Annex One: Public Health Service Development Proposals April 2013

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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