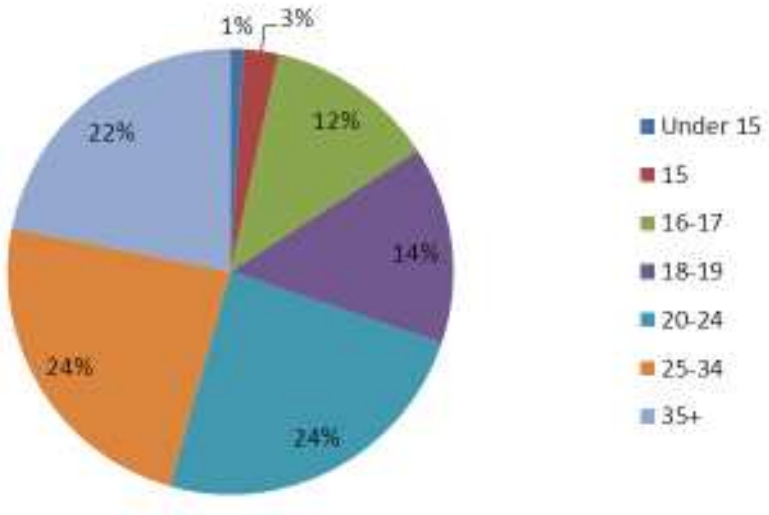
Figure 34 highlights were Nottinghamshire residents are accessing Contraceptive and Sexual Health Services (CaSH). It is important to note that a person may access services more than once. Sherwood Forest Hospital Trust tends to see older clients than both Bassetlaw and Nottingham University Hospital.

Figure 34: Percentage of attendances by Nottinghamshire resident clients at CASH clinics by age band and Sexual Health provider 2010 and 2011



Source: SHRAD

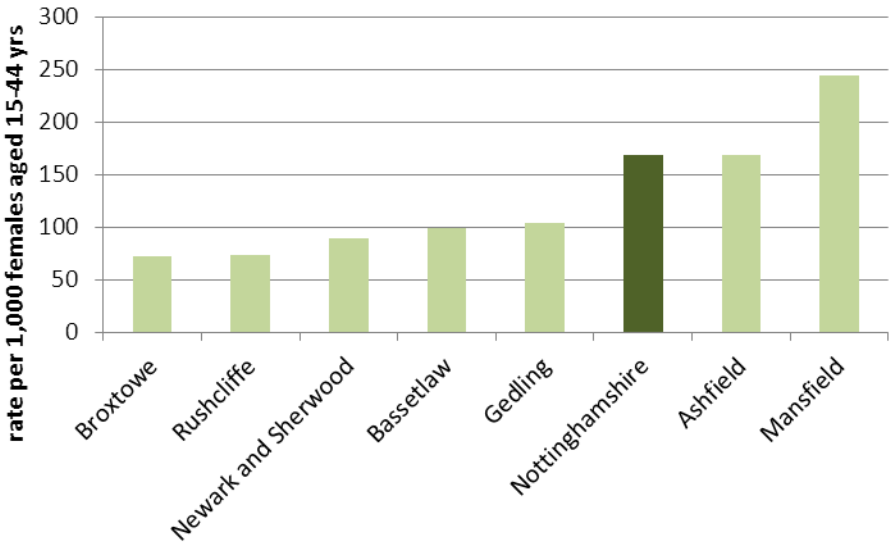
Figure 35 Percentage of attendances by Nottinghamshire clients at CASH clinics by age band, 2010 and 2011



Source: SHRAD

Figure 35 demonstrates the percentage of clients accessing CaSH clinics by age bands. The largest proportion accessing is those 35 +years (22%), 20-24 years (24%) and those 25-34 years (24%), in total 70% are above 20 years old, with 26% aged 16-19 years and only 4% of clients accessing CaSH services 15 years or younger.

Figure 36: Rate of attendance at CASH clinics in Nottinghamshire by district of residence, 2010 and 2011, rate per 1,000 females aged 15-44 years



Source: SHRAD

Figure 36 shows the rate of clients accessing CaSH services by district of residents. The largest percentage accessing CaSH services are from within the Mansfield and Ashfield Districts. The data shows that clients tend to access their local service apart from Ashfield who access both Sherwood Forest provider services and Nottingham University Hospitals.

Evidence of what works

HIV

In the mid-1980s, the introduction of needle exchange programmes decreased the frequency in Intravenous drug users and heat treatments to kill the virus in blood products did the same for those receiving blood products. In the late 1980s and early 1990s, an aggressive public awareness campaign launched by the UK Government resulted in a decline in the number of cases reported each year; however the epidemic still simmered below the surface. The introduction of anti-retroviral therapy, medications designed to prevent the progression to AIDS, dramatically decreased the number of AIDS incidence and AIDS-related deaths. Accordingly, the number of HIV cases continued to rise, while the death rate plummeted. AIDS-related deaths fell from 1,236 in 1996 to 395 in 1998 – approximately a 70 per cent drop. The figures since 1998 show a levelling off of this trend with around 400 deaths per year. Health promotion and education remain the cornerstones of STI and HIV prevention through improving public awareness of STIs and HIV and encouraging safer sexual behaviour such as consistent condom use and reductions in both the numbers and concurrency of sexual partnerships.

There needs to be greater focus on influencing behaviour to increase the use of condoms, reduce the number of partners, reduce the number of concurrent partners, and encourage sexual intercourse with people who have the same HIV status. Interventions need to be delivered at different levels, i.e. individually via helplines or counselling, in groups via group work or sex education, in communities via community development campaigns etc and using legislation.

Modification of the factors which give rise to the risky behaviour e.g. low self-esteem, lack of skills in how to use a condom, how to say no to sex, opinions of peers etc., although very little review evidence of this, it requires greater focus.

Evidence suggest voluntary counselling and testing is more effective when combined with another component than on its own and on accelerating prevention by select interventions which currently match patterns of HIV transmission, focus on targeting geographical areas and populations where it is spreading most rapidly.

STIs

Figures released in May 2012 by the Health Protection Agency (HPA) show new sexually transmitted infection (STI) diagnoses rose by two per cent in England in 2011, with nearly 427,000 new cases, reversing the small decline observed the previous year. However, rates of STIs in the East Midlands are generally lower than in England with Nottinghamshire mirroring the national picture. There is considerable geographic variation in the distribution of STIs with highest rates seen in urban areas, reflecting concentrations of the population who are at greatest risk. Young heterosexual adults (15-24 years) and men who have sex with men (MSM) remain the groups at highest risk. Chlamydia is the most commonly diagnosed of all STIs in the UK with highest rates seen in young people under the age of 25 and affects around 1 in 10. Chlamydia is symptomless and if left undiagnosed can lead to long term health problems such as infertility. Although the 2011 data from the Health Protection Agency (HPA) shows a four per cent drop in cases of Chlamydia in young adults diagnosed in GUM and community, from approximately 154,000 to 148,000, this is due to falling numbers of younger adults being screened, and consequently fewer cases being ascertained.

Although a small decline in STIs was seen in 2010 in England this has raised again in 2011, demonstrating that more work needs to be done to improve awareness and encouraging safe sex and ensuring easy and open access to sexual health services.

Teenage Pregnancy

Teenage pregnancies (under 18s) rates have been declining since 1998 and are at their lowest rate for almost 30 years and have reduced by 24%. International evidence as well as lessons learnt from areas where teenage conception rates have fallen the fastest shows the need for Sexual Relationship Education (SRE) which helps young people deal with the pressures to have sex as well as equipping them with the knowledge and skills to avoid unplanned pregnancies and sexually transmitted infections alongside easy access to young people centered contraceptive and sexual health services as they need them.

Termination of Pregnancy

The level of abortion is often used as an indicator of the degree of failure to use contraception, or failure of the contraception itself. It is important for those women who are legally entitled to access an abortion to be able to access the procedure as soon as possible. If a woman can access the service before she is nine weeks pregnant, she can have a choice of abortion method. The earlier in pregnancy an abortion is performed, the lower the risk of complications.

Contraception

It is estimated that nearly half of all pregnancies in England and Wales are unintended. While some pregnancies result from failure of a contraceptive method, most pregnancies occur either because no contraception was used or because the method was used inconsistently or incorrectly (Stopes 2009). Contraception is free and easily accessed through various sources. However uptake of LARC is low, with only 11% of women aged 16-49 using any of these methods (implants, injections and intrauterine devices). In comparison the oral contraceptive pill is the most popular choice used by 28% of women and the male condom a

close second at 24%. Use of emergency contraception remains low despite efforts to advance provision through over-the counter sales by pharmacists (Stopes 2009).
Evidence from the Marie Stopes research in 2009 suggests there needs to be easy access to quality information on a wide range of contraceptive methods including LARC. It highlighted that access to information about contraception needs to be strengthened through multiple channels, notably the school curriculum, magazines, the internet and most importantly the media (TV and radio)
Teenagers believe they are special and unique and that nothing bad will happen to them. This explains why teenagers are often focused on the present with little consideration of the long term consequences of their behaviour, future plans and personal values. Teenagers may be thinking that having sex without contraception is fine because the consequences "will never happen to me". Perhaps of most concern was the response that young people were too embarrassed to ask a healthcare professional about contraception. this was the main reason given in Great Britain (29%), 59% of women surveyed claimed to be well informed about available contraception options.

Young people in Great Britain appear to be particularly well informed about which methods of contraception are effective at preventing an unplanned pregnancy, with 98% indicating that condoms are an effective method If used correctly every time you have sex, male condoms are 98% effective (NHS Choices) and 94% stating that taking the pill is effective. Great Britain also has relatively low numbers of young people who believe that methods such as withdrawal, having sex during menstruation and having a bath/shower after sex are effective ways of preventing pregnancy. However, Great Britain still has one of the highest teenage pregnancy rates in Western Europe, which indicates that although young people are able to easily access accurate information, they are not necessarily acting on it (Bayer 2010).

Users views about Sexual health services

National
Local – several pieces of work have been undertaken to gain the views of service users locally. Two pieces of social marketing work have been undertaken with Children and Young people in relation to Teenage pregnancy and Chlamydia testing (2010). A further consultation was undertaken with Children and young people to gain their views on where, how, who, when sexual health services should be delivered and also to inform what they would wish to see from a Sexual Health service (2010). As part of a service review in 2012 clients accessing NUH services were also consulted upon to the timing and locations of sexual health and contraception clinics.

Where are the gaps?
Currently there are gaps within the data that is available from the Sexual Health service provision at a clinic level. Data historically has been activity based rather than outcome based. The GUM data is high level data, purely based on activity due to sensitivity of the data.

More joined up working with Drugs and Alcohol services on the preventative agenda that leads to risky sexual behaviour

Data is only available on those accessing services with an STI diagnosed. We do not currently have information of those individuals that are not diagnosed, therefore the size and scale of unmet need is not fully understood

Nottinghamshire County Council

Report to Health and Wellbeing Board

6th March 2013

Agenda Item: 7

REPORT OF DIRECTOR OF PUBLIC HEALTH

NOTTINGHAMSHIRE HEALTH AND WELLBEING LOCAL OUTCOMES FRAMEWORK

Purpose of the Report

1. This report describes and presents a proposed Local Outcomes Framework for Health and Wellbeing in Nottinghamshire. A list of proposed indicators is included in Appendix 1

Information and Advice

2. The Nottinghamshire Health and Wellbeing Board is committed to the development and use of a Local Outcomes Framework (LOF). This will allow the Board to assess the effectiveness of the Health and Wellbeing Strategy. If all the measures included in the framework improve over time, then the majority of people who live and use services in Nottinghamshire will experience better life chances and quality of life.

3. The Local Outcomes Framework is not intended to measure or performance-manage every aspect of the Board's work, but reflects the priority areas identified in the Strategy.

Development of the Local Outcomes Framework

4. The list of indicators contained in the Local Outcomes Framework is from four source documents:
   a. NHS Outcomes Framework for 2013/2014;
   b. Public Health Outcomes Framework, 2013 to 2016;
   c. Adult Social Care Outcomes Framework for 2013/2014;
   d. Nottinghamshire Children and Young People's Plan 2011-14.

5. To develop the list of proposed indicators, the JSNA, Strategy and Outcomes Group considered indicators in these documents and how they relate to Nottinghamshire's Health and Wellbeing Strategy. Integrated Commissioning Groups and partner organisations refined the list during the Autumn of 2012. A further check in January 2013 removed indicators where data was not available at County level.

6. **Figure 1** includes a detailed list of the indicators, and how Nottinghamshire compares to the overall England value for each measure.

7. This report provides baseline information. It does not include detailed information on each of the measures, or an explanation where performance is less than expected. Further information will form part of the next report, which will provide context and set the ambition for future performance.

Figure One: Proposed indicators for Nottinghamshire Health and Wellbeing Local Outcomes Framework - to be read in conjunction with the Nottinghamshire Health & Wellbeing Strategy

Health and Wellbeing Strategy Priority Area and potential indicators PH – Public Health OF, ASC – Adult Social Care OF, NHS – NHSOF, CYP – Nottinghamshire CYP plan	Comparison to England (1) ▲ Better ►Not significantly different ▼Worse — Comparison not possible	Notes
Prevention: Behaviour Change & Social Attitudes		
Smoking and tobacco control		
Smoking at time of delivery – PH 2.03	▼	
Smoking prevalence in over 18 years – PH 2.14	►	
Under 75 mortality from Respiratory diseases – NHS 1.2	►	
Under 75 mortality from Cancer – NHS 1.4vii	►	
Obesity		
Excess weight ages 4-5, 10-11 – PH 2.06i	▲	
Excess weight ages 10-11 – PH 2.06 ii	▲	
Breast–feeding prevalence rates at 6-8weeks – CYP 6, PH 2.02ii	▼	
Substance Misuse: Alcohol and Drugs		
Successful completions; drugs treatment – PH 2.15	►	
Alcohol–related admissions to hospital – PH 2.18	▲	Revised definition expected in 2013
Under 75 mortality from liver disease – NHS 1.3	▼	
Adult and Health Inequality Priorities		
Learning Disability		
People with learning disability in settled accommodation – PH 1.06i	▲	
Adults with learning disability in paid employment– ASC 1E	▲	
Adults with learning disability in own home or with family– ASC 1G	►	
Physical Disability, Long Term Conditions and Sensory Impairment		
Recorded diabetes – PH 2.17	►	
Preventable sight loss– PH 4.12 (i AMD, ii glaucoma, iii diabetic eye disease, iv sight loss certifications	►i, ►ii, ►iii, ▼iv	Choose most appropriate of these. (AMD: age related macular degeneration)
Under 75 mortality from cardiovascular – NHS 1.1	►	
Under 75 mortality from respiratory diseases – NHS 1.2	►	

Health and Wellbeing Strategy Priority Area and potential indicators PH – Public Health OF, ASC – Adult Social Care OF, NHS – NHSOF, CYP – Nottinghamshire CYP plan	Comparison to England (1) ▲ Better ►Not significantly different ▼Worse ▬ Comparison not possible	Notes
Adult and Health Inequality Priorities- continued		
Employment of people with long–term conditions – NHS 2.2	▬	No direct England comparator
Use social services with self–directed supported/direct payments – ASC 1C	▲	
Mental Health and Emotional Wellbeing		
Self–reported wellbeing – PH 2.23 i % low satisfaction score, ii %low worthwhile score, iii %low happiness score, iv % high anxiety score	►i, ▼ii, ►iii, ►iv	
Adults in 2y mental health services in paid employment – ASC 1F	▼	
Adults in 2y mental health live independently – ASC 1H	▼	
Employment of people with mental illness – NHS 2.5	▬	No direct England comparator (could be calculated
Community mental health services: patient experience – NHS 4.7	▲	Data by provider (Nottinghamshire Healthcare Trust compared to England)
Suicide rate – PH 4.10	▲	
Dementia		
Enhanced quality of life for people with dementia – NHS 2.6i (% of expected diagnoses)	▬	England figure only on NHSIC indicator portal.
Older People		
Falls and fall injuries in the over 65s – PH 2.24i	▲	Data reported for various age and gender splits. All significantly low.
Hip fractures in the over 65s – PH 4.14	▼	Data reported for various age groups.
Excess winter deaths – PH 4.15	►	Data from APHO Nottinghamshire Health Profile
Older people remain at home after re-enablement/ rehabilitation– ASC 2B	▲	
Permanent admissions to residential or nursing homes – ASC 2Aii	▲	

Health and Wellbeing Strategy Priority Area and potential indicators PH – Public Health OF, ASC – Adult Social Care OF, NHS – NHSOF, CYP – Nottinghamshire CYP plan	Comparison to England (1) ▲ Better ►Not significantly different ▼Worse ▬ Comparison not possible	Notes
Wider Determinants of Health		
Crime and Community Safety: Links to the work of the Safer Nottinghamshire Board		
1st entrants to youth justice – PH 1.04	▼	From published data for 2011-12. Local data suggests significant improvement has been made.
Re–offending – PH 1.13 i % offenders re-offend, ii average number re-offences	►i, ►ii	
Healthy Environments in which to live, work and play		
Utilise green space for exercise/health – PH 1.16	▲	

Notes:
(1): comparison to England based on published data on https://indicators.ic.nhs.uk/webview/ for NHSOF and ASCOF indicators, http://www.phoutcomes.info/ for PHOF. Accessed 21 January 2013.

(2): Indicators designated as 'placeholder' (definition not agreed) or 'in development' (data not available as of January 2013) are not included.

(3): Children & Young People indicators are included within other life course sections.

(4): The action plans developed by each Integrated Commissioning Group will address explicitly any areas where performance in Nottinghamshire is of concern.

8. Future implementation and development

The Local Outcomes Framework is intended for use from April 2013. To meet this timescale, the following actions will be completed:

- Compare the measures for Nottinghamshire against England and other suitable comparators
- For each indicator, bring together:
  - why the measure is included in the Local Outcomes Framework;
  - the definition, origin and frequency of publication;
  - a realistic assessment of how much each could change over 3 years and
  - whether any data exist at a sub-County level (for example districts, boroughs or Clinical Commissioning Group populations).

- Integrated Commissioning Groups will set ambitions for indicators to 2016/17, with supporting draft action plans. The action plans will address explicitly any areas where performance in Nottinghamshire is of concern.

9. To ensure safe, quality service delivery, the Local Outcomes Framework will be cross-referenced to relevant themes across other domains in the national outcomes frameworks, in particular the NHS Outcomes Framework.

10. To ensure that Children and Young People's health and wellbeing is properly represented, the Board may wish to review the Local Outcomes Framework following the publication of the national Children and Young People's Health Outcomes Framework and the revised Nottinghamshire Children and Young People's Plan. Both of these documents are due to be published in early 2013.

11. Clinical Commissioning Groups have recently submitted summary commissioning plans for 2013-14 to the NHS Commissioning Board. These plans include three local priorities for each CCG chosen from a defined list of indicators. The action plans described in point (7) above will identify where CCG priorities complement the LOF indicators.

12. The content of the Local Outcomes Framework will be reviewed as part of the process to review the whole Health and Wellbeing Strategy.

13. A follow up report will be presented to the Health and Wellbeing Board meeting in June 2013, detailing the ambition for each area.

RECOMMENDATION/S

1) The Health & Wellbeing Board is asked to comment on the proposed local outcomes framework and endorse this for implementation from 1st April 2013.

Name of Report Author(s): Chris Kenny
Title of Report Author(s): Director of Public Health

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

Constitutional Comments (SG 15/02/2013)

14. The shadow Board is the appropriate body to consider the matters referred to in this Report.

Financial Comments (NDR 19/02/13)

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

Background Papers:

- Our Strategy for Health & Wellbeing in Nottinghamshire 2012/13
- NHS Outcomes Framework for 2013/2014;
- Public Health Outcomes Framework, 2013 to 2016;
- Adult Social Care Outcomes Framework for 2013/2014;
- Nottinghamshire Children and Young People's Plan 2011-14

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

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to the Health and Wellbeing Board

6 March 2013

Agenda Item: 8

REPORT OF THE INTERIM DIRECTOR OF NURSING, NHS COMMISSIONING BOARD LOCAL AREA TEAM

NHS COMMISSIONING BOARD LOCAL AREA TEAM COMMISSIONING PLANS

Purpose of the Report

1. To invite the Board to consider the NHS Commissioning Board Local Area Team's draft plans for directly commissioned services.

Information and Advice

2. The attached document from the Derbyshire and Nottinghamshire Area Team of the NHS Commissioning Board summarises the Team's draft plans for directly commissioned services in 2013/14.

3. The Team has invited Health and Wellbeing Boards to feedback on the draft plans before final submission and subsequent publication on 5 April 2013.

4. The services directly commissioned by the Team are:

- primary care services (general practice, optometry, dental and community pharmacy
- public health
- military health
- offender health
- specialised care

5. The plans build on planning intentions developed both nationally and locally in previous years, and reflect both local Health and Wellbeing Strategies and Clinical Commissioning Group plans. Both the Military Health and Offender Health plans have been collectively developed with the national leads in these areas.

Statutory and Policy Implications

This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder and users.

Where such implications are material, they have been brought out in the text of the report.

RECOMMENDATION/S

That the Health and Wellbeing Board consider and comment on the NHS Commissioning Board Local Area Team's draft plans for directly commissioned services.

Dr Barbara Stuttle CBE
Interim Director of Nursing
NHS Commissioning Board, Derbyshire and Nottinghamshire Area Team

For any enquiries about this report please contact:
Dr Barbara Stuttle

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

National Commissioning Board Planning in 2013/14

Directly Commissioned Services

1. Introduction

This document describes the planning arrangements and intentions for 2013/14 in relation to Direct Commissioning in Area Teams. Directly commissioned services incorporates:

- Primary Care services (General Practice, Optometry, Dental and Community Pharmacy),
- Public Health
- Military Health
- Offender Health
- Specialised Care

The approach for Direct Commissioning will mirror the CCGs approach and be based on the priorities for single operating models outlined in the publications entitled "Securing Excellence", and in the Public Health section 7a Agreement:

- Primary Care published in July 2012;
- Specialised Commissioning published with commissioning intentions in November 2012;
- Military Health and Offender Health issued to Area teams in draft in November 2012 due for publication in January 2013;
- Dental Services due for publication in February 2013;
- Public Health section 7a.

2. Context

The context for Direct Commissioning is one of a single national operating model implemented locally with Clinical Commissioning Groups and Local Authorities to reflect local need.

Area teams supported by regions have a particular responsibility for ensuring the coherence of commissioning plans across England. All Area teams will have responsibility for commissioning both Primary and Public Health services, however a smaller number of Area Teams will take responsibility for commissioning Military health, Offender Health and Specialised Commissioning on behalf of the other Area Teams, as follows:

Specialised Commissioning	Offender Health	Military Health
Cheshire Warrington & Wirral	Durham, Darlington & Tees	North Yorkshire & Humber
Cumbria, Northumberland, Tyne & Wear	Lancashire	***Derbyshire & Nottinghamshire***
South Yorkshire & Bassetlaw	West Yorkshire	Bath, Gloucestershire, Swindon & Wiltshire
Birmingham & the Black Country	***Derbyshire & Nottinghamshire***	
East Anglia	East Anglia	
Leicestershire &	Shropshire & Staffordshire	

Lincolnshire		
Bristol, North Somerset, Somerset & South Gloucestershire	Bristol, North Somerset, Somerset & South Gloucestershire	
Surrey & Sussex	Surrey & Sussex	
Wessex	Thames Valley	
London	London	

3. Direct Commissioning Priorities 2013/14

The priorities and outcome measures for the directly commissioned services led by the Derbyshire and Nottinghamshire Area Team are summarised in the appendices. These priorities build on plans developed both nationally and locally in previous years, and are aligned to local Health and Wellbeing Strategies and Clinical Commissioning Group plans.

The safe transfer of services and agreement of contracts by 31st March 2013 within the resources available remains an overriding priority. Together with a clear commitment to transforming services to ensure improved quality, outcomes and equity across England. In addition, the following are required:

Primary Care (GP, Dental, Optical, Pharmaceutical)

- Safe transfer of:
    - PCT contracts to the NHS CB aiming for a 'steady state transfer' on 1 April 2013;
    - Safe transfer of contracts to CCGs and LA's e.g. enhanced services, Out of Hours and Home oxygen;
    - Business critical systems and processes;
    - Lift and shift of FHS functions;
    - GP appraisal systems and systems for revalidation.
- Implementation of a single operating framework;
- Implementation of single performers list;
- Implementation of performers support services to manage performers whose practice gives rise to concern;
- Introduction of the national quality framework including strategy for quality improvement, web-enabled database of general medical practice quality indicators and a national performance assessment framework;
- Implementation of Securing Excellence in commissioning NHS dental services;
- Supporting the development of Local Professional Networks;
- Develop and implement national dental care pathway commissioning framework;
- FHS transformation and cost reduction programme.

Public Health Services

- Safe transfer of the commissioning of services covered by the Section 7A agreement, with area teams addressing any specific local concerns highlighted through the National Quality Board's Quality Handover process;

- Continued effective commissioning of the healthy child programme;
- Full implementation of all immunisation and screening programmes including roll out of those currently in development;
- Maintenance and development of the National Screening programmes;
- Achievement and maintenance of the requirements to increase the numbers of Health Visitors and the family nurse partnership;
- Preparing for transfer of additional responsibilities to Local Authorities;
- Jointly with Offender Health Teams, commission services that improve care for victims of sexual assault.
- Working with Local Authorities and Public Health England's Centres to ensure screening and immunisation services are part of an effective local public health system.

Offender Health

- Implementation of the single operating model for the commissioning of services in:
    - General Prison Healthcare
    - Secondary Care
    - Substance Misuse
    - Secure Training Centres
    - Secure Children's' Homes
    - Immigration Removal Centres
    - Sexual Assault Services (* Link to Public Health)
    - Liaison & Diversion
    - Police Custody Suites

- Continue to develop and strengthen the partnership and co-commissioning arrangements with the National Offender Management Service, Youth Justice Board and the UK Border Agency;
- Implementation of the full role out of the liaison and diversion services;
- Effective commissioning of services for substance misuse.

Military Health

- Transfer from Ministry of Defence the commissioning of services for serving personnel (including mobilised reservists and families served by Defence Medical Centres) and the establishment of the new single operating model for Armed Forces Commissioning, including IVF services.

- Assure CCGs deliver the Mandate requirement for the Armed Forces covenant in particular for Veterans, Reservists and their families (and serving families not

covered by Defence Medical Centres), including: commissioning for prosthetics, mental health and establishing a base line for activity, finance and performance.
- Ensuring continuation of the delivery of the principle of “no disadvantage” as set out in the Armed Forces covenant and NHS Mandate, in particular the transition of service personnel and their families out of service back into the community (whether due to injury, end of service or as a demobilised Reservist)..
- Supporting the continuation and development of the Armed Forces Networks across England.

Specialised Commissioning

- One single operating model for the commissioning of specialised services through the 10 nominated Area teams;
- One national budget which will be cash limited;
- Staff resource and knowledge shared across the NHS CB structure;
- A framework approach to contracting set once nationally shaped by Area and Regional teams;
- All specialised activity is defined in the manual captured in contracts with providers;
- Core specifications in place for all services or derogations applied for;
- Clinical access policies in place and applied across all providers.

6. Assurance

First draft submissions were submitted on 25 January, with final submissions expected to be published on 5 April, thus allowing time for local partners to review and comment on the plans prior to final submission.

As the National Commissioning Board (NCB) is one organisation and there are a number of shared accountabilities, assurance between Central, Regional and Area Teams will include an opportunity for face to face regional discussions to enable area and regional teams to co-produce plans and hold each other to account. This discussion should involve CCG representatives, Local Authorities, Public Health England where appropriate and in the case of Armed Forces the AF Networks. It should be clear at the end of the process how priorities have been identified and how outcomes have been agreed across all commissioning roles and responsibilities.

The Assurance process will seek to ensure that there is adherence of Direct Commissioning, Clinical Commissioning Group plans and Health and Wellbeing Board strategies in delivering improvement in health outcomes.

7. Recommendations:

To note the directly commissioned services planning arrangements

To comment on the first draft priority plans prior to submission and then publication on 5 April 2013.

Vikki Taylor
23 January 2013

Area Team – Derbyshire and Nottinghamshire

Military Health Programme

Values and Principles	Delivery of high quality and safe care to patients	Improved outcomes are delivered across each of the domains	The wider system addresses the needs of Armed Forces, their families and veterans	Seamless transition of care, no disadvantage or exclusion from the Constitution
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13	Strategic Context and Challenges	QIPP Improvements	Organisational Development

• *Delivery of health component of the Armed Forces Covenant*
• *Maintenance of Armed Forces Networks*
• *Delivery of Murrision "Fighting Fit" mental health agenda*
• *Delivery of Murrison Prosthetics agenda*
• *Development of new health care contract for care of Serving Personnel*
• *Establish CSU and Business Intelligence gathering*
• *Safe transfer from PCT commissioned care existing services to new contracts*
• *Ensuring that all service personnel are visible to NHS IT systems*
• *Establish base line for activity, finance and quality*
• *Ensure robust safeguarding arrangements are in place*
	• *Mandate emphasis on the Armed Forces Covenant*
	• *First time that this patient group has been explicitly commissioned*
	• *Patient group has high expectations and occupational health requirements*
	• *Direct Commissioning only covers serving personnel and those families registered at Defence Medical Centres.*
	• *Data quality issues with historic activity, finance and performance information*
	• *Transition needs assurance :*
	  • *Armed Forces Networks are maintained*
	  • *CCGs discharge duties for Veterans, Reservists, Families*
		• *Establish robust baseline of spend*
		• *Establish Quality benchmarks for future CQUIN*
		• *Improve mental health quality*
		• *Ensure that small numbers eligible for screening are able to access the screening programme*
		• *Improve transition out of Service, to improve mental and physical health and wellbeing.*
			• *Establish integrated virtual Armed Forces Commissioning Team with Regions/Area Teams*
			• *Establish joint MoD/NHS committees*
			• *Source or provide hosts for AF Networks*
			• *Establish national mental health Network*
			• *Establish permanent new home for Veterans' Prosthetics and ensure strong links to the AFN*

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Prosthetics*	• Confirm the providers of veterans' prosthetics services • continuation of the veterans' prosthetics panel to ensure access to high quality components continues	• Standard of prosthetics care for veterans' is consistent and improved	• universal and sustainable standard of prosthetic care that can be transferred to the wider NHS as the model of care.
Infertility Treatment	• Establish and agree the policy for IVF for serving personnel that covers issues of geographic mobility • Establish and agree the operational model for the provision of IVF for the very seriously injured	• Contracts in place • Serving personnel and their families at no disadvantage within IVF care provision	• international best practice model for IVF for injured personnel
Armed forces covenant	• Embed the principle of No Disadvantage and proper return for sacrifice • Improved access to information about services available to the Armed Forces community	• Directory of services for Armed Forces services • Increased coverage of Community Covenants	• All areas covered by a Community Covenant
Mental Health	• Establish the Veterans' Mental Health network • Increase / Improve access to mental health services	• Evidence based practice for serving personnel & Veterans' mental health services	• Transparent and consistent pathways of care both during and after service
Armed Forces Network	• Maintain and improve Armed Forces Networks	• Local Armed Forces Network development plans in place • Safe transition from serving to civilian life for wounded injured and sick personnel • CCG engagement in and ownership of the Armed Forces Networks	• Armed Forces Networks hosted collaboratively by CCGs • Model secures seamless transition from care secured by the NHS CB to care secured by CCGs • Full co-operation between statutory and third sectors to support the Armed Forces community
Contracting	• Establish new contracts and baselines for activity, finance and performance • Development of clinically appropriate service specifications	• Improved transition between Defence and NHS pathways	• Integrated pathways between Defence and NHS services • Working towards prime contractor outcome based payment contracts (pilot)

Area Team - Derbyshire and Nottinghamshire

Offender Health Programme

Values and Principles	Early Intervention and diversion	High quality and safe standards of patient care	Partnership working to deliver integrated care		Continuous improvement in NHS and PH outcomes
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13	Strategic Context and Challenges	QIPP Improvements	Organisational Development
•To reduce offending behaviour *•To improve health outcomes and patient experience* *•To reduce health inequalities*	*•Capacity and capability to deliver in a changing health landscape.* *•Embedding of patient and carer engagement* *•Scale of Contract transition/mobilisation ahead of April 2013.* *•Delivering safe, equitable and quality care in a safe environment* *•Assuring Governance throughout transition process and into new structures.* *•Maintaining Performance as responsibilities change* *•Managing expectations and expectations of stakeholders and partners* *•Setting up a clinical governance framework across the local area teams to ensure patient safety .* *•Maintaining effective risk management systems.*	*• Medicines Management and Pharmacy Savings* *• Use of benchmarking (including workforce benchmarking) in order to inform existing and future contract negotiations* *• Working with Providers in order to make contract Savings for Re-investment in services* *• Review of all services currently provided in terms of whether these services contribute to strategic healthcare objectives – Could resources be diverted towards other areas of provision where there are risk issues?* *- Secondary Care Referrals, escort and bed watches, tele-medicine*	*Clarity around roles and functions in new landscape* *Effective Communication and engagement plan, internal and external stakeholders actively involved.* *Skills and learning audit – cross boundary working to boost capacity and capability* *Due diligence* *Emphasis on improving the quality of service to patients and ensuring engagement and participation*

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
General Prison Healthcare	• Address general performance issues across the region • Identify Opportunities to address gaps in in provision in dental services, specialist mental health services and hep c screening services across the region • Continue with minor capital works on areas of the prison estate where Prison Premises not fit for purpose/not meeting Care Quality Commission (CQC) quality and safety standards. •Encourage innovation through business cases for unmet or changing need •Identify best value provision •To procure high number of healthcare provision across 16 Prisons and to review and undertake Health Needs Assessments in order to action integrated service specs and contracts with lead providers including a model sub contracting with the 3rd sector •Ensure Equality and Diversity are core to all commissioning intentions and service provision •A need to commission further work on private sector and PFI Prison estate healthcare working alongside NOMS. •Ensuring patient safety through robust clinical governance processes and systems •Effective Clinical Risk Management systems and processes.	• consistent Contractual arrangements established between NHSCB and prison healthcare including variations to facilitate improved performance and quality as per national priorities and identified local risks • Clinical leadership arrangements confirmed with host AT and communicated to the regions Providers • Patient Satisfaction and feedback to be embedded into performance management framework as well as the commissioning cycle, and commissioning intentions. •Developing a clinical Governance framework which assures quality of service delivery and patient safety. •Clear lines of accountability and responsibility for Serious incident reporting across the LAT and learning the lessons embedded into organisational culture. •Identification of key performance indicators including use of CQUINs,PROMS	•Manageable number of robust healthcare contracts with high quality and respected providers, subject to regular, and robust performance and quality management arrangements •Clinical leadership and patients to support commissioners in assessing and assuring quality of services. •Continued development of high quality, safe and innovative services, with improved performance against PHPQIs and community standards.
Secondary Care	• In order to enable the effective commissioning of services, key partnerships have to be developed with local CCGs. It is a recommendation that OH AT's are named associates to the contract. This will enable OH AT's to work in conjunction with local CCGs to commission seamless pathways of care allowing treatment to be continued from both prison and community.	• Establish secondary care activity and expenditure reporting for all prisons in the region • Identify capacity to lead secondary care redesign across the East Midlands with the aim of improving the patient experience, as well as reducing spend, with a view to releasing funds to re-invest in prison healthcare services (e.g. Potential Outline Business Case for a secure Regional Healthcare Facility at Rampton)	• A clear understanding of prisoners use of secondary care services, prison by prison, understanding the reasons for variation •A number of hospital admission avoidance initiatives in place, working in partnership to address Escorts and Bedwatcher cost to increase breadth of in-house provision and alternatives including telemedicine.

Area Team - Derbyshire & Nottinghamshire

Primary Care Programme

Values and Principles	Common core offer of high quality patient centred primary care	Continuous improvement in health outcomes across the domains	Patient experience and clinical leadership driving the commissioning agenda	Balance between standardisation and local empowerment	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13	Strategic Context and Challenges	QIPP Improvements	Organisational Development
Effectively managing the transition of primary care commissioning from PCTs to the NHS CB Area Team including: • Establishment of the new team • Transfer of PCT contracts to the NHS CB on 1st April • Transfer of Enhanced Services to receiving organisations (CCGs and LAs) • Safe transfer of business critical systems and processes • Transition of GP appraisal systems and revalidation systems • Successful Lift and shift of FHS services	There are 10 CCGs across the Area Team, 282 GP Contracts, 419 community pharmacies (644 contracts), 246 Dental Practices (327 contracts) and 214 Opticians (333) contracts. A strategic challenge will be to develop and enable delivery of a coherent clinical strategy to transform primary care and improve clinical outcomes that aligns national, HWB and CCG strategies with population needs and current service deficiencies. Critical to this will be strong clinical leadership and patient and public engagement. This clinical strategy will need to challenge the status quo of primary care provision which has been built up over many years. A related challenge will be to agree relative roles and responsibilities between the AT and CCGs to improve quality and clinical outcomes.	Primary care budget comprises GP £249m, Pharmacy £62.6m, Dental £81.8m and Optometry £ 18.8m. The provisional budget for secondary dental care is £14.5m. 2% savings to be applied across Primary Care to achieve target, with the 0.5% contingency to be considered from appropriate resources. QIPP schemes are being developed in line with the overall desired transformation. Specific efficiencies in spend will be considered from: • Decommissioning of underperforming contracts • Reduction of Contract Values to reflect performance • Reducing variation, duplication and waste • Identification of recurrent and non recurrent savings • Medicines optimisation schemes	OD to support implementation of the single operating model, policies and procedures through the Area Team primary care team staff. Supporting development of effective local professional networks and strong relationships with local professional committees to provide clinical leadership and clinical engagement in decision making and service transformation. With respect to LPNS a particular focus on dental, pharmaceutical and optometry networks as CCG and Medical Directorate should provide an effective network for primary medical contracts. Ensuring strong alignment between new organisations in the system to support delivery of shared priorities (e.g. LETB priorities support improvements CCGs / AT want to see in primary care). This will require strong engagement in the formative stages.

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Assurance	• Implement robust governance of primary care decisions • Implement national quality framework and performance assessment framework to improve clinical outcomes, working closely with the Medical and Nursing Directorate • Medical Directorate assurance of clinical practice	• Clear Governance of decision making • Reduced unwarranted variation in quality, performance and clinical outcomes • Assurance of clinical workforce • Single performers list	• Transformed quality, performance and clinical outcomes across all primary care contractors • Transformed outcomes in all 5 domains • High quality clinical workforce
Quality	• Commission a consistent offer of high quality primary care services • Build on the very best practice to deliver continuous improvements in the quality, clinical outcomes and value of primary care • Enable transformation of primary care in line with NHS CB, HWB, CCG visions and plans	• Improve quality, clinical outcomes and value in line with the 5 domains • Maintain access in line with the NHS Constitution • Improved patient experience of GP services and GP OOHs • Network providing access to pharmaceutical services 7 days a week	• High quality responsive primary care offering 7 day and online access to proactive and personalised care as part of an integrated system delivering exceptional quality, clinicial outcomes and value. • Patients empowered to self care supported by the latest technology (telecare / telehealth) and securely linked records
Single Operating Model	• Implementing a SOM across primary care commissioning for all four contractor groups • Enable development of LPNs and sustain effective working relationships with CCGs and LPCs	• SOM used to manage contracts across all four contractor groups • Effective LPNs in place covering all contractor groups • Effective working relationships in place with CCGs and LPCs	• Highly efficient operating models within the NHS CB enabling consistently high performing primary care services delivering outstanding outcomes and value
Securing Excellence-Dentistry	• Implement Securing excellence in commissioning NHS dental services • Implement national dental care pathway commissioning framework • Ensuring consistent secondary care contracting	• Securing excellence in commissioning NHS dental services in place delivering improved oral health and clinical outcomes • Provide easy and convenient access	• High quality responsive dental services delivering improved clinical outcomes, with greater emphasis on promotion of oral health and meeting the complex dental needs of an ageing population
FHS	• Contribute towards the strategic review of FHS services whilst delivering local efficiencies / QIPP • Locally support national performers list management, provide local	• Responsive high quality FHS services provided efficiently on behalf of the NHS CB and supporting contractors	•Fully functioning, high quality, integrated FHS function meeting the requirements and needs of the NHS CB efficiently and cost effectively

Area Team - Derbyshire & Nottinghamshire Public Health Programme

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment
Strategic Context and Challenges	*• Improve uptake • Reduce health inequalities • Reduce inequity of access*	*•Low birth weight of term babies •Breastfeeding initiation and prevalence at 6-8 weeks*	*• Infant mortality per 1000 live births*	*•Screening & immunisation programmes require robust monitoring and reporting systems supported by appropriate informatics, administration and communications resource*	*range of commissioners across the HCP 0-19 years pathway could lead to fragmentation of the pathway* / *safe transfer of existing services (HCP 0-5)to new commissioner (NHSCB) April 2013 and then to Local Authority March 2015*

General Strategic Priorities	QIPP Improvements	Organisational Development
•Ensure continuity of screening and service provision •Ensure safe transfer of contracts to NHSCB especially with regard to those currently managed through lead PCT commissioning arrangements •Benchmark screening and immunisation provision across Nottingham and Derbyshire to achieve uniform high level of service provision across LAT •Maintain appropriate commitment to LAT contribution to increased health Visitor numbers and FNP places •Implementation of Section 7 Agreement	*•Establish current baseline of spend across all screening and immunisation programmes •Increase quality & efficiency of programmes •Scope opportunity for QIPP to be introduced into some contracts e.g. HPV service contracts with primary and community care providers or DES . •Establish current baseline of spend across 0-5 HCP •Align current models of delivery of Health Visitors and Family Nurse Practitioners to better meet increased numbers and places I •Identification of any national QIPP schemes for implementation*	*•Screening, immunisation and other PH Commissioning teams that will support PH commissioning will need to be integrated into the Area team organisational culture and cross directorate decision making groups •Establish/maintain collaborative networks across the all commissioners and the full pathway of Healthy Child Programme 0-19 years, to ensure robust local working arrangements that avoid fragmentation or duplication of services •Capacity and capability to deliver in a changing NHS landscape*

	National Priorities 2013-15	Transformational Change locally 2013-15	End State Ambition 2015-16
Immunisation	• Ensure the continuity of commissioning and provision of all immunisation programmes as set out in Section 7a agreement •Reduce variation in provider performance and uptake to improve health inequalities •Commission and coordinate any new immunisation programmes as directed by DH (likely to include seasonal flu and Rotavirus for children)	• Scope current service commissioning models and performance • Review arrangements for engaging hard to reach communities across are team geography •Review arrangements within area team and with service providers for managing and responding to vaccine preventable outbreaks •Establish new working relationships with primary care commissioners and CCGs to drive up service delivery performance .	• herd immunity levels achieved across all immunisation programmes (i.e. 95%) • Where herd immunity not appropriate or possible within one year evidence of increase of uptake (i.e. re HPV and MMR at 5 years) • geographical/ population variations in uptake reduced across Area Team • All DH mandated programmes successfully commissioned •Systems in place for managing and responding to SI s and infectious disease outbreaks
Screening Programmes (Cancer)	• maintain screening programme performance and standards • benchmark current service specifications against NHSCB services specifications to ensure concordance and standardisation of deliverables • continue plans to implement/ roll out new screening programme developments e.g. age extension •engage with the national cancer screening programmes for extension bowel, breast screening and HPV triage	• Support the introduction of screening programme developments e.g. age extension for breast and bowel programmes and Flexi Sig Pilot in Bowel Screening •Establish and or strengthen screening Programme Boards to engage all service providers in including all acute Trust providers across the area team •Improve screening programme uptake / coverage and reduce inequalities of access in vulnerable groups including offenders and armed forces groups •Ensure safe contract transition of all elements of screening programme pathways (including sample taker register, bowel screening hub)	• All screening programmes commissioned as per Section 7a agreement •All new service developments implemented • Programme delivered and managed to a high level • Serious incidents reporting systems well established • programme uptake and coverage improved •Evidence of reduced inequalities of access in defined vulnerable groups
Screening Programmes (Non-Cancer)	• maintain cross programme performance and standards • introduce Common Pathway for Diabetic Eye Screening • Continue roll out of AAA Screening • Benchmark current service specifications against NHSCB specifications to ensure concordance, with particular focus on	• Establish and or strengthen screening Programme Boards to engage all service providers in including all acute Trust providers across the area team •Improve screening programme uptake / coverage and reduce inequalities of access in vulnerable groups including offenders and	• All screening programmes commissioned as per Section 7a agreement •All new service developments implemented • Programme delivered and managed to a high level • Serious incidents reporting systems well established

Area Team Leicestershire and Lincolnshire

Specialised Services Programme

Values and Principles	Services are patient centred and outcome based	Improved outcomes are delivered across each of the domains	Fairness and Consistency – patients have access to services regardless of location	Productivity and efficiency improves	
Domains	Prevent premature death	Quality of life for patients with LTCs	Help recover from ill health/injury	Ensure positive experience of care	Care delivered in a safe environment

Pre-existing Priorities 12/13

- *Major Trauma Reconfiguration*
- *Safe and Sustainable Children's Cardiac*
- *Safe and Sustainable Children's Neurosurgery*
- *Implementation of 24/7 PPCI*
- *Reconfiguration of vascular surgery*
- *Increase access to Intensity modulating /guiding radiotherapy.*
- *Planning of Radiotherapy capacity*
- *South East Midlands Acute Service Review*
- *Review of neonatal services.*
- *Providing full support to our trusts to implement the findings of the Francis review .*
- *Implement action plans identified for +26 week waits (in particular spinal at NUH).*
- *Build approach to Compassion in Practice working with Nursing Directorate.*

Strategic Context and Challenges

- *Single operating model for the commissioning of specialised services with one national budget.*
- *New approach to contracting - set nationally & shaped by area and regional teams.*
- *Program for identifying relative outcomes – including analysing weekend and weekday performance.*
- *Development of engagement strategies with area teams including the "friends & family "test.*
- *All specialised activity is defined captured in contracts with providers.*
- *Core specifications in place for all services or derogations applied for.*
- *Clinical access policies in place and applied across all providers.*
- *Creation of Strategic Clinical and Operational Delivery Networks*

QIPP Improvements

- *Review the use of Tele health across the East Midlands for specialised providers.*
- *Review case mix comparison data set for consultants with Medical Director and program of care leads.*
- *Implement appropriate National QIPP Schemes schemes and local schemes including the management of readmissions and MRET to focus funds on improving outcomes..*
- *Implementation of Service Specifications and service policies*
- *Continued support of local clinical networks: haemophilia, haemoglobinopathy, learning disability and neuromuscular.*
- *Support formation of specialist spinal network.*
- *Improve 24/7 access to paediatric radiology.*
- *Secure MH and CAMHS T 4 case management.*

Organisational Development

- *Set up shared service for CDF and IFR across the Midlands and East area.*
- *Continue to develop local team having moved 20% of current team to national/regional roles.*
- *Implement systems and processes for safety thermometer for specialised services.*
- *Implement revised process within teams for managing cancelled operations and quality KPI's.*
- *Embed new culture in team. & support staff through change*
- *Implement comply or explain regime across new supplier management team..*
- *Deliver area, regional & national Integration of team to include matrix working.*
- *Support Clinical Reference Groups and Programmes of Care.*
- *Improve patient and public engagement.*

	National Priorities 2013-14	Expected Outcomes of Implementing National Guidance Locally in 2013-2014	End State Ambition 2015-16
Internal Medicine	• Implementation of Service Specifications • Access to 24/7 PPCI. • Completion of vascular surgery reconfiguration. • Capacity to deliver bariatric surgery	• Improved quality of services and achievement of core clinical requirements. •Identification of development needs or reconfiguration of services. • Improved mortality and consistent access	•Adherence to the 5 Offers in Everyone Counts (7 days/week/transparency and choice/Listening to patients/more informed decision making/safer care) •100% specification compliant services.
Cancer and Blood	•I increase access to intensity modulating radiotherapy. • Develop radiotherapy services including use of new currencies • Build single process, policies and list for the cancer drug fund. • Compliance with national cancer register & data sets .	• Reduced morbidity and consistent access for patients. • Regional plan for location and number of Linear accelerators • 4 lead areas for administering CDF, within single operating model •Development of adult & children's cancer services in line with IOGs	• IMRT/IGRT embedded in normal practise. • Capacity matches demand and anticipated growth – cancer waiting targets met. •100% specification compliant services •Adherence to the 5 offers in Everyone Counts
Trauma	• Fully implement major trauma reconfiguration • Integrate neuromuscular care advisor posts within provider network arrangements	• Improved outcomes for patients with a major trauma •Establishment of EM Spinal Network. Impact on other services fully mapped &f Further development of neuromuscular network	Full implementation of major trauma plan & 24/7 access to specialist spinal services and delivery of waiting times. •Adherence to the 5 offers in Everyone Counts •100% specification compliant services
Women and Children	• Children's Safe and Sustainable Review (Cardiac and Neurosurgery) • Demand and capacity review of PIC /PHDU and retrieval services • Paediatric radiology • Review of neonatal services against BAPM/Specification (legacy	• Implementation plan in place and networks established. • PIC/PHDU capacity in right place responsive to the needs of patients throughout the year including winter pressures •24/7 timely access to paediatric radiology	• Services reconfigured. • Robust reactive services in place. • Adherence to the 5 offers in Everyone Counts •100% specification compliant services
Mental Health	•New system for Secure Service Case Management & Gate keeping •Ensure compliance with Winterbourne report . • Develop and improve CAMHS Case management •Roll out of " My Shared Pathway" and Patient Involvement • Implement Offender PD Project d with National Offender team. •Review of Eating Disorder Services	• Reduce admissions, length of stay and associated costs. Improved pathway management for patients, delivered in appropriate level of security (secure services) • Improve quality of services and threshold management. • Roll out of national Offender PD work programme . •Updated manual of prescribed services	• Case management embedded into practise. • Adherence to the 5 offers in Everyone Counts •100% specification compliant services

Appendix G – Direct Commissioning Outcome Measures

NHS Outcomes Framework measures which the NHS Commissioning Board will use to track Progress. These outcomes apply to the directly commissioned programmes, and for some programmes will be supplemented by further indicators. Further work is required to ensure that the data can be gathered to form a baseline, and for some programmes implementation of IT systems is required to support this.				
Domain	**Measures that are suitable for both in year and annual assessment**	**Measures that are suitable for annual assessment only**	**In Quality Premium**	**Alignment with Directly Commissioned Programmes**
Preventing people from dying prematurely	None	Potential years of life lost (PYLL) causes considered amenable to healthcare Under 75 mortality rate from cardiovascular disease Under 75 mortality rate from respiratory disease Under 75 mortality rate from liver disease Under 75 mortality rate from cancer	Potential years of life lost (PYLL) from causes considered amenable to healthcare	Aligns with all programmes
Enhancing quality of life for people with long term conditions	Combined measure of unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Unplanned hospitalisation for	Proportion of people feeling supported to manage their condition Health related quality of life for people with long-term conditions Dementia Diagnosis Rates	Combined measure of unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s Emergency admissions for acute	Aligns with all programmes

	asthma, diabetes and epilepsy in under 19s and 2 measures from domain 3		conditions that should not usually require hospital admission Emergency admissions for children with lower respiratory tract infections (LRTI)	
Helping people to recover from episodes of ill health or following injury	Combined measure as above with – Emergency admissions for acute conditions that should not usually require hospital admission Emergency admissions for children with LRTI Emergency readmissions within 30 days of discharge from hospital	Patient Reported Outcomes Measure (PROMs) for elective procedures a)hip replacement, b) knee replacement c) Groin hernia d) Varicose Veins	Combined with above	Applies to military, specialised services Further development of IT and data management systems may be required to support measurement
Ensuring that people have a positive experience of care	Patient experience of a) GP services b) out of hours services	Patient Experience of hospital care (needs attribution to CCG)	Patient Experience Measure	Applies to primary care, specialised services and military –for dependents

	Family and Friends Test			
Treating and Caring for People in a safe environment and protecting them from avoidable harm	Incidence of healthcare associated infection: MRSA Incidence of healthcare associated infection: Clostridium difficile	None	Incidence of healthcare associated infection: MRSA Incidence of healthcare associated infection: Clostridium difficile	Applies to primary care, offender health and specialised commissioning

NHS Commissioning Board

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25th January 2013

Ref: VT/LF/LTR.011

FAO Cllr Martin Suthers
Nottingham County Council

Dear Chair,

Further to today's submission by the Derbyshire and Nottinghamshire Area team to the National Commissioning Board, of the draft directly commissioned 'Plans on a Page' there is now an opportunity to seek wider partner views prior to final submission and subsequent publication on 5 April 2013.

I am therefore writing to seek your feedback in advance of final submission, and have attached a paper outlining the context and plans for each of the Area Team directly commissioned services.

The plans build on planning intentions developed both nationally and locally in previous years, and reflect both local Health and Wellbeing Strategies and Clinical Commissioning Group plans. Both the Military Health and Offender Health plans have been collectively developed with the national leads in these areas.

I would be grateful if you would consider the attached draft plans at your next Health and Wellbeing Board, I have asked Helen Pledger, to present the paper on my behalf however I would be happy to meet with you directly if helpful.

I look forward to hearing from you.

Yours sincerely,

Vikki Taylor
Director of Commissioning
NHS National Commissioning Board (Derbyshire & Nottinghamshire) Area Team

c Helen Pledger

Nottinghamshire County Council

Report to Health and Wellbeing Board

6 March 2013

Agenda Item: 9

REPORT OF THE CHIEF CLINICAL OFFICER FOR NHS NOTTINGHAM WEST CLINICAL COMMISSIONING GROUP

DEVELOPMENT OF CLINICAL COMMISSIONING GROUP COMMISSIOING PLANS FOR 2013-14

Purpose of the Report

1. This report provides information on the development of the CCG commissioning plans for 2013-14. It presents the six individual summary plans for information, which have recently been submitted to the NHS Commissioning Board.

Information and Advice

2. Each Clinical Commissioning Group undertakes an annual planning cycle and produces an agreed commissioning plan following proper communication and engagement process. As part of this process, the NHS Commissioning Board has requested a “plan on a page” from each CCG. In addition, each CCG has been asked to highlight three priorities from a defined list of indicators for monitoring purposes.

3. It is important that the Health & Wellbeing Board is made aware of these priorities, however this information alone does not give an accurate picture of CCG priorities. It also only reflects a moment in time, and the ongoing complex contract negotiation and QIPP planning still needs to be completed before the plans for 13/14 are approved.

4. Given that each of the CCGs is in the middle of the planning cycle, this paper provides the opportunity for each CCG to present their “plan on a page.” This document provides a good indicator of the local commissioning intent for each organisation at this point in the process. As part of the planning guidance, each CCG have submitted their plan to the NHS Commissioning Board in early February 2013.

5. The submission of these summary plans to the Health & Wellbeing Board forms part of the engagement process being undertaken by the organisations, and is an important step in the development of the final CCG plans

6. The Health & Wellbeing Board is asked to consider the information and raise questions about the individual plans or general process being followed.

7. Following consultation, feedback from the Commissioning Board and other stakeholders will be used to review the plans. Once completed, it is proposed that final CCG plans are presented to the Health & Wellbeing Board for information at the June meeting.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) The Health & Wellbeing Board is asked to consider and comment on the content of the attached CCG plans on a page.

Dr Guy Mansford
Chief Clinical Officer and Accountable Officer for NHS Nottingham West Clinical Commissioning Group (on behalf of the six CCGs within Nottinghamshire.)

For any enquiries about this report please contact: Dr Guy Mansford, Clinical Lead for Nottingham West Clinical Commissioning Group (CCG).

Constitutional Comments (SG 15/02/2013)

9. The shadow Board is the appropriate body to consider the matters referred to in this Report.

Financial Comments (NDR 19/02/13)

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

Background Papers

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

Electoral Division(s) and Member(s) Affected

All

Our Mission
To ensure that the people of Bassetlaw have equitable access to local, best possible quality and cost-effective health care and well-being services which meet their assessed health needs.

Our Vision
A clinically led commissioning organisation, enabled and empowered by a supportive management team, which puts the needs of patients, carers and service users at the core of its business. The organisation will be lean, efficient, responsive and free from unnecessary bureaucracy and will be accountable and answerable to the community it serves

Our Values
We will: • Collaborate and develop productive relationships. • Focus on patients • Treat each other with dignity and respect • Listen to others, share information, be transparent • Trust each other and our partners • Embrace innovation

Focus on Quality	Delivered through	Will Lead to
Deliver the NHS Constitutional Rights and Pledges	• Access to health services • Quality of care and environment. • Respect, consent and confidentiality • Informed choice • Involvement in your healthcare and in the NHS • Complaints and redress	High quality services Increasing patient involvement and responsibility for and in their care Learns lessons when things go wrong
Adopt and spread the 6 C's	Creating a clear focus on: • The National Compassion in practice action plan. • Adopting whole health community approaches to reducing harms and healthcare acquired infection. • Increasing and monitoring the level of information commissioners receive around patient experiences. • Leading by example and • Reinforcing the values within Compassion in Practice through contracts, training and in all of our partnership forums.	Helping people to stay independent, maximising well being and improving health outcomes. People being provided with a positive experience of care. The building and strengthening of leadership Ensuring we have the right staff, right skills in the right place. Supports a positive staff experience.
Francis Report: local learning and action.	• A local response to national report • Capturing enhanced patient experience data. • Development of early warning monitoring systems. • Reinforcing and monitoring safeguarding systems for those at risk. • Quality surveillance development	Safer care and more transparency between providers, commissioners and patients across health systems
Winterbourne Report: local learning and action	• A local action plan. • Enhanced levels of patient experience captured for individuals with Learning Difficulties. • Commissioning development for alternative models of care.	Safe and improved care options for individuals with Learning Difficulties and carers who support them
Action on Member feedback to improve local care experience	• Working with practices to enhance systems which capture poor clinical outcomes in our commissioned services. • Supplement current safeguarding awareness and engagement. • Support a South Yorkshire Practice Nurse Development Forum. • Support local practice education through BEST events. • Support the development of a forum for lead nurses of care homes. •	Improved engagement, responsiveness and Quality of Care.

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- Listen to others, share information, be transparent
- Trust each other and our partners
- Embrace innovation

Outcomes		Delivered through		Will Lead to
Preventing People from dying prematurely	Potential years of life lost (PYLL) from causes considered amenable to healthcare Under 75 mortality rate from Cardiovascular disease Under 75 mortality rate from respiratory disease Under 75 mortality rate from liver disease Under 75 mortality rate from cancer	Promoting Better Health	Smoking Obesity Alcohol Cancer CVD	Fewer deaths in the years that follow. Improved local services in 2013/14
Enhancing quality of life for people with long term conditions	Health related quality of life for people with long term conditions. Proportion of people feeling supported to manage their conditions Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adult) Unplanned hospitalisation for asthmas, diabetes and epilepsy in under 19's. Estimated diagnosis rate for people with dementia	Long Term Conditions	Telehealth CHC/PHB Carers Care of the Elderly	More patients with LTC managing their own conditions, with more support for carers. A new care pathway for care of the elderly.
Helping people to recover from episodes of ill health or following injury	Emergency admissions for acute conditions that should not usually require hospital admission. Emergency readmissions within 30 days of discharge from hospital Total health gain assessed by patients i) hip replacement, ii) Knee replacement, iii) Groin hernia, iv) varicose veins Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)	Mental Health	Dementia IAPT	Improved diagnosis and service for patients and better access for all patients with a mental health condition
Ensuring that people have a positive experience of care	Patient experience of primary care i) GP Out of Hours services. Patient experience of hospital care Friends and Family Test	Integrated Care	Capacity and re-ablement review Urgent Care • 111 • Primary Care Quality • A&E	Providers delivering seamless care for patients by taking integrated responsibility for care.
Treating and caring for people in a safe environment and protecting them from avoidable harm	Incidence of healthcare associated infection (HCAI) i) MRSA, ii) C. Difficile	Children	Community Paediatrics	New community based service delivered by DBHFT

VALUES:	**P**atient focused **A**ccountable **R**esponsive **T**rue partners **N**ear to home **E**quitable **R**espectful **S**eamless NHS Mansfield and Ashfield Clinical Commissioning Group
STRATEGIC AIMS: Prevent unnecessary hospital admissions and / or visits Tackle preventable ill health and disability and help people to live independently Promote better health through addressing key areas of health need STRATEGIC RISKS: Rising demand for healthcare, causing pressures on non-elective care system (LxI: 4x4 = 16) Financial sustainability of local acute provider (LxI: 5x5 = 25) Non-delivery of QIPP / financial balance (LxI: 3x4 = 12) Quality failure as a result of poor monitoring or financial challenge (LxI: 3x5 = 15) **FINANCIAL PLAN:** Healthcare - £226,289,000 Running Costs - £4,540,000 QIPP requirement: £6,563,000 (2.9%)	**TRANSFORMATIONAL CHANGE:** **National planning requirements will be met. Additional local ambitions are:** **BUILDING SYSTEM CAPACITY TO MANAGE THE RISING DEMAND FOR HEALTHCARE** • Develop and implement integrated long-term conditions care in the community • Develop the workforce for new integrated ways of working across organisational boundaries and care settings • Develop data sharing processes and mechanisms to improve care • Develop care pathways for patients with co-morbidities • Review intermediate care / sub-acute care capacity and ensure this is adequate to prevent unnecessary acute hospital admissions **LOCAL PRIORITY OUTCOMES FOR QUALITY PREMIUM:** • 10% reduction in non-elective admissions for COPD, heart failure and diabetes • Increase primary care capability to prevent ill health and manage demand – 75% of practice achieve care bundles for CHD and diabetes in Q4 • Increased deaths in place of choice – 10% increase in deaths at home **JOINING UP SERVICES TO IMPROVE CARE** • Increase community / sub-acute capacity and capability to increase deaths in place of choice • Develop clinical navigator services to ensure that patients are signposted appropriately. This service should be accessible to GPs, ambulance crews, community and hospital staff to ensure patients are treated in the most appropriate location first time • Expand consultant-led community-based services • Review and refine referral triage, diagnostic pathways and community pathway provision to maximise care closer to home **TACKLING THE MAJOR CAUSES OF ILL HEALTH AND DISEASE** • Roll out COPD pathway and ensure the pathway is comprehensive across primary and community care settings (10% reduction in admissions) • Care of the elderly –Roll out ANP care homes scheme for universal coverage, implement one stop shop with comprehensive geriatric assessment at AHV • Diabetes – 10% reduction in non-elective admissions • Mental illness – 10.4% coverage target for IAPT, 50% recovery rates • Dementia – Increased memory clinics and intermediate care provision • Early years – 1% reduction in smoking in pregnancy rates • Cancer – 16% reduction in deaths <75 years • CHD – 10% reduction in admissions for heart failure **PROMOTING WELLBEING, IN LINE WITH THE HEALTH AND WELLBEING STRATEGY** • Work with local authorities to reduce smoking, obesity and alcohol misuse • Joint commissioning for learning disability services to meet Winterbourne View SCR recommendations
ENABLERS: Clinical work streams for disease priority areas Asset utilisation – Ashfield Health Village being developed as a hub for care of the elderly, long-term conditions and early years Transformation Partnership Board and strategic review of services across Mid-Nottinghamshire Robust contracting and quality monitoring across services Organisational Development Plan Procurement Strategy – to be developed in 2013/14 Communications and Engagement Plan	

VISION:	Residents are PROUD of their NHS: Personalised care Robust safety Ownership and control for patients and citizens Unified, joined up services Dignity at all times NHS Newark and Sherwood Clinical Commissioning Group

STRATEGIC AIMS:	**TRANSFORMATIONAL CHANGE:** **National planning requirements will be met. Additional local ambitions are:**
Best quality within available resources (incorporating safety, effectiveness and patient experience Best service design Partnership working to achieve the safest and most effective services within overall available resources	**BUILDING SYSTEM CAPACITY TO MANAGE THE RISING DEMAND FOR HEALTHCARE** • Embed PRISM (integrated care programme), with focus on risk stratification, systematic self-management, assistive technology • Develop the workforce for new integrated ways of working across organisational boundaries and care settings • Develop data sharing processes and mechanisms to improve care • Develop care pathways for patients with co-morbidities within PRISM • Review intermediate care / sub-acute care capacity and ensure this is adequate to prevent unnecessary acute hospital admissions – retain additional capacity procured for winter pressures **LOCAL PRIORITY OUTCOMES FOR QUALITY PREMIUM:** • 10% reduction in non-elective admissions for COPD, heart failure and diabetes, 12.5% reduction in length of stay • 10% reduction in mental health admissions, 5% reduction in length of stay • 10% reduction in children's admissions with LRTI, 80% CYP (<16 years) with asthma have review and care plan
STRATEGIC RISKS: Rising demand for healthcare, causing pressures on non-elective care system (LxI: 4x4 = 16) Financial sustainability of local acute provider (LxI: 5x5 = 25) Non-delivery of QIPP / financial balance (LxI: 3x4 = 12) Quality failure as a result of poor monitoring or financial challenge (LxI: 3x5 = 15)	**JOINING UP SERVICES TO IMPROVE CARE** • Develop clinical navigator services to ensure that patients are signposted appropriately. This service should be accessible to GPs, ambulance crews, community and hospital staff to ensure patients are treated in the most appropriate location first time • Expand consultant-led community-based services • Increase community cardiac rehabilitation • Review diagnostic pathways and implement direct access where appropriate
FINANCIAL PLAN: Recurrent allocation: Healthcare - £144,993,000 Running Costs - £3,150,000 QIPP requirement: £4,525,000 (3.1%)	**TACKLING THE MAJOR CAUSES OF ILL HEALTH AND DISEASE** • Embed PANNASH care pathway for respiratory disease. Maintain 20% reduction in non-elective admissions • Cardiovascular disease – 10% reduction in non-elective admissions • Diabetes – 10% reduction in non-elective admissions • Mental illness – Improve diagnosis rates to national average • Dementia – 10% reduction in non-elective admissions • End of life – 85% deaths in chosen place • Early years – 1% reduction in smoking rates in pregnancy
	PROMOTING WELLBEING, IN LINE WITH THE HEALTH AND WELLBEING STRATEGY • Ensure appropriate health checks (12,500 by April 2015) to reduce cardiovascular morbidity • Ensure appropriate IAPT coverage for the population (12.5% target coverage) • Work with local authorities to reduce smoking • Joint commissioning for learning disability services to meet Winterbourne View SCR recommendations

ENABLERS:
Clinical work streams for disease priority areas
Asset utilisation – Newark Hospital provides scope for development as a healthcare hub in Newark
Transformation Partnership Board and strategic review of services across Mid-Nottinghamshire
Robust contracting and quality monitoring across services
Organisational Development Plan
Procurement Strategy – to be developed in 2013/14
Communications and Engagement Plan

Nottingham North and East CCG Plan on a Page

Vision

"Putting good health *into practice*"

Strategic Aims

Delivery supported by CCG overarching values, principles, & priorities:

- Strong PPI & stake-holder engagement
- Interests of patients & the community at the heart of decision-making
- Increased patient satisfaction
- Strong clinical/member practice engagement & leadership
- Collaborative commissioning & partnership working
- Safe & high-quality services to ensure the best outcomes for patients within available resources
- Effective & robust performance management
- Effective governance
- Robust financial planning
- On-going clinical & non-clinical education & professional development

Strategic Context

- Diverse health needs & significant variations in level of deprivation across the CCG
- Increasing demand for healthcare services
- Rates of planned & unplanned care above national average
- Above average over 65 population
- Interdependency between Nottinghamshire CCGs
- CCG population distributed across five local authority areas
- Challenging financial position

NHS
Nottingham North and East
Clinical Commissioning Group

Transformational Change

Underpinned by implementation of the Right Care programme to ensure continuous improvement and effective change management

Planned Care

- Reduce the number of new OP & follow-up appointments in secondary care
- Increase & improve planned care activity in the community through pathway redesign
- Transfer patient care from secondary to primary care where appropriate

Primary Care

Improve quality, efficiency & capacity in primary care by:

- Developing innovative ways of working & sharing good practice
- Reducing unwarranted clinical variation between GP practices
- Implementing a Right Care shared decision-making approach
- Implementing the Productive General Practice programme
- Increasing the use of tools such as eHealthScope, Balanced Scorecard & accreditation tools
- Implementing a GP practice seven days a week service pilot
- Reviewing existing LES & developing new ones where appropriate, e.g. Carers' Health Checks & Medicines Related Harm

People with Long-Term Conditions

- Increase the number of patients cared for in the community through pathway redesign & the development of community-based services
- Support patients to manage their conditions at home through increased use of telehealth technologies
- Increase the number of patients who die in their preferred place

Health & Wellbeing

- Continue to develop a strong relationship with the Health & Wellbeing Board to deliver the HWB strategy
- Develop shared commissioning priorities to address issues that impact on health & wellbeing (smoking, diet, exercise, support for carers, loneliness) through NNE CCG's District & Borough Councils Partnership Group

People with Mental Health issues & Learning Disabilities

- Increase dementia diagnosis rates & improve services
- Reduce admissions of patients with advanced dementia
- Provide additional support for carers
- Reduce the rate of hospital admissions for people with learning disabilities
- Improve the quality of community care for younger people with mental health issues

Older People

- Increase capacity to support demand management through the development of an integrated adult community nursing & therapy scheme
- Avoid admissions through the implementation of a crisis response service to support the care of patients at home
- Improve the case management of older people through increased use of the Community Geriatrician service, including assessment

Children & Young People

- Work collaboratively with partner organisations to maximise the range, integration & quality of services for children
- Develop a joint CCG/NCC Children's Commissioning Team to support integration of services
- Improve pregnancy outcomes, & child health & development, through implementation of the Family Nurse Partnership programme
- Improve breastfeeding rates at 6-8 weeks
- Reduce the rate of emergency admissions

Unplanned Care

- Reduce the number of 0-4 year olds attending A&E out of hours
- Reduce the rate of emergency admissions & length of stay of patients with long-term conditions such as COPD, heart failure & diabetes
- Reduce the overall number of patients attending A&E
- Identify & target patients at high risk of emergency admission
- Support patients to make appropriate emergency care choices

NHS Nottingham West Clinical Commissioning Group

Our Values

- Clinical leadership at the heart of the organization
- Constantly innovate to improve quality and experience for patients
- Work closely with local providers and partners for the benefit of the whole of our population
- Apply the best evidence available to improve local services and reduce health inequalities
- By good governance, openness and sensible use of resources, produce the maximum health outcomes for the whole of our population

Our Strategic objectives

- Reduce health inequalities in the local population by targeting the health and wellbeing of people with the greatest health needs
- Improve the quality of our local health services, particularly around health outcomes, patient safety, access and patient satisfaction
- Organise services around the needs of local service users wherever possible
- Maintain and optimise the health of people with long term or chronic illness living in our community
- Focus our available resources where they will deliver the greatest benefit to our population

For 2013/14 we are grouping our priorities around the needs of cohorts of local people

These link to the NHS Outcomes Framework domains and reflect our published strategic intentions

http://www.nottinghamwestccg.nhs.uk/index.php/publications/authorisation-documents

CARERS AND FAMILY SUPPORT

Why? **Breakdown in support is a major factor in health crises**

Focus on:
- *Identifying carers*
- *Supporting young carers*
- *Ongoing support and information*

Proposed targets:
- Increase numbers of local people registered as carers
- Increase range of services supporting carers
- Hold an annual roadshow event for carers

PEOPLE WITH MENTAL HEALTH ISSUES, LEARNING DISABILITIES AND DEMENTIA

Why? **To end poorer outcomes and access**

Focus on:
- *Early intervention*
- *Reducing the perceived stigma of mental health problems*
- *Thresholds and access*

Proposed targets:
- Deliver actions in the mental health strategy and Learning Disabilities action plan
- Increase the diagnosis and treatment rates for dementia

CHILDREN AND YOUNG PEOPLE

Why? **To make healthy living a way of life**

Focus on:
- *Prevention & Lifestyle*
- *Information and education*
- *Links to schools*

Proposed targets:
- Increase early intervention services targeted at young people
- Deliver increased range of services linked to schools and other education establishments
- Support delivery of the Broxtowe Partnership Children &Young People's Task Group

OLDER PEOPLE

Why? **To enable people to live as independently as possible for as long as possible**

Focus on:
- *Local services*
- *Care Homes*
- *Information and getting positive messages out*
- *Holistic approach*
- *Integration of health and social care*

Proposed targets:
- Expand range of community services
- Expand proactive care and education models for care homes
- Reduce emergency re-admissions
- Reduce the number of over 65s admitted with fracture neck of femur as a result of falls in nursing and residential homes
- Improve PROMs for hip replacement

PEOPLE WITH LONG TERM CONDITIONS AND THOSE APPROACHING THE END OF THEIR LIFE

Why? **To empower people to manage their condition and support their choices**

Focus on:
- *Early diagnosis and continual intervention*
- *Ongoing support needed for the family and/or carers not just the patient*
- *Support at home and integration of services*

Proposed targets:
- Spread and sustain proactive case management of LTC
- Increase EOL registers for non-cancer conditions
- All practices to use the end of life log on eHealthscope
- Increase the number and percentage of people supported to die in the place of their choice
- Reduce admissions in the last 12 months of life of patients on end of life registers

SUPPORTING PEOPLE ACROSS THE LOCAL POPULATION

Why? **To maximise health benefits and improvement for all**

Focus on:
- *Living healthily, primary and secondary prevention*
- *Managing medication*
- *Improving services in primary care and across the community*
- *Reducing the need to go to hospital*

Proposed targets:
- Deliver targets in prescribing plan for 2013/14
- In line with ECIST recommendations re-audit urgent access in primary care and reduce variation/improve good practice
- Reduce elective admissions
- Reduce follow-ups
- Improve patient experience of out of hours services

NHS Rushcliffe CCG 'Plan on a Page'

Rushcliffe Clinical Commissioning Group

Mission Statement

Our mission is to improve the health outcomes of people registered with a practice in NHS Rushcliffe CCG, and other patients who live in the locality, by commissioning high quality and affordable health care services.

Partnership Working

- We will promote health and wellbeing for our local population, working with the Health and Wellbeing Board, Local Authorities, patient groups, charitable organisations, other NHS organisations and community groups.
- We will develop our staff to improve patient care and the health and wellbeing of the people in Rushcliffe.

Commissioning Work-streams

Elective Care: We will reduce the variation between GP practices in referrals to first outpatient appointments by maximising clinical leadership, using GP leads for 15 specialties and utilising clinical education sessions. We will localise services to improve patient experience and streamline pathways for patients by using referral protocols and self-management.

Non-Elective Care (including re-admissions): Unnecessary emergency admissions to hospital will be reduced by involving patients in their own care, ensuring timely access to primary care services and developing and implementing a primary care and community system for unplanned care.

Community Services: Integrated teams will be developed further in order to support primary and acute services in managing patients. A single point of access will be developed in adult services and the interface between mental health services and physical health services will be strengthened. Children and Young Person's services will be reviewed.

Long Term Conditions: We will implement tele-care and tele-health schemes to support people to manage their long-term conditions, working with end-of-life care teams to support more people to die at home, utilising specialist support and encouraging self-care to help patients manage their long-term conditions and improve their quality of life.

Prescribing: A prescribing plan will be developed to target specific areas of prescribing and will focus on a range of areas to ensure cost effective prescribing in line with national and local best practice.

Mental Health and Emotional Wellbeing: Earlier intervention and support for people with mental health conditions within primary care, including support for patients to self-manage their symptoms. GP practice packs will be developed to show mental health service activity at practice levels and identify trends and areas for improvement.

Primary Care: GP practice data will be studied to highlight the pattern of access to primary care and increased avoidable activity in non-elective secondary care services. Actions will be taken to address this if correlation is demonstrated.

NHS Outcomes Framework

Domain 1: Preventing people from dying prematurely
Domain 2: Enhancing quality of life for people with Long Term Conditions
Domain 3: Helping people to recover from episodes of ill health or following injury
Domain 4: Ensuring that people have a positive experience of care
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Nottinghamshire County Council

Report to the Health & Wellbeing Board

6 March 2013

Agenda Item: 10

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH GRANT AND BUDGET PLANNING REPORT

Purpose of the Report

1. To update the Health & Wellbeing Board on the Public Health Grant and associated arrangements announced in January and to provide an outline Financial Plan for 2013/14 for consideration.

Information and Advice

Public Health Grant & Reporting Arrangements

2. As from April 2013, Public Health functions will be funded through three principal routes:
   - Ring-fenced grants to upper tier and unitary local authorities
   - Through the NHS Commissioning Board
   - Public Health England commissioning or providing services itself

3. The ring fenced Public Health Grant for 2013/14 and 2014/15 was announced on the 10th January 2013, along with supporting guidance detailing the determinants, conditions and administering arrangements.

4. The allocations for Nottinghamshire (including Bassetlaw) are as follows (NB: This includes 2.8% growth and additional elements that were previously excluded from calculations):
   - 2013/14 £35.1m
   - 2014/15 £36.1m

   (Average growth is 5.5% in 2013/14 – the minimum growth is 2.8%)

5. The Joint Strategic Needs Assessment and Health & Wellbeing Strategy will drive commissioning plans and hence public health expenditure. The Public Health Outcomes Framework should also be regarded when setting budgets.

6. It is important that the Public Health Grant is only spent on activities whose main or primary purpose is to improve the health and wellbeing of local populations (including restoring or protecting their health where appropriate) and reducing health inequalities.

7. Nottinghamshire County Council will report financial plans and actual spend against the grant through existing quarterly revenue outturn (RO) returns. Annex 1 lists the Public Health sub categories, which will need to be reported against.

8. Nottinghamshire County Council will need to ensure that the finances reported are verified and in line with the purpose set out in the grant conditions and the Chief Executive will need to return a statement confirming that the grant has been used in line with these conditions.

9. The use of the grant will be subject to existing local authority financial management requirements and the Department of Health will expect the External Auditor to highlight any issues of concern in the account of the grant spend.

10. Public Health England will review plans and returns relating to the Public Health Grant on behalf of the Department of Health.

Outline Financial Plan 2013/14

11. A draft financial plan was produced in October 2012, following the Public Health Confirm and Challenge session and a financial options paper was presented to the Corporate Leadership Team and Health & Wellbeing Board. The options paper was based on receiving a PH Grant of £29.9m in 2013/14 with contractual pre-commitments (including staffing and directorate non pay) estimating the same.

12. The paper also highlighted that expenditure proposals put forward by the PH Directorate at the Confirm & Challenge session (including pre-commitments) totalled £32.8m. Annex 2 is based on the information previously collated, which is now amended to include elements that now fall within the grant allocation. It analyses the total value at Public Health policy area level.

13. Further validation work has now taken place between Local Authority Procurement, Finance and NHS Contracting Teams and table 1 below summarises the outline financial plan for consideration. This formed a report to the Public Health Subcommittee on 11 February 2013.

Table 1

	£
Pre-commitments (inc Staff costs and Directorate expenses)	29.9
Estimated Local Authority Overheads	0.4
Income from Police and Crime Commissioner	(0.6)
Estimated Prescribing Costs relating to Primary Care Services (Sexual Health & Tobacco Control)	0.9
PH Directorate proposals (Annex 2 – column 3)	2.8
Innovation/Development fund	1.2
Earmarked Reserves for recurrent items (premises, service growth)	0.5
Total £	**35.1**

14. The Public Health Subcommittee approved the outline plan and supported the need to consider the PH Department proposals of £2.8M further as part of a separate report.

15. The Subcommittee also approved the creation of a Public Health Innovation/Development fund with the remaining Public Health Grant balance of £1.2m. Proposals against this fund

will be prioritised in line with the Health & Wellbeing Strategy, the Business Plan and the Public Health Outcomes Framework.

16. A supporting presentation will provide further detail on each proposal that has been identified to underpin the delivery of the Health & Wellbeing Strategy and related Public Health functions. The Health & Wellbeing Board are asked to consider this information along with the report by way of consultation.

17. A follow up report to be presented to the Public Health Subcommittee in April for approval of any proposed plans following consultation with the Health & Wellbeing Board.

Statutory and Policy Implications

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

RECOMMENDATION/S

The Health & Wellbeing Board are asked to:

1) Note the information on the Public Health Grant for Nottinghamshire, including the allocation, purpose and reporting arrangements.

2) Endorse the Outline Financial Plan, and creation of an innovation/development fund approved by the PH Subcommittee.

3) Comment on proposals for further investment outlined in the supporting presentation.

Chris Kenny
Director of Public Health

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

Constitutional Comments (SG 15/02/2013)

19. The shadow Board is the appropriate body to consider the matters referred to in this Report.

Financial Comments (NDR 19/02/13)

20. The financial implications are outlined throughout the report.

Background Papers

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

Electoral Division(s) and Member(s) Affected

All

Annex 1

Local Authority spend will need to be reported against the following categories:

Priority mandated functions:

1. Sexual Health Services – STI Testing and Treatment
2. Sexual Health Services – Contraception
3. NHS Health Check programme
4. Local Authority role in Health Protection
5. Public Health Advice
6. National Childhood Measurement Programme

(The services and steps that will be prescribed are set out in 'Public Health in Local Government – factsheets')

Other functions:

7. Sexual Health Services – Advice, prevention and promotion
8. Obesity – Adults
9. Obesity – Children
10. Physical Activity – Adults
11. Physical Activity – Children
12. Drug Misuse – Adults
13. Alcohol Misuse – Adults
14. Substance Misuse (drugs and alcohol) – youth services
15. Stop smoking services and interventions
16. Wider tobacco control
17. Children 5-19 public health programmes
18. Miscellaneous, which includes:
    - Non-mandatory elements of the NHS Health Check Programme
    - Nutrition initiatives
    - Health at work
    - Programmes to prevent accidents
    - Public mental health
    - General prevention activities

- Community safety, violence prevention and social exclusion
- Dental public health
- Fluoridation
- Local authority role in surveillance and control of infectious disease
- Information and intelligence
- Any public health spend on environmental hazards protection
- Local initiatives to reduce excess deaths from seasonal mortality
- Population level interventions to reduce and prevent birth defects (supporting role)
- Wider determinants

Annex 2

Public Health - Financial Plan 2013/14 by policy area

Programme Area	2013/14 Budgets Requested at Confirm & Challenge			
	Pre-committed £	Additional requested £	Total Recurrent £	Non Recurrent requested £
Public Health Directorate Pay	2,958,300	-	2,958,300	-
Directorate Non Pay	150,000	-	150,000	-
Mandated Functions:				
Dealing with Health protection incidents & emergencies	-	2,500	2,500	-
Comprehensive sexual health services	5,998,213	507,376	6,505,589	-
National Child Measurement Programme (inc in School Nursing Contract - Children 5-19)	-	-	-	-
NHS Health Checks (Assessment & Lifestyle interventions)	889,221	459,452	1,348,673	32,000
Non Mandated Functions:				
Obesity, Nutrition and Exercise	959,950	540,050	1,500,000	500,000
Tobacco control	1,891,236	766,834	2,658,070	-
Alcohol and Drug Misuse services (includes Police & Crime Commissioner contracts)	12,097,185	-	12,097,185	-
Local initiatives on workplace health	-	227,000	227,000	-
Dental public health & Fluoridation	235,700	-	235,700	-
Public mental health services	-	107,900	107,900	-
Public health services for children and young people aged 5-19, including healthy schools	4,173,785	-	4,173,785	-
Accidental injury prevention, including falls prevention	-	5,000	5,000	-
Population level interventions to reduce and prevent birth defects	33,000	-	33,000	-
Behavioural and lifestyle campaigns to prevent cancer and long-term conditions	258,391	15,000	273,391	-
Local initiatives to reduce excess deaths as a result of seasonal mortality	15,000	-	15,000	-
Public health aspects of promotion of community safety, violence prevention and response	103,775	152,895	256,670	
Public aspects of local initiatives to tackle social exclusion	155,396	5,000	160,396	36,000
Local initiatives to reduce public health impacts of environmental risks	-	-	-	-
Infection prevention and control services	32,012	1,000	33,012	
Totals (£)	**29,951,164**	**2,790,007**	**32,741,171**	**568,000**

Nottinghamshire County Council

Report to the Health and Wellbeing Board

6 March 2013

Agenda Item: 11

REPORT OF THE CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

HEALTH AND WELLBEING BOARD REGULATIONS

Purpose of the Report

1. To inform the Board of regulations recently issued by the Department of Health and of the steps being taken so that the Board can take on its statutory role on 1 April 2013.

Information and Advice

Regulations

2. The Health and Wellbeing Board has been meeting as a Shadow Board since May 2011 in anticipation of assuming its full statutory role from 1 April 2013.

3. The Department of Health has recently published the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Part 2 of the Regulations applies to Health and Wellbeing Boards and comes into force on 1 April 2013. Last summer, the Department of Health conducted an informal engagement exercise with stakeholders about which parts of existing legislation should be disapplied in order to allow Boards to operate effectively. The Regulations take account of responses received during that engagement exercise.

4. The effect of the Regulations is that

(a) a Board may delegate functions to a sub-committee of the Board or to an officer (reg. 3);
(b) a Board may be established as a joint committee with another local authority, and may appoint a joint sub-committee (reg. 4);
(c) a Board may appoint an advisory sub-committee (reg. 4);
(d) people who are bankrupt or who have criminal convictions may be Board members (reg. 5). This is because some authorities, when consulted, said that they did not want there to be a constraint on who might be appointed as a service user representative.
(e) employees of the local authority may be Board members (reg. 5); This enables the three chief officers to be full members of the Board.

(f) all Board members will have voting rights, unless the local authority (having consulted the Board) decides otherwise (reg. 6);
(g) membership of the Board does not have to reflect the overall political balance of the local authority (reg. 7).

5. The Regulations are silent on whether the Councillors' Code of Conduct applies to the whole membership of the Board. Guidance is awaited at the time of writing this report.

Preparations for the Board becoming statutory

6. County Council on 28 February 2013 considered a report which will enable the Health and Wellbeing Board to take on its full statutory role from 1 April. The Board's existing terms of reference, with minor changes to accord with the Health and Social Care Act, have been continued, as set out in Appendix 1.

7. This membership is in accordance with the statutory requirements and no amendments are proposed at this time other than (with the establishment of Healthwatch) the Chairman of Healthwatch replacing the LINk representative from 1 April 2013. The membership includes three County Council chief officers, and the County Councillor membership maintains political balance.

8. The Constitution has been amended to remove all references to the Shadow Board, and to make reference to the Director of Public Health where appropriate.

Other Options Considered

None.

Reason/s for Recommendation/s

To brief Board members on the recent Regulations and associated matters.

Statutory and Policy Implications

This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder and users. Where such implications are material, they have been brought out in the text of the report.

RECOMMENDATION/S

That the report be noted.

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

For any enquiries about this report please contact:
Paul Davies, Democratic Services ext 73299

Constitutional Comments

As the report is for noting only, constitutional comments are not required.

Financial Comments (NR 22/2/13)

There are no financial implications arising directly from this report.

Background Papers

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

a. Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

Electoral Division(s) and Member(s) Affected

All.

(County Council Constitution 'Part 4 – Responsibility for Functions', page 4-12)

HEALTH AND WELLBEING BOARD

TERMS OF REFERENCE

44. To prepare and publish a joint strategic needs assessment.

45. To prepare and publish a health and wellbeing strategy based on the needs identified in the
joint strategic needs assessment and to oversee the implementation of the strategy.

46. Discretion to give Nottinghamshire County Council an opinion on whether the Council is discharging its statutory duty to have due regard to the joint strategic needs assessment and the health and wellbeing strategy.

47. To promote and encourage integrated working including joint commissioning in order to deliver cost effective services and appropriate choice. This includes providing assistance and advice and other support as appropriate, and joint working with services that impact on wider health determinants.

MEMBERSHIP FROM 1 APRIL 2013

- Five County Councillor members appointed at the annual meeting of Full Council (currently Councillors Reg Adair, Mrs Kay Cutts, Stan Heptinstall MBE, Alan Rhodes and Martin Suthers OBE)
- Two representatives from District Councils (currently Councillor Jenny Hollingsworth of Gedling Borough Council and Councillor Tony Roberts of Newark and Sherwood District Council)
- Corporate Director, Adult Social Care, Health and Public Protection Services – David Pearson
- Corporate Director, Children, Families and Cultural Services – Anthony May
- Director of Public Health – Chris Kenny
- Six NHS Clinical Commissioning Groups (CCGs)
    - Dr Steve Kell - Bassetlaw CCG
    - Dr Raian Shiekh - Mansfield and Ashfield CCG
    - Dr Mark Jefford – Newark and Sherwood CCG
    - Dr Guy Mansford – Nottingham West CCG
    - Dr Tony Marsh – Nottingham North & East CCG
    - Dr Jeremy Griffiths – Rushcliffe CCG
- Chairman of the Local Healthwatch
- One representative from the NHS Commissioning Board – Helen Pledger - Director of Finance, Local Area Team.