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Members of the Shadow Health and Wellbeing Board

Tel: 01629 538324
Ask for: Gemma Duckworth
Ref:
Date: 17 November 2011

Dear Member

Shadow Health and Wellbeing Board

Please attend the meeting of the **Shadow Health and Wellbeing Board** to be held on **Thursday 24 November 2011** commencing at **10.00am** in **Committee Room No 1, County Hall, Matlock**

The agenda is set out below.

Yours faithfully

John McElvaney
Director of Legal Services

A G E N D A

1. Introductions and Apologies for Absence
2. To confirm the minutes of the meeting held on 22 September 2011
3. Population Screening and Immunisation Programmes
4. Sexual Health Services: Funding and Commissioning issues
5. School Lunch Take Up 2010-2011 ' Keeping Children Healthy' Report
6. Children's Services Integrated Commissioning Task Group
7. Progress with Implementing Self-Directed Support

8. Developing a Health and Wellbeing Strategy for Derbyshire

9. HealthWatch Update

10. Tameside & Glossop Transition of Public Health into Local Authorities

11. Any Other Business

12. Dates of Future Meetings:

    26 January 2012
    29 March 2012
    31 May 2012
    26 July 2012
    27 September 2012
    29 November 2012

All meetings will start at 10am, and will be held in Committee Room 1 at County Hall.

MINUTES of a meeting of the **SHADOW HEALTH AND WELLBEING BOARD** held on 22 September 2011 at County Hall, Matlock

PRESENT

Councillor A I Lewer (in the Chair)

H Bowen	Chesterfield Borough Council
D Briggs	Derbyshire LINK
Councillor J Burrows	Chesterfield Borough Council
A Dow	Tameside & Glossop Clinical Commissioning Group
Councillor C Hart	Derbyshire County Council
Councillor C Jones	Derbyshire County Council
S King	High Peak Clinical Commissioning Group
B Laurence	Derbyshire County Council/Derbyshire County PCT
A Layzell	Southern Derbyshire Clinical Commissioning Group
Councillor B Lewis	Derbyshire County Council
D Lowe	Derbyshire County Council
R Marwaha	Erewash Clinical Commissioning Group
A Mott	Southern Derbyshire Clinical Commissioning Group
J Pendleton	North Derbyshire Clinical Commissioning Group
B Robertson	Derbyshire County Council
W Sunney	Hardwick Health Clinical Commissioning Group
I Thomas	Derbyshire County Council
T Thompson	NHS PCT Cluster
Councillor B Wheeler	South Derbyshire District Council

Also in Attendance – Councillors S J Ellis and G Farrington, S Burkinshaw, K Riley, S Savage (Derbyshire County Council), and A Thomas (NHS PCT Cluster)

Apologies for absence were submitted on behalf of D Collins and E Michel

The Chairman informed the meeting that the Shadow Cabinet Member for Public Health would be appointed to the Board. This position was held by Councillor Clive Moesby, who had given his apologies to this meeting.

13/11 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 7 July 2011 be confirmed as a correct record.

14/11 **JOINT STRATEGIC NEEDS ASSESSMENT 2011** A summary was given of the key health and wellbeing priorities for Derbyshire that had been identified by the Joint Strategic Needs Assessment (JSNA). Actions to address the priorities would be considered in the development of the Health and Wellbeing Strategy.

There were three types of data that made up the JSNA – the contextual data that would have a significant influence on health and wellbeing over the next few years, data that related to specific health conditions that were unusually higher than in other parts of the country, and key performance indicators which had been systematically measured and which stated how Derbyshire compared with other areas.

Two approaches used in identifying something as a priority for attention in the JSNA was if the condition was significantly above or below the national average, and if the condition had historically been overlooked and not enough was known about it. Some of the priorities for improving health and wellbeing depended upon the ability to change people's behaviour, and this fitted with the national strategy of prevention.

The Board was informed of the priorities for consideration – health inequalities, older people, dementia, carers, obesity, diabetes, hospital stays for alcohol related harm, autism, and long-term conditions. For Children's Health and Wellbeing, the priorities were highlighted as the early identification of vulnerable children and families, neglect, reduction of alcohol and substance misuse, increase breastfeeding at 6/8 weeks, reduction of childhood obesity, reducing teenage pregnancy, and emotional and psychological wellbeing.

It was reported that the strategy would begin to be developed, and it was the intention to have a first draft circulated by late autumn, with an updated version in Spring 2012. Further input would then be included by mid 2012

RESOLVED that (1) the Health and Wellbeing Board notes the health and wellbeing priorities identified; and

(2) consideration be given to address the priorities as part of the development of the new Health and Wellbeing Strategy.

15/11 **STAKEHOLDER FORUM FEEDBACK** A key requirement in the development of shadow Health and Wellbeing Board arrangements was the effective engagement of a wide range of stakeholders in the work of the Board. To begin this process, a wide range of stakeholders from the statutory and voluntary sectors had been invited to attend the first meeting of the Derbyshire HWB Stakeholder Engagement Forum, which had taken place on 13 September 2011. The Forum had been well attended by a wide range of organisations, and had provided an opportunity for participants to consider how to achieve effective communications between the Health and Wellbeing Board, Public Health professionals and other stakeholders, and to highlight priorities for the Health and Wellbeing Strategy.

Two workshop sessions had allowed participants to discuss Communications and Engagement and Health and Wellbeing Priorities. An overview was given of the key discussion points arising from the workshop sessions. In terms of communication and engagement, it had been suggested to have a dedicated website page to ensure effective engagement with a range of agencies. It was stated that the comments made at the Forum would be considered, and a report would be made to the next meeting of the Board.

It was agreed that it would be useful to have a more formalised Stakeholder Forum in future, as it was felt that this would be a good way to pass information on from the Board. Terms of Reference would be developed for the Forum.

RESOLVED to (1) formalise the Stakeholder Engagement Forum and a develop Terms of Reference and a draft programme of topics for future discussion;

(2) develop draft communications/engagement processes for the Health and Wellbeing Board; and

(3) feed the priorities and evidence identified into the development of the Derbyshire Health and Wellbeing Strategy.

16/11 **HEALTH VISITING IMPLEMENTATION PLAN** The Health Visiting Implementation Plan – A Call to Action – set out the Government's commitment to a larger health visiting service in order to deliver a new model of support for families, and the NHS Operating Framework 2011/12 set targets for individual health communities to increase the number of health visitors over the next five years. NHS Derbyshire County and NHS Derby City were working together to maximise the delivery of the targets, and NHS Derbyshire County was one of two 'early implementer' sites across the region. The Department of Health had been clear about the number of health visitors each authority was expected to recruit, and Derbyshire would be required to recruit an additional 5.8 health visitors each year until 2015.

As part of the recruitment programme, the Family Nurse Partnership had been jointly commissioned by NHS Derbyshire County and the County Council, and would be ready to start delivery of the programme to young mothers in early 2012 in targeted areas. This would assist in meeting part of the Healthy Child Programme. Gaps remained in achieving the ante-natal visits in the early stages of pregnancy, and this area had been prioritised for the increased investment required by the Health Visiting Implementation Plan in subsequent years. The outcomes expected from this investment were highlighted. Partnership working was critical in delivering the outcomes, and it was essential that effective integrated working with other early years services was developed.

Additional in vestment would be required in order to meet the target of 5.8 additional health visitors each year until 2015. In order to meet the strategic objectives of 'Supporting Families in the Foundation Years' and the early intervention agenda, the Health Visiting Implementation Plan Steering Group was aiming to prioritise the ante-natal home visit as a key strand in the early identification of vulnerable families, and would utilise additional health visitor resource in implementing the target.

In partnership with strategies to reduce teenage pregnancy and to respond to areas of higher need, an analysis was being undertaken of areas where there were pockets of higher teenage conception and pregnancy rates, with a view to extending the Family Nurse Partnership to Swadlincote in 2012, and also possibly to the Fairfield Estate in Buxton and Hurst Farm in Matlock.

The Board was requested to support the engagement of commissioners in order to prioritise the investment required. Investment of £450,000 had already been committed for the current financial year, and this was delivering the Family Nurse Partnership in the targeted areas. Work was currently being undertaken to identify the resource required, and it was envisaged that a recurrent investment of £300,000 would be required each year until 2015. This would provide an additional 24 health visitors working across the Family Nurse Partnership and health visiting service.

RESOLVED to (1) recognise the importance of the delivery of the Healthy Child Programme and the government's drive to prioritise this area by securing additional health visitors, and to endorse this work becoming part of a wider strategy for early intervention;

(2) support and promote the ongoing commitment to vulnerable families through the investment in the Health Visiting Implementation Plan and Family Nurse Partnership as a key part of future commissioning plans of the Health and Wellbeing Board; and

(3) support the providers to further improve the delivery of integrated services to improve outcomes for children and families.

17/11 **FAMILY LITERACY STRATEGY** The Board received a presentation from Sarah Burkinshaw, Read on Write Away! (ROWA), on the Family Literacy Strategy. ROWA had previously led a study into a strategic partnership approach to support literacy in family homes, and this had been part of a national pilot. The National Literacy Trust had wanted to test the premise that if literacy challenges could be addressed through a strategic and partnership approach, the 'achievement gap', which characterised the difference in school achievement between deprived and less deprived communities, could be significantly reduced.

In year one of the pilot in Derbyshire, harder to reach parents were asked about their views concerning their children's language and reading and their role in this, and non-literacy colleagues were asked about their views on clients' literacy and the impact this had on the achievement of their objectives. From this, it was noted that many parents did not know that they had a role in language development, and that many of those who thought they had a role but lacked confidence did not access existing support. Many non-literacy colleagues who had access to these families wanted to be part of the solution but lacked the experience or confidence to offer the relevant support.

In year two of the pilot, the service experimented with pilot studies to redefine and redesign literacy support to make it more available and accessible through a range of support services. A wide range of partnership services had also been identified which could become part of a broad, sustainable, shared goal to eliminate the effects of disadvantage in the development of children's language and literacy.

Specifically relating to Derbyshire, the statistics were typical of those nationally. Low levels of literacy were linked to a range of lower housing, employment, income, unplanned pregnancy, and health and wellbeing outcomes. A range of national reports outlined the importance of early intervention as key to preventing social, health and learning problems being passed from one generation to the next, and the importance of the parent's role in early education.

National statistics showed that approximately 16.5% of all adults in the UK had literacy skills limited to those of an average eleven year old. Those who had limited skills were over represented in areas of socio-economic disadvantage, unemployment figures and offender figures. In Derbyshire, the literacy achievements of children who were eligible for free school meals was significantly different to those who were not eligible.

The ROWA! survey had included 63 harder to reach families from three disadvantaged areas of Derbyshire. This had found that although two thirds of parents had said that they wanted to help their children to succeed, few knew how to do this. Parents had been asked what they did to help their children learn, and the number of parents who gave a positive response to various suggestions was low.

The Derbyshire Family Reading Homes Strategy was a result of the study, and aimed to develop a cohesive approach to supporting the development of language and literacy in early years by bringing together services to target and support families who needed help. Many parents were not sure of their role in children's development and many were not confident to get involved in their child's learning. This was largely true of socio-economically disadvantaged parents, but was not restricted to this group. Parents needed to be made aware what they had to do. The available literacy

support was not always visible, accessible or appropriate, and it was felt that the current service provision needed to be reviewed to meet the needs of the clients.

It was stated that service providers with access to families were not sure how they could contribute to literacy. It would be necessary to promote the view that everyone with access to families could be part of the solution, and it was felt that more community members and champions were needed who were willing to talk to parents about family reading or to take a mentor role.

It had been highlighted that support and advice did not start early enough, and ante-natal services needed to identify families who would require additional support. It was also noted that school engagement/partnership with parents often started too late, and schools could be poor communicators about their expectations of parents. Overall, services needed to radically rethink their literature to be socially inclusive.

The Board was presented with suggestions of how issues could be addressed through a partnership approach, along with the aims, objectives and principles of the Derbyshire Family Homes Reading Strategy. The Derbyshire Children's Trust Board had recently considered the strategy, and had asked for a further report which combined an implementation plan for the strategy with that of the Derbyshire Family Support Strategy. This would be presented back to this Board once the work had been completed. Clinical Commissioning Groups had also been asked to consider how they could play a part in the delivery of the strategy, and the ongoing implementation needed to be supported by the Family Reading Champion and a partnership strategic planning group.

The development and implementation of the strategy would require resources to further integrate the approach into partnership planning and pathway delivery, supporting workforce development, developing partnership monitoring and creating a social marketing campaign.

RESOLVED that (1) the Derbyshire Family Homes Reading Strategy be adopted by the Health and Wellbeing Board;

(2) the Children's Trust Board and Clinical Commissioning Groups be asked to consider how the proposals can best be implemented and report back to the Health and Wellbeing Board early in the new year; and

(3) a 'Reading Works: Pass it on' strategic planning group, chaired by the Family Reading Champion, be identified to share information and to identify cross partnership implementation methods.

18/11 CLINICAL COMMISSIONING GROUPS – PROGRESS The Board received progress reports on the Clinical Commissioning Groups throughout Derbyshire.

Erewash – It was stated that Erewash had 13 practices to cover a population of 96,000 within the Erewash borough and had a budget of £164m. Erewash had a group of proactive GPs and Practices who had worked on improvement as an area for the last ten years. The CCG considered itself to be small enough to be in touch with every practice to effect change and improvement, but large enough to sustain financial stability. The patient flow from Erewash was to both Derby, Nottingham and Ilkeston hospitals and Long Eaton Health Centre. The Group was building on success that had already been achieved in a number of areas, and trying to extend this work.

In terms of the CCG Board, membership was currently a GP Chair, 13 GPs representing each Practice, two Practice Managers, and one non-executive/lay member. It was anticipated, however, that further changes would be forthcoming through the Future Forums paper. The range of priorities and the agenda for the Group were highlighted.

North Derbyshire – North Derbyshire had 30 practices to cover a population of 228,000, and the main acute flow was into Chesterfield hospital services. The Group had four localities to ensure local engagement. The Clinical Commissioning Group Board and Clinical Reference Group had been established, and the Board was presented with the interim organisational structure. It was emphasised that the Board would focus on a range of different issues to the Clinical Reference Group. North Derbyshire CCG was leading on the Chesterfield hospital contract, working with Hardwick Health CCG, Derbyshire Community Services contracts for the whole county, and the urgent care network for Derby City and Derbyshire County health and social care system. The immediate priorities for the Group were detailed.

Hardwick Health – Information was given on the areas covered by the Hardwick Health practices. There were 15 practices covering approximately 100,000 patients. The practices had been working together since 2007, and covered the majority of Bolsover and North East Derbyshire. It had responsibility for the Mental Health contract/commissioning, and was also responsible for contracting for Care Homes and specific hospitals. Joint working was already taking place with local authorities and the local CCGs, and it was the intention to produce joint priorities for North East Derbyshire and Bolsover.

Details were given on the Group's approach with contracts, and it was stated that any change would be strategy led and evolutionary. The range of ongoing activities being undertaken was also presented, with particular information being given on the work around care homes and dementia care. In terms of team around the expert patient, evidence of the key interventions

and what had been done so far were reported, along with areas for development.

Southern Derbyshire – The Group had 58 practices to cover a population of 520,000, and had a budget of £807m. The Group covered Derby City, Amber Valley, Ashbourne, and South Derbyshire. The area had been chosen due to the patient flow into Derby hospitals, the ability to have consistent care pathways, financial stability and economies of scale. The CCG worked through four localities, and this allowed for local ownership, local identification of health need, local priorities, and co-working with local authorities and other organisations.

The Board currently consisted of a GP Chair, four GPs to represent the localities, two local authority representatives for Derby City and Derbyshire County Council, two lay representatives, one secondary care clinician and one nurse representative. The Board was still in its early days, although a constitution had been agreed. It had been approved as a national pathfinder and also as a sub-committee of the joint PCT (Cluster) Board. Appointments were being made to the Board, priorities were being identified, the financial position was being understood, staff to support the CCG were being identified, and relationships were being developed. The priorities identified were stated.

High Peak – The Group covered a predominantly urban population of around 60,000 with some areas of deprivation. The patient flow was varied, and went into Stockport and Macclesfield. The Board had now been formed, and consisted of GP representatives from each of the eight practices, public health, High Peak Borough Council, and it was the intention to also have a representative from Derbyshire County Council. It was stated that the Group was currently planning a move to premises in Buxton, but the current priority was to get things moving with a view to have a clearer pattern of the way forward over the coming months.

Tameside and Glossop – The Group had 44 practices which covered a population of 250,000 with 120 GPs. It was a possibility that the Group may need to form with other CCGs. The area had below average ill health, and there were pockets of deprivation. The Group was still in its infancy, and was not as far forward as others, but had held an away day.

19/11 PCT TRANSITION – PROGRESS The PCT had agreed a scheme of delegation, and the process was in place around transition. A number of Task and Finish Groups had been established, and it was agreed to receive updates at the next meeting of the Board.

20/11 EQUALITY AND DIVERSITY The Board was informed of the recent launch of the Department of Health's Equality Delivery System (EDS). This had been developed to improve the equality performance of the NHS and to embed equality into mainstream business. It was proposed that the EDS

would focus on the things that mattered the most for patients, communities and staff. It emphasised genuine engagement, transparency and the effective use of evidence.

The EDS applied to both current and planned NHS commissioning organisations, including Clinical Commissioning Groups and to NHS providers. By using the EDS, it was anticipated that organisations would improve their equality performance and also be better able to meet the requirement of the Equality Act 2010 and the equality requirement relating to CQC registration.

During 2011/12, NHS organisations would be expected to develop four year Equality Objectives and priorities, based on a grading of their equality performance against a set of EDS goals and outcomes. There were 18 outcomes grouped under four goals – better health outcomes for all, improved patient access and experience, empowered, engaged and well supported staff, and inclusive leadership at all levels. Based on transparency, NHS organisations and local interests would agree one of four grades for each outcome – excellent, achieving, developing or undeveloped. Following consideration and analysis of stakeholder views and relevant data and evidence, NHS organisations would confirm their Equality Objectives for the coming business planning period, and agree the priority actions. It was the intention to review annually the performance against the selected priorities.

The Department of Health EDS guidance recommended that, once finalised, equality objectives and associated actions be formally reported to the local Health and Wellbeing Board. The EDS guidance stated that LINKs could play a key role in facilitating this process. Taking into account the key EDS requirement of ensuring that local interests were centrally involved in reviewing NHS organisations' equality performance, a pilot Derbyshire Community Health Equality Panel had been established. The key roles of the Panel were detailed, along with the draft Terms of Reference.

It was proposed that the Health and Wellbeing Board could receive EDS assurance information and performance reports from local NHS organisations, and these would either directly include, or be supported by, an overview statement from the Panel on the key feedback from local interests on each organisation's EDS performance and equality priorities and objectives. In order for the Board to assure itself that the Panel had involved all relevant groups in the analysis of performance, it was considered appropriate for the Board to have an annual report from the Panel which summarised the groups with which it had engaged.

The EDS encouraged continuous improvement and the delivery of positive outcomes for protected groups, and it had a key enabling role in helping NHS organisations to identify and address health inequalities and deliver accessible equitable health services. A formal launch of the EDS

would take place on 6 October, to which members of the Health and Wellbeing Board were invited to attend.

RESOLVED to (1) note the background to, and key requirements of, the new Equality Delivery System;

(2) approve the proposed role and Terms of Reference of the recently convened pilot Derbyshire Community Health Equality Panel;

(3) ask the Panel to produce annually a short report which summarises the groups with which it has engaged;

(4) approve that it receives, considers and comments on EDS assurance information and performance reports from local NHS organisations; and

(5) note the invitation to the Equality Delivery System launch event on 6 October 2011.

21/11 **HEALTH AND WELLBEING BOARD – LEARNING SETS** The Board was updated on a series of Learning Sets that were being established as part of the Health and Wellbeing Board National Learning Network. As an early implementer for Health and Wellbeing Boards, Derbyshire had been asked to become involved in Learning Sets. The Learning Network aimed to enable Board members to share knowledge and experiences with peers, and this would cover both practical and developmental issues that would ultimately improve outcomes for local people.

As a result of consultation, Learning Sets had been developed and would enable groups of Health and Wellbeing Boards to work together on issues of mutual interest to share learning and best practice, find new approaches to delivering outcomes and to produce a summary of the work of the set which would then be used as guidance for others.

The Learning Sets would cover a number of themes, and these were highlighted. Membership of the sets would be based on the principle of co-production between the Department of Health, Local Government Group and Health and Wellbeing Board early implementers. While a core membership would deliver the themes, a wider membership would be able to access the learning of the core and share their own experiences. Designated Health and Wellbeing Board early implementers would work with a Department of Health sponsor to lead the initial development of the set, agree the terms of reference and deliver monthly progress updates.

A maximum of 15 Boards would make up the core membership of each Learning Set, with responsibility for active participation and the dissemination of learning across their Health and Wellbeing Boards. Once the Learning Set

was established, a maximum of 140 associate members would be able to read and access relevant content and where appropriate, engage with the work of the set. Each early implementer had been asked to indicate their preferred Learning Sets.

At this stage in the development of the Shadow Board, it was not felt appropriate to become a core Learning Set member. However, Board Members were invited to consider whether there were any priority issues where they wished to be involved to support the Board's ongoing development. It was anticipated that the majority of meetings and discussions would take place online, and therefore, the Board would still have access to the learning opportunities available.

RESOLVED (1) to note that the Board had been invited to become involved in a series of learning sets as part of the Health and Wellbeing Board National Learning Network; and

(2) that Board Members become involved in the Learning Sets as appropriate.

22/11 **ANY OTHER BUSINESS** It was stated that, in future, any items to be considered under 'Any Other Business' should be sent to the Chairman in advance of the meeting.

Agenda Item No.3

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

PUBLIC HEALTH BRIEFING: POPULATION SCREENING AND IMMUNISATION PROGRAMMES

Purpose

This briefing paper sets out the Primary Care Trust Cluster's current screening and immunisation responsibilities and provides information to date regarding the future commissioning and management arrangements, during the transition and post NHS Reforms. This includes the likely role and responsibilities of the Health and Wellbeing Board.

Information and Analysis: Screening Programmes

Screening is a process of identifying apparently healthy people, in a given population, who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition[1].

The NHS Constitution[2] sets out in statute PCTs responsibilities to commission all National Screening Committee recommended screening programmes as detailed in appendix A and as follows;

- Three cancer screening programmes
- Two non –cancer screening programmes
- Six ante natal and newborn screening programmes

Other Department of Health nationally recommended screening initiatives such as NHS health Checks and Chlamydia screening and are also commissioned although they are not part of the strict subset of NSC screening programmes.

Screening programmes must do more good than harm. The PCT is responsible for the coordination, performance management and quality assurance (QA) of all the programmes it commissions. This work is led by public health in partnership with Regional Q/A teams and PCT employed coordinators, secondary care providers and primary care clinicians. The screening pathways are often complex and involve multiple providers and are supported by a range of different clinical and non clinical data management systems.

[1] http://www.screening.nhs.uk/screening
[2] The NHS Constitution for England (2009) DH

Information and Analysis: Immunisation programmes

Health protection is one of three core domains of public health practice[3] and includes population Immunisation against Infectious diseases. Vaccination and immunisation programmes are one of the single most important ways of preventing childhood and adult morbidity and mortality. The overall aim of the routine childhood immunisation programme is to protect children against vaccine preventable infections and reduce the incidence of community acquired preventable infections in un- immunised children**.** The aim of the adult immunisation programmes is protect vulnerable adult populations against vaccine preventable infections such as seasonal flu, pneumococcal disease and hepatitis.

Primary Care Trusts in England have overall responsibility for the implementation of the national immunisation programme and the right to immunisation is now part of the NHS Constitution[4]. The PCT commissions immunisation programmes from general practices and other providers such as health visitors, occupational health services and school nursing. These health professionals all have a role to play in promoting uptake, and providing routine or 'one-off' immunisation services, such as catch-up campaigns[5] or supporting the management of outbreaks of infectious disease through vaccination.

In Derbyshire County the best uptake rates have been achieved through an integrated primary care team approach to immunisation delivery in which the whole primary care team participate, however further improvements can be gained by extending this integration to the local Authority Multi Agency Teams.

Next Steps:

Future screening and Immunisation commissioning arrangements under NHS reforms

Following the publication of Healthy Lives, Healthy People, it is clear that screening will be a core responsibility of Public Health England but the commissioning of programmes will be mandated to the National Commissioning Board. This is likely to take place at differing levels of the system but there will be a need to recognise that screening services are interdependent with other NHS services e.g. ante-natal and new born screening and maternity services.

Public Health England will provide public health advice and quality assurance of screening and possibly immunisation programmes however the details of how this will be delivered at a local level are yet to be shared.

The role of the Director of Public Health in screening programmes has not yet been fully defined but it is anticipated that the need to work in partnership with

[3] http://www.fph.org.uk/what_is_public_health includes heath services and health improvement

[4] The NHS Constitution for England (2009) DH

[5] ttp://www.immunisation.nhs.uk/Local_coordinators_toolkit/Commissioning_and_providing_immunisation_services

the National Commissioning Board will be integral to ensuring that screening programmes are based on and deliver population needs.

Health and Wellbeing Boards have a responsibility to determine local priorities and strategies for which they will be held accountable to deliver and the draft Public Health Outcomes Framework identifies indicators for both immunisation and screening[6]. Scrutiny of health services will also encompass screening and immunisation programmes

Further detail regarding the interrelationships between PHE, the NCB and Clinical Commissioning Groups at a varying levels is expected through the publication of Public health reform Updates. Appendix B shows the likely role and responsibilities of Local Authorities, the health and Wellbeing Board clinical commissioning groups, PHE and NHSCB as currently understood.

Managing programmes during transition

The NHS reforms and necessary transition arrangements present both risks and opportunities for immunisation and screening programme commissioning and management. Although public health lead the commissioning, oversight and co-ordination of national screening and immunisation programmes this depends at PCT cluster level on expert support from other directorates/ departments. As commissioning and other directorate functions are devolved to Clinical Commissioning Groups there is a risk that the interdependencies with public health especially in relation to screening are overlooked or not prioritised.

These include;

- The overall loss of capacity arising from the voluntary redundancy scheme may result loss of critical commissioning and contracting expertise and local commissioning memory
- Changes to governance and accountability arrangements that may fully not be understood by stakeholders
- Loss of expert knowledge regarding data collection and analysis
- Slippage in service developments or performance monitoring plans
- Loss of capacity to adequately identify and respond to clinical screening Incidents
- Professional and clinical isolation of public health screening staff

The above risks are compounded by the continued requirement from the National Screening Committee and National Cancer Screening Director for PCTs implement significant and new service developments such as HPV triage, revised programme standards and new key performance indicators.

The NHS Reforms also afford opportunities for improvement. The new Clinical Commissioning Groups (CCGs) recognise the importance of health protection

[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

and immunisation programmes and are initiating work to support the small number of practices that are struggling to achieve the necessary uptake rates.

Summary and Recommendation

- The PCT cluster remains accountable for commissioning and performance management of screening and immunisation programmes.

- These programmes are often complex and involve clinical pathways that cross primary secondary and tertiary services.

- Overall screening and immunisation programmes perform well and in some instances are amongst the best in England (e.g. bowel and Cervical screening) and East Midlands (primary childhood vaccination uptake rates)

- However there are and will continue to be programme areas that require careful and continued monitoring to ensure both the quality and effectiveness of these programmes is not compromised during the transition period.

- The Health and Wellbeing Board take this into account when developing their strategic intentions to improve health and address health inequalities

Linda Syson-Nibbs
Nurse Consultant Public Health
NHS Derby City and NHS Derbyshire County

Agenda Item No.4

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

SEXUAL HEALTH SERVICES IN DERBYSHIRE: FUNDING AND COMMISSIONING ISSUES

1. Purpose

To give a brief overview of sexual health needs and services in Derbyshire, and to provide a summary of key issues relating to the transfer of responsibility for commissioning most sexual health services to Derbyshire County Council from NHS Derbyshire County in April 2013.

2. Background

Sexual health is an important element of both physical and mental health and wellbeing. Good sexual health is facilitated by access to information and services to avoid the risk of unintended pregnancy, sexually transmitted infections and coercive or abusive relationships.

The consequences of poor sexual health can be serious and costly for the individual, health and social services and for society as a whole. Improving sexual health service provision makes good economic sense. Unintended pregnancy and sexually transmitted infections (STIs) have both short term and longer term effects on health and wellbeing. The consequences of poor sexual health include[7]:

- Pelvic inflammatory disease (PID), ectopic pregnancy and infertility
- Cervical and other genital cancers
- Hepatitis, chronic liver disease and liver cancer
- Chronic or recurrent infection such as genital herpes and HIV infection
- Unintended pregnancies, a proportion of which result in abortion
- Psychological consequences of sexual coercion and abuse
- Poor educational, social and economic opportunities for teenage mothers

Inequalities in sexual health outcomes are an important public health priority. We know that certain groups in society experience greater risk of poor sexual health[8], and these include men who have sex with men (MSM), teenagers and young adults, especially those in care, certain minority ethnic groups, especially those of Black African origin, injecting drug users, sex workers and those in the criminal justice system.

[7] Department of Health (2001) *The National strategy for sexual health and HIV.* Department of Health, July 2001.
[8] National Institute for Health and Clinical Excellence. (2007) *One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups.* NICE Public Health Intervention Guidance 3. February 2007.

3. Information and Analysis: Sexual health in Derbyshire

As a result of a ten year programme to improve sexual health in Derbyshire, there has been a marked improvement in a number of key sexual health outcome indicators, and in general Derbyshire has better sexual health than the population of England as a whole (see appendix 1 Sexual Health Balanced Scorecard).

However, maintaining progress requires further service development to secure effective and efficient pathways of care. Commissioning a comprehensive range of sexual health treatment, care and prevention across a number of providers is complex, and needs to respond to a breadth of needs across different populations. Table 1 summarises the range of sexual health provision currently commissioned in Derbyshire. The current budget for sexual health services is £7.3 million[9].

4. Next Steps/Way Forward

The Public Health white paper proposes that Tier 1 Local Authorities will take on responsibility for commissioning most sexual health services from April 2013. These include community contraception services (C&SH), sexually transmitted infections, including specialist genitourinary medicine (GUM) services, termination of pregnancy (TOP) services and sexual health promotion, HIV prevention and outreach services.

The NHS Commissioning Board will have responsibility for commissioning some sexual health services, including contraception provision via GPs and HIV treatment services. Commissioning responsibility for some other services such as sexual violence services and psychosexual counselling services has not yet been finalised. Further clarity is expected once the DH sexual health policy framework is published in Spring 2012.

In order that Local Authorities can effectively discharge their new responsibilities for sexual health commissioning, they will need expertise in:

- assessing sexual health need,
- evaluating clinical and cost effectiveness of sexual health services,
- ensuring services are delivered to appropriate quality,
- ensuring services are used equitably, and
- evidence-based prioritisation.

The Health and Wellbeing Board has overall responsibility for determining local priorities through Joint Strategic Needs Assessment and for developing the strategic framework to ensure delivery against these priorities. It is important that sexual health is included in this prioritisation process.

Maintaining progress on the sexual health agenda during the transition needs to be managed effectively to ensure that current improving trends in sexual health outcomes are sustained. The overarching strategic aims remain: to

[9] This excludes sexual health services that will be the responsibility of the NHS Commissioning Board (including HIV treatment and care, contraception provision via primary care core contract and Sexual Assault Services).

reduce unplanned pregnancy, reduce rates of undiagnosed STIs and HIV and ensure access to effective sexual health prevention, treatment and care services.

The on-going NHS and public health system reforms present a number of challenges and opportunities, which need addressing to ensure successful transition to the new arrangements. The most important challenge is to maintain sufficient capacity and infrastructure to support effective sexual health commissioning, contracting, procurement, performance management and governance. This will be facilitated by clear prioritisation of the sexual health commissioning work programme, developing strong links with evolving Clinical Commissioning Groups[10], and working collaboratively with Derby city.

Another key challenge is the need to maintain costs within available financial resources, and to ensure productivity and efficiency gains while simultaneously improving sexual health outcomes and reducing inequalities. The Public Health ring-fenced budget will be calculated based on actual public health spend in 2010-11, but has not yet been confirmed. If demand for and access to sexual health services continues to increase this will result in financial pressure on the budget. It is essential therefore to maintain investment in preventive interventions (eg Long Acting Reversible Contraception provision, sexual health promotion, condom distribution to at risk groups) to avoid rising treatment costs for poor sexual health outcomes (eg unplanned pregnancies, new HIV infections and other STIs).

There are important opportunities arising from the transfer of sexual health commissioning responsibilities to the local authority including ensuring preventive efforts are more co-ordinated across young people's services and health, developing more integrated approaches to tackling issues related to sexual risk behaviours including alcohol and substance misuse, and better integration of health and social care for people living with HIV.

Securing sustainability, quality, effectiveness and efficiency of sexual health services for the population of Derbyshire into the future, within the resources available will require:

- Improved data and information technology systems within provider services to enable better performance monitoring and evaluation.
- Further development of detailed service specifications for existing services stipulating clear quality standards and outcomes
- Workforce development to develop capacity across the whole system and maximise the potential for prevention
- Further awareness raising about local sexual health services among key target groups, using existing channels and new media
- An integrated sexual health budget to improve transparency, consistency and balance between prevention and treatment

[10] Clinical Commissioning Groups have lead commissioning responsibilities for the main provider organisations that deliver sexual health services in Derbyshire (listed in Table 1)

Table 1: Sexual Health Services in Derbyshire

Service type	Providers	Services provided
Sexually Transmitted Infection Services	Acute Trust Genitourinary Medicine (GUM) Departments GP practices (non-specialist STI testing/ treatment)	▪ Sexual history & risk assessment / SH promotion ▪ Sexually Transmitted Infection (STI) testing and treatment including complex case management ▪ Specialist partner notification ▪ HIV counselling, testing and diagnosis ▪ Post-exposure prophylaxis for HIV ▪ Vaccination for blood-borne viruses ▪ Teaching and clinical training in STI management
HIV Treatment Services	Acute Trust GUM Departments	▪ Clinical care and monitoring progress of people with HIV including management of treatment ▪ Sexual health advice and support
Contraception and Sexual Health (C&SH) Service	Derbyshire Community Health Services (DCHS) (delivery in a diverse range of settings including health centres, colleges and Connexions)	▪ Sexual history & risk assessment / SH promotion ▪ STI testing, treatment and partner notification ▪ Full range of contraception provision ▪ Pregnancy testing ▪ Psychosexual counselling ▪ Erectile dysfunction treatment ▪ Management of complex cases for contraception ▪ Pre-abortion assessment and counselling ▪ Contraception outreach for vulnerable groups ▪ Teaching / clinical training in contraception / STIs ▪ Cervical screening provision ▪ Vasectomy counselling and provision
Termination of pregnancy	Acute Trusts British Pregnancy Advisory Service Private sector	▪ Pre-abortion assessment and counselling ▪ Early medical abortions ▪ Late Medical abortions ▪ Surgical abortions
Emergency contraception	Community pharmacies	▪ Pregnancy testing ▪ Provision of emergency contraception
Contraception	GP practices	▪ Oral, patch and injection contraception provision ▪ Emergency contraception ▪ Contraceptive implant fitting and removal ▪ Intra-uterine contraceptive device fitting/removal
Sexual Health Promotion and Outreach	DCHS Voluntary sector	▪ Condom scheme management and coordination ▪ Sexual health promotion training ▪ Young people's peer support (including LGBT) ▪ Targeted sexual health support for vulnerable YP ▪ Outreach work with MSM and young people ▪ Support for people living with HIV
Chlamydia screening programme	DCHS Chesterfield Royal Hospital Multi-agency screening providers	▪ Chlamydia Screening Office: training & co-ordination of screening sites, notifying results, partner notification, data management and analysis, quality assurance, audit ▪ Treatment and partner notification ▪ Outreach screening provision ▪ CRH laboratory: processing of samples and reporting results to CSO/Health Protection Agency
Sexual Assault Services	Derbyshire Rape Crisis Derbyshire Health United - Forensic Medical Service	▪ Management of Sexual Assault Referral Centre ▪ Treatment and care of victims of rape and serious sexual assault ▪ Forensic medical examination of victims ▪ Emergency contraception provision ▪ Counselling and support for victims ▪ Referral for STI testing and treatment

In summary, unlike most other areas of public health, clinical services such as STI treatment, partner notification and contraception services are integral to the preventive strategy for sexual health. Public health commissioning of these preventive treatment services is essentially a critical role of the new local authority-based Public Health Service.

5. Recommendations

The Health and Wellbeing Board is asked to:

- **Note** the significant changes to sexual health commissioning responsibilities proposed in the public health system reforms
- **Comment on** and **support** the proposed measures for managing the transition to the new commissioning arrangements

Maureen Whittaker
Associate Director of Public Health
NHS Derby City and Derbyshire County

Appendix 1: Sexual Health Balanced Scorecard data for NHS Derbyshire County

Source: Association of Public Health Observatories
http://www.apho.org.uk/default.aspx?QN=SBS_DEFAULT

Indicator	PCT	Count	Value	England ...	Significance	Compare Values	
▼ Teenage Conceptions							
Rate age under 18 conceptions (LA partners*), 2009: Rate per 1,000...	Derbyshire County PCT	*477	33.3	38.2	●	19.6	67.4
Rate age under 18 conceptions, 2007-09 (combined 3 years): Rate p...	Derbyshire County PCT	1430	34	40.2	●	19.5	69.4
Rate age under 16 conceptions (LA partners*), 2006-08 (combined ...	Derbyshire County PCT	*285	6.6	7.9	●	3.2	16.1
% change rate age under 18 conceptions (LA partners*), 1998 to 20...	Derbyshire County PCT	*-40	-19.9	-18.1	▬	-49.9	33.8
▼ Abortions							
% all NHS-funded abortions <10 weeks, 2009 (CMO recommended t...	Derbyshire County PCT	988	68.4	74.4	◆	46.9	85.3
% age under 18 abortions <10 weeks, 2009: Percentage	Derbyshire County PCT	118	66.3	68.2	▬	40.3	85.2
% age under 16 abortions <10 weeks, 2006-08 (combined 3 years): ...	Derbyshire County PCT	89	60.1	60.8	▬	31.3	78.2
% age under 19 repeat abortions, 2009: Percentage	Derbyshire County PCT	17	5.8	11.1	●	5.3	22.8
% age under 25 repeat abortions, 2009: Percentage	Derbyshire County PCT	157	19.4	24.7	●	14.9	35.9
% age under 18 conceptions 2009 leading to abortion (no traffic light...	Derbyshire County PCT	*215	45	49.0		29	71
Rate age under 18 abortions, 2009: Rate per 1,000 females aged 15-...	Derbyshire County PCT	178	12.6	17.7	●	10	40.4
Rate age under 16 abortions, 2006-08 (combined 3 years): Rate per ...	Derbyshire County PCT	148	3.6	4.2	▬	2.3	9.2
Rate all abortions, 2009: Age-stand rate per 1,000 females aged 15-...	Derbyshire County PCT	1520	12.3	17.6	●	10	40.1
▼ Contraception							
Rate GP prescribed LARC, 2009/10: Rate per 1,000 females aged 15...	Derbyshire County PCT	8960	68.8	46.9	●	5.7	94
% age under 18 CSRH services choose LARC (PCT host), 2009/10: ...	Derbyshire County PCT	552	17.9	11.3	●	0	50.6
% age under 16 CSRH services choose LARC (PCT host), 2009/10: ...	Derbyshire County PCT	205	21	9.7	●	0	36.9
▼ Sexually Transmitted Infections and HIV							
% age 15-24 screened for chlamydia outside GUM clinics, 2009-10 ...	Derbyshire County PCT	25396	29.7	22.1	●	8.3	40.8
% age 15-24 test positive for chlamydia outside GUM clinics, 2009-...	Derbyshire County PCT	1347	5.3	6.0		2.4	10.4
Rate age 15-24 chlamydia diagnoses in all settings, 2009 (no traffic l...	Derbyshire County PCT	1807	2,125.1	2212.8		775.7	5,171.6
Rate age under 30 Pelvic Inflammatory Disease admissions, 2009/1...	Derbyshire County PCT	68	117.9	87.4	◆	21.7	245.1
Rate gonorrhoea diagnoses in GUM clinics, 2009 (no traffic lights): R...	Derbyshire County PCT	104	14.3	29.7		1.9	213.8
Rate syphilis diagnoses in GUM clinics, 2009 (no traffic lights): Rate ...	Derbyshire County PCT	15	2.1	5.5		1	59.4
% Uptake HIV tests in GUM clinics, 2009: Percentage	Derbyshire County PCT	6875	79.8	76.6	●	26.8	99.2
% HIV diagnoses with CD4 cell count <200 at time of diagnosis, 200...	Derbyshire County PCT	3	21.4	29.6	▬	0	66.7
Prevalence of diagnosed HIV, 2009 (no traffic lights): Rate per 1000 ...	Derbyshire County PCT	178	0.42	1.81		0.3	13.3
% GUM clinic clients offered appointment within 2 working days, 200...	Derbyshire County PCT	11245	100	99.8	●	92.4	100
% GUM clinic clients seen within 2 working days, 2009: Percentage	Derbyshire County PCT	9421	83.8	88.2	◆	68.3	99.7
% GUM clinic clients did not attend first appointment, 2009: Percent...	Derbyshire County PCT	604	5.4	6.1	●	0.1	21.3
% GUM clinic clients seen after 10 working days, 2009: Percentage	Derbyshire County PCT	126	1.1	1.3	▬	0	8.4
▼ Awareness, Attitudes & Risk Behaviour							
% age 12-13 uptake HPV vaccine first dose, Sep08-Aug09: Percent...	Derbyshire County PCT	3846	88.5	87.5	●	54.3	99.9
% age 12-15 sex & relationship advice needs improving (LA partners...	Derbyshire County PCT	*205	37.7	37.0	▬	23.2	49.6
% age 10-15 frequent substance misuse (LA partners*), 2008 (only ...	Derbyshire County PCT	*no data	15.1	10.9	◆	2.2	17.2
▼ Schools & Connexions Services							
% Schools with on-site sexual health services (approx. value, LA part...	Derbyshire County PCT	*no data	no data	28.7		0	98
% 16-19 mothers in EET where known to Connexions (LA partners*),...	Derbyshire County PCT	*129	24.8	28.4	▬	14.4	53.9
% 16-19 mothers not known to Connexions (LA partners*), Dec 200...	Derbyshire County PCT	*208	30.2	40.4	●	2.5	81.7
% 16&17 mothers not known to Connexions (LA partners*), Dec 200...	Derbyshire County PCT	*24	20.7	33.8	●	0	82.7
▼ Sexual Assaults							
Rate police recorded rape in women, 2007/08: Rate per 100,000 fem...	Derbyshire County PCT	117	31.9	42.5	●	13.9	120.0
▼ Other related factors							
% GCSE achievement 5 A-C grades incl English & maths, 2008/09: ...	Derbyshire County PCT	4331	51	50.9	▬	33.5	68.2
Index of Multiple Deprivation 2007 average score (no traffic lights): ...	Derbyshire County PCT		18.8	21.6		8.1	50.8

Significantly worse than England average ◆ Not significantly different ▬ Significantly better than England average ●
England average | SHA average ◆ PCT Value ●
Quartile Q1 Q2 and Q3 Q4
− +

Agenda Item No.5

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

REPORT ON SCHOOL LUNCH TAKE UP 2010-2011: KEEPING CHILDREN HEALTHY

Background and Context

On the 7th July 2011 the results of the 2010-2011 national school lunch take up survey were published. A statistical release and a full survey report, based on take up data and other contextual information provided by Local Authorities as part of the School Food Trust (SFT) and Local Authority Caterers Association (LACA) annual survey, were provided.

Purpose of the Report

This report summarises the progress made with increasing the take up of paid and free meals in Derbyshire Schools for 2010/11

School Lunch Take Up-Derbyshire

	2010/11	***2009/10***	***2008/09***
Primary & Special	***46.90%***	***44.10%***	***42.90%***
Secondary	***42.00%***	***39.70%***	***38.00%***

National level

At a National level, school lunch take up in England continues to increase. On average 44.1% of Primary School pupils and 37.6% of Secondary school pupils had a school lunch each day between April 2010 and March 2011, an increase of 2.7 and 1.8 percentage points respectively compared with 2009-2010. Since 2008-2009, we have now seen a total rise in take up of 4.8% in Primary Sector, and 2.6% in the Secondary Sector.

Derbyshire

In Derbyshire school lunch take up also continues to increase. The figures for 2010-2011 show an increase of 2.8% in Primary school pupils and 2.3% in Secondary school pupils compared with 2009-2010. Since 2008-2009 we have now seen a total rise in take up of 4% in Primary sector, and 4% in the Secondary Sector.

This means in Derbyshire that since 2008 over 1200 more children are eating a school lunch per day. The increase in the school lunch take up is due to the dedication and hard work of all those involved in the school workforce who have brought about real improvements in the quality of school food provision. Some of the initiatives have been:

- Improved choices on menus

- Acting on pupils and parent feedback
- Food for Life Partnership project
- Marketing campaign in Secondary schools
- Introduction of Deli bars in Secondary schools
- Intensive staff training
- Quality assurance training programme with increased targets

These figures show that the provision of healthy foods in schools can be popular with pupils. At the same time, it is important to recognize that many schools and caterers still have an uphill struggle to engage with pupils and parents to increase take up of healthy meals at lunchtime. On average take up of school lunches is still below 50%. This means that over half of pupils in Derbyshire are either taking packed lunches to school (which are known to be less healthy) or eating off school premises (which is likely to be less healthy still). While the reported increase in take up are encouraging, there is no room for complacency. Much needs to be done to ensure that the percentage of pupils taking school lunches continues to increase in the coming years.

Other main findings of the report

- All 152 Local Authorities (LAs) in England were approached for information regarding school catering services. Of these 129 (85%) responded providing information.
- The response rate and coverage are both sufficiently high to be confident that findings representative of local authority organised school meal provision in England. The coverage nationally relating to take up of school lunches is 78% in the primary sector and 54% in the secondary sector.
- Average school lunch prices for 2010/11 were £1.88 in the LA catered primary sector (Derbyshire £1.85) and £1.98 in the LA catered secondary sector (Derbyshire £1.90).

Derbyshire County Council will continue its strategy to improve school meal take up by using its experience and working with schools across the county to deliver low cost, practical solutions to increase the numbers of pupils eating food. We will continue to improve kitchens (including kitchen conversions) and dining spaces to increase free school meal take up and introduce new marketing campaigns.

Recommendations

That the Health and wellbeing Board note the continued increase in the take up of Healthy and Nutritious meals in Derbyshire Schools

Ian Thomas
Strategic Director – CAYA
Derbyshire County Council

Derbyshire

School catering - services offered to schools

None	
Catering with LA in-house provider	x
Catering with LA contracted provider	
Catering support/advice	x
Other	

Source: SFT/LACA annual survey 2010/11

School food catering providers

	Total number of schools in LA	LA contracted catering service - LA in-house provider	LA contracted catering service - private contractor (one or more)	School contracted catering service - LA provider	School contracted catering service - private contractor	School contracted catering service - school in-house service	FSM service only	Don't know
Primary	**350**	**345**	**0**	**0**	**0**	**4**	**1**	**0**
Secondary	**47**	**25**	**0**	**0**	**11**	**11**	**0**	**0**
Special	**10**	**10**	**0**	**0**	**0**	**0**	**0**	**0**

Source: SFT/LACA annual survey 2010/11

Meal price

	2010/11	2009/10	2008/09		2010/11	2009/10	2008/09
Primary	**£1.85**	**£1.85**	**£1.70**	Secondary	**£1.90**	**£1.90**	**£1.95**

Source: SFT/LACA annual survey 2010/11, 2009/10, 2008/09

Current LA survey contact

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04 November 2011

Agenda Item No.6

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

CHILDREN'S SERVICES INTEGRATED COMMISSIONING TASK GROUP

Purpose of Report

At its meeting on 7th July 2011 the Shadow Health and Wellbeing Board endorsed the establishment of a time limited group to make recommendations regarding the future model for integrated commissioning of Children's Services. This report sets out progress to date and sets out a proposed model for commissioning on behalf of the 5 Clinical Commissioning Groups (CCGs) that cover the area of NHS Derbyshire and Derbyshire County Council.

Background and Context

Commissioning of Children's Services in Derbyshire is currently managed jointly across NHS Derbyshire and Derbyshire County Council, by a jointly appointed Assistant Director and teams in both PCT and Council who work as a single team.

The draft Health and Social Care Bill indicates that there will be an increased number of funding streams for Children's Services in the future and changes to the lead commissioning arrangements for a number of services. The model described below aims to build on the existing successful joint arrangements and reduce the possible fragmentation resulting from the proposed national changes.

Proposed Model

It is proposed that the existing joint arrangements are retained and strengthened to ensure co-ordination across the county and maximise efficiency. Governance will be via the Children's Trust Board, therefore effective links with CCGs will need to be developed.

A single integrated Children's Commissioning Team would commission services through a range of joint arrangements as set out in the attached table. The employment options for this team require further exploration.

The team would continue to include input from public health colleagues, especially in relation to those outcomes which will be within the Health and Wellbeing Strategy.

Joint work with Derby City will take place where there are common populations, common objectives and in relation to services being provided by common providers.

The ongoing development of this model will need to take account of any changes in policy/direction at a national/regional level and progress should be formally reviewed in April 2012.

Recommendation

- Members are asked to agree the proposed approach
- Members are asked to endorse the further work required to develop this approach.

Sally Savage
Assistant Director of Commissioning (CAYA)
Derbyshire County Council

Commissioning Model	**Service/Care Group**	**Lead Commissioner**	**Rationale**
Co-ordinated – joint development of needs assessment and agreement of shared priorities Individual organisations free to view these alongside their own priorities Service design, resource allocation, contracting and performance management remain separate	• Planned care • Urgent care	NHS Contracting teams	These services are "core business" for CCGs Service changes are largely transacted by the contracting teams
Joint - joint development of needs assessment and agreement of shared priorities Joint agreement of resource allocation and aligning budgets Joint design of	• Immunisation and Vaccinations • Obesity/Physical Activity/Nutrition • Drug and Alcohol Services • Teenage pregnancy/Sexual health • Health Child Programme –	Children's Commissioning Team Transacted via CCG contracting leads	These services will be funded via either the PH grant or the Local Authority – joint commissioning provides opportunities for increased efficiency Many are already jointly

Commissioning Model	Service/Care Group	Lead Commissioner	Rationale
service specifications and joint work on procurement/ contracting through a lead commissioner CCGs retain responsibility for performance management through agreed contracting and governance arrangements but will require coordination and communication pathways.	including Health Visiting and School Nursing • Family Nurse Partnership • Maternity Services	 Still awaiting clarification of where maternity commissioning will be located nationally	commissioned There are multiple providers and these services are already jointly commissioned with Derby City
Integrated – Responsibility for the whole commissioning cycle delegated to an integrated team through a pooled budget	• CAMHS • Health Needs of Disabled Children • Health Needs of Looked After Children • Complex Cases • Therapy Services	Children's Commissioning Team To include formal pooling of budgets	Existing successful joint arrangements in place (including an existing Section 75 agreement for Complex cases) Potential to make savings through pooling Some services already secured via a joint service specification Proposed changes in legislation (eg SEN Green paper) to achieve greater integration between Health and Social Care
National/Regional Commissioning – some services will be commissioned either by the NHS Commissioning Board or at a regional level	• Primary Care • Screening • CAMHS Tier 4 • Neonatal/PICU • Tertiary Care	NHS Commissioning Board	Specialist services commissioned collectively to achieve economies of scale and to maximise quality.

Agenda Item No.7

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

PROGRESS WITH IMPLEMENTING SELF-DIRECTED SUPPORT

1. Purpose of the Report

This report outlines the progress made with the development and implementation of the assessment, support planning and service access arrangements introduced fully from 1st April 2011 that deliver Self-Directed Support in Adult Care in the County Council.

2. Information and Analysis

The system for assessment, care/support planning and the arrangement of services meeting eligible care/support needs is referred to as Self-Directed Support (SDS). The public information provided about the system is attached as an Appendix to this report.

The approach developed for Derbyshire is based on national policy and extensive local development work completed through the Making Care Personal Programme. The re-organisation of Adult Care approved by Cabinet in October 2010 and mostly completed by the beginning of April 2011 reduced management costs to protect front line services and established a structure relevant and capable of delivering a sustainable system of personalised adult social care.

Following the completion of development work coinciding with the conclusion of the Making Care Personal programme and the re-organisation of the department, principal responsibility for the implementation and development of SDS has transferred to the Fieldwork Division assisted by a cross departmental strategy group.
All new referrals are now received and dealt with using the new assessment approach, tools and systems, including the Resource Allocation System (RAS) that has been developed as part of national consortia of local authorities working in partnership with FACE Measurement Systems Ltd.

The performance of councils for the delivery of SDS is measured by NI 130. The criteria for SDS NI 130 is the number of people receiving personal budgets or Direct Payments and for those people receiving personal budgets, those people who were informed about their indicative budget before care/support plans were developed and who will either have had the opportunity to receive their support via a Direct Payment or have taken a Direct Payment.

The following table shows the growth of clients in receipt of a personal budget or a direct payment within each financial year since April 2008 and a projected outturn for 2011-12 and 2012-13.

Year	Number
2008/09	998
2009/10	1663
2010/11	4219
Projected 2011/12	7983
Projected 2012/13	11021

Exponential trend analysis of national returns for all local authorities dating back to 2005/06 suggests that the forecast for 7983 would be within the top 25 of local authorities in terms of the volume of clients. However, it is anticipated that a range of work currently in hand will increase the number of clients reviewed and assessed over the period and, as a result, the final position may vary from the projections for 2011/12 and 2012/13.

The progress and performance of the Department with the implementation and further development of SDS has been reviewed during September by the SDS performance and strategy group. This took into account the data available (reported above), the evidence obtained from file audits completed by Group Managers and the detailed examination of 45 cases involving people with high support and complex needs (including people with severe learning disabilities) as part of work completed to assist the further refinement of the RAS. Learning from a recent national conference attended by a number of officers has also been considered.

The summary conclusions reached from this exercise are as follows:

- Overall the Department has established a strong position when considered against the seven principles set out in “A Vision for Adult Social Care: Capable Communities and Active Citizens”
- There is now confidence that most people are being advised of their Indicative Budget before work to develop a support plan commences. This is a key element of NI 130 and is fundamental to delivering the genuine shift in choice and control for local people.
- The introduction of the automated calculation system for the Indicative Budget into Frameworki and no longer requiring manual calculations by the Purchasing Support Team, has significantly improved the speed of response.
- There has been a reduction in the number of cases where the Indicative Budget appears to be significantly in error or is disputed.
- The further development of the RAS to be completed shortly is expected to further improve the accuracy and consistency of the

calculation of the Indicative Budget particularly for those people with high support needs and complex difficulties, especially where care and support relies on shared care/support to secure independent living.

- There is strong evidence that the reliability of the Indicative Budget derived from the RAS is as a result of the steady improvement in the quality of assessments. The quality of descriptions of the personal circumstances of people has significantly improved.
- The quality of person centred assessment work is reflected in the low level of complaints or referral to the review process established to deal with cases where clients dispute the outcome of their assessment including the level of Indicative Budget or Personal Budget.
- There has been a strong and positive response from care/support providers, which needs to be matched by a further improvement in the quality of outcome descriptions developed for people by caseworkers. This is important as it shapes the level of innovation and creativity i.e. the range and quality of options, especially the extent of the emergence of less traditional models of social care support “new ways of working”.
- Brokerage has developed well and is widely used to secure speedy access to care/support services provided by the independent sector and Direct Care domiciliary care services. It is available to assist people who are fully self-funding. The use of the Brokerage service for access to other personal care/support services provided by Direct Care including day services and registered residential care needs to be developed.
- The Brokerage Team has been able to secure flexible and imaginative responses to an increasing number of support plans. We expect this experience will continue to expand the diversity of solutions used and the Brokerage Team invests a proportion of time to publicising the outcomes being achieved and the experience derived from work to establish cost effective support plans for individuals.
- Independent brokerage and support planning provided by Disability Derbyshire Coalition for Inclusive Living (DDCIL) through the service level agreement still needs to be more widely promoted and take up encouraged.
- Costing for Direct Care services needs further development and this has now been addressed by the Adult Care Senior Management Team.
- The inclusion of transport as an integral part of support planning is still limited and the structure and budget for transport needs to be addressed to ensure this important element of care/support provision is delivered appropriately.
- The Prevention Strategy 2011-2014 has been formally approved by Cabinet and the investment proposed in the development of a Trusted Befriending Scheme as part of the changes to Adult Care approved by Cabinet earlier this year, is progressing well. Cabinet dealt with the selection of the strategic partner for the development of the Trusted Befriending Network on 11th October.

The priorities for development identified by the performance and strategy group include:

- Consolidating the revised casework approach that aims to bring together the effective assessment of FACS eligibility and co-funding with effective utilisation of prevention services and universal support.
- Further development of prevention services including befriending, enhanced functionality for Call Derbyshire and First Contact.
- Brokerage – ensuring all systems support access to all services via the Brokerage Team unless in an emergency and out of hours.
- Costing for Direct Care services
- Transport costing
- Assessment and casework tasks – test and develop the efficiency and effectiveness of the fieldwork/brokerage partnership
- Further development of information and managing access to knowledge about service and care/support options
- Workforce and professional practice development
- Market development
- User engagement – maintaining systems and processes to secure client feedback on the implementation of SDS and development
- Capacity – delivering enhanced capacity for casework and support planning from the various investments made through the re-organisation of the Department

The SDS performance and strategy group will also look at a range of other matters in more detail over the next six months:

- Safeguarding and SDS
- Positive person centred risk management
- Equalities
- Advocacy
- User Led Organisation (ULO) brokerage and support planning
- Managed bank accounts and financial management
- Leaner approaches to operating systems drawing on the advice and approaches developed nationally by Think Local, Act Personal to assist streamlined and person centred administration.

3. Equality and Diversity

The development and monitoring of SDS has taken into account the Equality Impact Assessment completed in support of the report to Cabinet when recommending the service changes the Council should consider and approve, including the revision of Fair access to Care Services eligibility criteria and the introduction of the Co-funding (Fairer Charging) scheme. The investment in prevention service developments, specifically the Trusted Befriending Scheme development approved by Cabinet in June 2011, addresses the potential adverse impacts that could arise from the

changes being made to the way Adult care services are provided in Derbyshire.

4. Background Papers

1. Cabinet report 1st October 2010 – "Re-organisation of Adult Care"
2. Cabinet Member report 1st October 2010 – "The Making Care Personal Programme"
3. Cabinet reports – "25th of January 2011 on Consultation on Community Care Services, specifically the expansion of the Prevention and Early Intervention Strategy 2011-2014
4. Cabinet report 29th March 2011 on Eligibility for Personal Care.
5. Prevention Strategy 2011-2014
6. A Vision for Adult Care: *Capable Communities and Active Citizens.* Department of Health 16th November 2011

5. Recommendation

That the progress made with the implementation of Self-Directed Support (SDS) for Adult Care and priorities for further work is noted.

JAMES MATTHEWS
ASSISTANT DIRECTOR OF
STRATEGY & COMMISSIONING (ADULT CARE)
DERBYSHIRE COUNTY COUNCIL

Agenda Item No.8

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

DEVELOPING A HEALTH AND WELLBEING STRATEGY FOR DERBYSHIRE

1. Purpose

This paper is intended to inform the process of developing the Derbyshire Health and Well Being Strategy by describing current plans and priorities which the HWB Board will need to consider in its development of the strategy. It is proposed that the strategy be framed around a small number of high level strategic priorities, which will need to be agreed by the HWB Board, and that a task and finish group be convened to manage the day-to-day process of writing the strategy. It is suggested that an agreed set of principles will be helpful in guiding the development of the high-level strategic themes.

2. Background

Previous reports to the Health and Well Being Board have highlighted the following key elements of the HWB strategy

- Adoption of a life-course framework approach (as highlighted in Healthy Lives, Healthy People)
- Requirement for an overarching strategy across all three outcomes frameworks (Public Health, Social Care and NHS)
- The need to balance county-wide with local priorities

To be effective the HWB strategy will need to be a means to:

- Drive local change including service transformation
- Tackle public health challenges such as health inequalities
- Achieve the better use of resources through integrated commissioning
- Link Health and Wellbeing Boards to wider public services including transport, planning, leisure, environment and education
- Develop productive relationships with Clinical Commissioning Groups

3. Approach to prioritisation in the HWB Strategy

In order to develop the HWB Strategy, the HWB Board will need to agree a small number of high level priorities around which the strategy can be framed. The development of these agreed priorities will be an evolving process over the next few months.

It is suggested that the prioritisation process adopted by the HWB Board should be guided by an agreed set of principles incorporating clear criteria such as population health need, the need to reduce health inequalities as well as improving health overall, and evidence for effectiveness (including cost-effectiveness).

The Derbyshire JSNA for 2011 has summarised key health and wellbeing priorities for Derbyshire, based on population health need. Views on priority issues have also been gathered via the recent HWB Stakeholder Engagement event. As well as taking the JSNA and stakeholder views into account, the priorities agreed by the HWB Board will also need to take account of existing priorities for partner organisations as well as national and other local priorities:

3.1 Current commissioning and partnership plans

The prioritisation process will also need to take account of current commissioning and partnership plans such as Derbyshire's adult care and children's plans and the local strategic partnership plans.

At a national level current NHS commissioning priorities are described in the NHS Strategic and Operational Plan (SOP) 2011/12. Clinical Commissioning Groups (CCGs) are currently undergoing their authorisation process part of which will involve producing a commissioning plan. In developing their plans CCGs will need to make reference to the next NHS Operational Plan (2012-2013), which is anticipated later this autumn.

3.2 Other key current or emerging strategies

*Mental Health Strategy***.** A local strategy for Derbyshire and Derby City is currently being developed in response to the cross-government strategy 'No Health without Mental Health' published in February 2011. A multi-agency consultation is currently underway. The work is being led by public health and overseen by the Mental Health Commissioning Board for Derbyshire and Derby City. The strategy will be used to inform the development of the Derbyshire Health and Well Being Strategy.

Derbyshire DAAT strategies for substance misuse are due to be refreshed next year in line with the recently published drug strategy, 'Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life'. and the forthcoming national alcohol strategy.

*Smoking. '*Healthy Lives, Healthy People: a Tobacco Control Plan for England' sets out how tobacco control will be delivered in the context of the new public health system.

*Obesity***.** 'Healthy Lives, Healthy People: A call to action on obesity in England' was published in October 2011.

Sexual Health is a key policy theme in Healthy Lives Healthy People. A new national sexual health policy document is due to be published in 2012.

4. Way forward: developing the strategy

A task and finish group will be convened comprising representatives from public health and DCC to manage the day-to-day process of writing the

strategy. This group will be supported by a wider reference group including GP/CCG representatives.

5. Recommendations

- A small number of high level priorities will need to be agreed by the HWB Board, in line with agreed prioritisation principles, around which the strategy can be developed.
- These priorities should be those with clear benefits from joint action by the different agencies represented
- The selected priorities will need to be linked with clear outcome indicators in order to ensure progress can be monitored
- The HWB Board to approve the convening of a task and finish group to undertake the day-to-day management of the strategy development.

Alison Pritchard
Consultant in Public Health
NHS Derby City and Derbyshire County

Agenda Item No.9

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

SHAPING DERBYSHIRE HEALTHWATCH

1. Purpose

To provide an update on work being undertaken to develop a local HealthWatch service in Derbyshire and to outline the likely timetable for its procurement.

2. Background

HealthWatch will be the new consumer champion for health and social care in England. It will exist in two distinct forms;

- Local HealthWatch organisations which will be set up at a local level,
- HealthWatch England which will operate at a national level.

2.1 HealthWatch England

HealthWatch England will be a national organisation that will enable the collective views of the people who use NHS and social care services to influence national policy. It will be a statutory committee of the Care Quality Commission (CQC), with a Chair who will be a non-executive director of CQC. HealthWatch England will have its own identity within CQC, but it will be supported by CQC's infrastructure and it will have access to CQC's expertise.

2.2 Local HealthWatch

The Council has the responsibility to facilitate the development of an effective local Derbyshire HealthWatch service to commence in October 2012. Derbyshire HealthWatch will provide;

- Opportunities for people to have their say about the quality and development of their local health and adult social care services.
- Promote opportunities for local people to influence the commissioning of local public services and to provide additional voices to scrutinise them.
- Signpost people to sources of information and advice to help people access and make choices about services.

- A service to support people to gain access to independent complaints advocacy, if they need help to complain about NHS services.

Derbyshire HealthWatch will take on all current LINk (Local Involvement Network) statutory roles and functions, build upon what is already working well and have a specific focus on the need to be representative of diverse communities.

2.2.1 Background to Derbyshire LINk

LINks were established following implementation of guidance in the Local Government and Public Involvement in Health Act 2007. The Derbyshire LINk was awarded, following a tender exercise, to a consortia bid made by Amber Valley Council for Voluntary Services and North Derbyshire Voluntary Action to act as a 'Host' to the Derbyshire LINk. This contract has been extended whilst planning is undertaken to develop a new service specification for Derbyshire HealthWatch before going to tender for the new service.

2.2.2 Operational Model and Governance of LINk

The Derbyshire Host was tasked with employing the LINk staff and to initially offer management and technical support whilst a LINk steering group was established. The LINk steering group is made up of volunteers who are representative of their communities and have expressed a willingness to take on the responsibility of overseeing the work of the LINk. Discussions have been held with the Chair of the LINk steering group about how the volunteers and members of the LINk could be encouraged to continue when the service changes to HealthWatch.

3. Planning for Derbyshire HealthWatch

The draft Health and Social Care Bill that is currently going through Parliament, places a duty on all Local Authorities in England which providesAdult Social Care services to commission a local HealthWatch service by October 2012. Derby City Council on behalf of the regional Association of Directors of Adult Social Services, commissioned a partner agency, following a competitive exercise, to assist the Local Authorities in the East Midlands Region to set up Local HealthWatch provision. The organisation that was successful was the Community Development Foundation and they are helping commissioners and representatives of local LINks to work through the various guidance from the Department of Health and Care Quality Commission and develop a local HealthWatch. The work programme has already commenced and consists of 5 sessions for commissioners and 4 workshops for LINks members. To encourage

collaboration between the two groups, LINks members will be invited to one of the commissioners' sessions, and commissioners will be invited to one of the LINks' workshops.

4. Initial Considerations for HealthWatch Development

4.1 Low visibility of Derbyshire LINk

It is generally felt that local LINks including Derbyshire LINk lacked visibility and that this had reduced their potential membership and consequential impact. Local HealthWatch will need to be more visible and better evidence its activity to ensure greatest representation for local people.

To promote a wider pool of stakeholders with an understanding of HealthWatch it is proposed that a clause is written into contracts that providers need to encourage membership of the local HealthWatch.

4.2 Local Sensitivity to the Health Community

The Local HealthWatch service will need to effectively manage relationships with currently the six new Clinical Commissioning Groups in Derbyshire and up to 17 external acute hospitals that provide services to Derbyshire residents. This will require building excellent communication with the relevant Health providers as well as linking other HealthWatch providers across the region. This is in addition to local adult social care services.

The current South Derbyshire Clinical (CCG) Commissioning Group straddles Derby City and the County Council. This will clearly require Derbyshire HealthWatch and Derby City HealthWatch to work closely together in representing citizen's views in respect of this CCG. It is likely that we will also need to see similar close working relationships with other HealthWatch services, e.g. Tameside and Glossop CCG will provide services to the people of Glossop.

Liaison between Derbyshire and Derby City commissioners is already in place to ensure that Derbyshire and Derby City HealthWatch are visible to the public across the council boundaries and to ensure that there is good communication between them to ensure that there is no confusion for the public and that local people's views are not lost.

5. Next Steps

The current timetable for the delivery of a Derbyshire HealthWatch requires a service to be prepared and in place by October 2012. It is planned to have procurement documentation including the service specification ready for February 2012. Adverts to tender the service will follow soon after with a target of having Derbyshire HealthWatch in place by October 2012.
A small project group is being set up to oversee the development of a vision for HealthWatch in Derbyshire. This group will take on the responsibility for shaping the specification in partnership with local stakeholders. It will include representation from; Derbyshire County Council Adult Care, Derbyshire County Council Policy Unit, Derbyshire County Council Children and Younger Adults, Derbyshire Primary Care Trust Cluster, Derby City Council and the Chair of the Derbyshire LINk.

6. Recommendation

That work continues on developing a vision for Derbyshire HealthWatch to include;

- To continue drafting the service specification, taking account of any further Department of Health guidance about the expectations of HealthWatch and funding available.
- Identify with colleagues in Derby City potential ways of ensuring that each HealthWatch organisation provides clear advice across Health boundaries and to consider how infrastructure costs might be shared to promote Best Value.
- To promote within the tender the expectation that a Host provider will work with the HealthWatch membership to develop a distinct/high profile organisation that has its own corporate identity.
- To ensure that all new contracts set by Derbyshire Adult Care and the local NHS require providers to take responsibility to promote to people HealthWatch when it is operational.
- That further reports are submitted to the Health and Wellbeing Board updating it on progress in establishing Derbyshire Healthwatch

JAMES MATTHEWS
ASSISTANT DIRECTOR OF
STRATEGY & COMMISSIONING (ADULT CARE)
DERBYSHIRE COUNTY COUNCIL

Agenda Item No.10

DERBYSHIRE HEALTH AND WELLBEING BOARD

24 November 2011

TAMESIDE & GLOSSOP
TRANSITION OF PUBLIC HEALTH INTO LOCAL AUTHORITIES

1. Background

In November 2010 the Department of Health published the White Paper, 'Healthy Lives Healthy People: our strategy for public health in England'. This followed the earlier White Paper, 'Equity and Excellence – Liberating the NHS' (July 2010). Both papers set out the government's vision for the future of health service provision in England and both propose radical changes to the commissioning and management arrangements for health.

Under the proposals contained within Healthy Lives Healthy People, the challenges facing the nation in terms of reducing smoking, alcohol and substance misuse, obesity, sexually transmitted infections, poor mental health and deep rooted health inequalities are outlined. As part of the approach to addressing these challenges, the White Paper proposes ending central government control and giving local government the freedom, responsibility and funding to innovate and develop their own ways of improving public health. In addition, local government will be given new functions to increase local accountability and support integration and partnership working across social care, the NHS and public health.

Integral to the delivery of the government's vision is the proposed transition of Public Health functions, activities and potentially teams from the NHS to local government. It is expected that these transfers will take place nationally by April 2013, the proposed date at which Primary Care Trusts will be dissolved. The public health function will be funded via the allocation of a ring fenced public health budget and measured against a set of public health outcomes that local government will be expected to deliver.

This report updates the Locality Board on progress thus far and proposes a process to manage the transition and facilitate the alignment of PCT Public Health staff to Tameside MBC without changing responsibilities at this stage or terms and condition of employment or accountabilities to the PCT Cluster, which will remain responsible for public health until 2013.

Local authorities are able to begin preparations for the change in responsibilities from April 2011 onwards. The Human Resources Framework for transition of public health staff or Concordat is expected to be issued by the Department of Health during Autumn 2011. Shadow arrangements for

discharging the public health responsibilities within upper tier local authorities should be in place by April 2012.

Indicative budgets will be issued for April 2012 onwards. Ring fenced budgets based on the funding currently devoted to public health activity in the NHS and according to population profiles will be given to local authorities from 2013. Current proposals are that public health commissioning will be subject to oversight by the Tameside Health and Wellbeing Board (HWB) to ensure it reflects the priorities identified in the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy that the new legislation requires. Derbyshire HWB will provide this oversight for the Glossopdale area. HWBs should be established in shadow form by April 2012 and be fully operational by April 2013.

Responsibility for the health and wellbeing of Glossopdale residents will remain the responsibility of the public health department at NHS Tameside & Glossop until the transfer of responsibility to Derbyshire County Council in April 2013. The Director of Public Health is a member of the Derbyshire Health & Wellbeing Board alongside Dr Alan Dow during the transition period.

For many years there has been effective partnership working with Tameside MBC and Derbyshire CC. As organisational change gathers pace this strong foundation will provide an excellent basis on which to develop success.

2. Roles and responsibilities of the public health team

The Director of Public Health (DPH) carries statutory responsibilities for health protection and safeguarding and is accountable for delivery on public health outcomes. Current priorities are supporting the development of the Health and Wellbeing Board and Joint Health and Wellbeing Strategy, the PH team transition to the Council and engaging the Clinical Commissioning Group in improving population health.

The senior team supporting the interim DPH comprises two consultants. Each of these carries strategic leadership for the delivery of specified priority health outcomes. Their responsibilities include tackling the determinants of health through partnership working; health improvement; commissioning for health, and pathway and service redesign to deliver health outcomes. The medically qualified consultants carry responsibilities for health protection, safeguarding and prevention including screening. In addition the team provide public health specialist training and currently hosts two public health trainees who contribute to strategic delivery.

The senior team are supported by three public health development managers and one partnership senior manager who implement strategies to improve health outcomes. The public health managers also support needs assessment, JSNA and production of the public health annual report.

Establishment includes four public health data analyst posts with two currently filled. It should be noted that, relative to other departments of public health across the North West the team is small. Appendix 2 shows the current structure.

3. Overview

In driving the transition agenda forward, a fundamental aim is to sustain and review existing programmes, maintain the resilience of local public health functions and minimise risks from transition. There are a number of practical and technical issues to work through plus a number of grey areas within the white paper. Much of this uncertainty is due to a lack of clarity in aspects of the role and function of the NHS Commissioning Board, Public Health England and the scope of Local Authority Public Health responsibility. Clarity for some of these issues will flow from emerging policy and guidance over the months.

4. Public health functions

The overarching function of public health is to protect and improve population health and wellbeing, and provide public health leadership, shaping and influencing efforts towards reducing inequalities and improving quality of life. The public health team has responsibility to progress a varied portfolio across the three domains of public health, namely, health protection, health services and health improvement. Appendix 3 provides a summary of the range of programs included in the current public health work programme.

Delivery of this comprehensive programme involves specialist inputs across ten public health competency areas:

- Surveillance and assessment of the population's health and wellbeing
- Promoting and protecting the populations health and wellbeing specifically to reduce inequalities
- Assessing evidence and its impact, audit and evaluation
- Collaborative working for health
- Developing and guiding health programmes and services to reduce inequalities
- Policy and strategy development and implementation to improve health and wellbeing
- Working with and for communities
- Strategic leadership for health and wellbeing
- Research and development
- Managing resources

The public health service team will:

- Lead on health improvement, taking a proactive role in developing the health and well being of local communities across partnerships and service boundaries
- Lead the Joint Strategic Needs Assessment including joint commissioning and procurement of health and well being services as outlined in the Public Health Outcomes Framework. This will include Glossopdale in collaboration with public health colleagues in Derbyshire.
- Exercise certain statutory functions (to be confirmed) for the Public Health service:
    - Local co-ordination of health protection
    - Commissioning of preventive services
- Provide specialist advice and knowledge around public health
- Promote comprehensive understanding of the wider determinants of health, ensuring that public health considerations are integrated in all core policies and subject to scrutiny.
- Manage the public health resource, managing the proposed ring-fenced budget
- Ensure quality control on behalf of the public health service e.g. for screening and immunisation programmes
- Provide public health leadership to the Health & Wellbeing Boards and the Clinical Commissioning Group
- Improve the research and intelligence capability around health and wellbeing

5. Enabling transition

In order to support transition of the function to Tameside MBC a joint transition group is planned which will focus on the key areas below. Guidance from DH is expected imminently about the expected contents of the PH Transition plan which will have to be submitted to the Strategic Health Authority in December.

- **Public Health Role and Functions**
  Detailed mapping of existing roles and functions of public health and the identification of potential opportunities to enhance joined up working between public health and wider council departments will be undertaken. Discussion about the alignment of specific work stream and programmes will be further developed over the coming months as part of the transition process. This exercise will help to clarify internal and external dependencies that contribute and impact on the delivery of the existing public health portfolio.

- **Finance**
  Detailed work to scope resources required to support the functions being transferred has started as part of the public health spend audit. Wider considerations will include work to ensure all financial data is validated and verified and that support service costs and transition costs are considered.

  Further work will be needed across Greater Manchester and in response to DH requirements to look beyond the baseline year of 2010/11

- **Human Resources (HR)**
  The national HR framework is expected to be published in the autumn. This should provide clear direction in terms of the future employment arrangements for public health staff. An outline HR plan will be required, this will underpin the local transitional arrangements once these have been agreed ensuring due process is followed in relation to staff consultation and engagement.

  In the event that staff are aligned with the LA as an interim step ahead of the formal decision, a memorandum of understanding, clarifying the scope of responsibility and governance arrangements, will need to be agreed between the PCT and Local Authorities. Public health staff included in such an arrangement will be consulted on proposed interim changes. Public health staff seconded under the interim arrangements will remain employed by the PCT in accordance with their contracts of employment and the PCT will remain entirely responsible for all payments due to or with respect to them until such time that the formal transfer is agreed.

- **IT and Information**
  Ensuring business continuity and access to data and intelligence via existing `PCT systems and the emerging GM level support functions is essential to enable the delivery of the public health intelligence. Data sharing, data protection and governance issues present significant challenges both locally and nationally. Local agreements will need to be defined, informed by national guidance and policy, to ensure and give the necessary assurance that robust information governance arrangements are in place both during and post transition.

  The public health intelligence function is pivotal in providing intelligence, data analysis and interpretation across a range of programmes. It is important for public health to give expert public health advice on what is effective in improving health. It will need to advise not only the LA but also all other partners about the contribution they can make to public health, based on an accurate interpretation of the evidence. Public health will have a particular responsibility in liaising with the NHS

including the local Clinical Commissioning Group The advisory function is supported by intelligence staff but the relationship with the LA intelligence function will need early exploration to consider opportunities for early alignment to ensure optimum performance of intelligence expertise and capacity across public health and the health, social care and wider economy as appropriate.

- **Commissioning public health services**
  An exercise to determine where support for commissioning and contracting public health programmes will be sourced will be needed. Consideration of the appropriate geography in relation to the GM cluster, CCG and TMBC levels and the availability of expertise will be required. For example sexual health services, school nurses, primary care commissioning such as for smoking cessation will have to be explored.

- **Glossopdale**
  Work will be needed with Derbyshire County Council and Derbyshire County PCT to determine a safe transition of responsibilities and commissioned services.

  All the issues highlighted will be translated into the action plans, implementation of which will facilitate and enable the formal establishment of public health within the LAs, ensuring resilience during transition, and that the function continues to be fit for purpose.

  The Director of Public Health recruitment process has started. This post will continue as a shared post with Tameside MBC and the post holder will continue with responsibilities for the Tameside & Glossop locality until April 2013

6. Organisational fit of public health

The LA is driving forward a comprehensive change agenda. This will incorporate a clear vision for public health across all functions of the LA that deliver health and well being. Fundamentally, leadership for health, wellbeing and health inequalities – including the development of public health policy, is pivotal to delivering improved outcomes for the area and should be a corporate responsibility. As such, the Director of Public Health must be positioned accordingly within the local authority to retain the independence that is essential to fulfil the role.

In the **transition period,** the Interim DPH will:

- Provide leadership and influence the future vision for health and wellbeing in Tameside & Glossop.

- Provide expert public health leadership and advice to the emerging Shadow Health & Wellbeing Boards and Clinical Commissioning Group.
- Ensure the best deployment of public health leadership and expertise in care pathway development across the health and social care economy.
- Ensure resilience in the performance review and management of key public health programmes and targets.
- Ensure resilience of the local health protection system and arrangements, ensuring these align with Public Health England and the National Commissioning Board.
- Ensure resilience of public health intelligence, strengthening local integration and supporting progress in the development of effective knowledge management.
- Ensure the resilience of the local vaccination and immunisation programme during transition.
- Ensure effective community infection control services are in place to maximise the quality and consistency of interventions locally.
- Produce the Director of Public Health Annual report in 2012.
- Secure the Public Health training function within Tameside MBC.

In this capacity the DPH would provide the public facing, expert advisory role on public health within the locality. Part of this role will be to advise and monitor work programmes across all local authority directorates and guide the work of the Health and Well Being Boards and Clinical Commissioning Group. Location at a senior level, reporting for certain responsibilities to the Chief Executive, is commensurate with the responsibility and importance of this function. Certain tasks would need to be retained by the DPH to undertake this role eg the public health intelligence role and the policy and support to CCG. This support will help the DPH continue to shape and influence the wider public health programmes.

Whilst managerially accountable to the Chief Executive and as the leading public health champion for Tameside & Glossop, the DPH will provide a critical independent advisory role directly to the Chief Executive, the Leader of the Local Authority and the Cabinet Member with a health lead, on all high level issues relating to public health.

It is expected that certain functions within this structure, for example, dental public health, will transfer to other parts of the new NHS system. This will be determined by further policy guidance as and when it becomes available.

Discussion will be needed as part of the transition plan about where the public health function will sit in TMBC.

Ensuring robust organisational governance arrangements are in place for the transition period is critical to the effective functioning of the structure. Discussion to clarify roles, responsibilities and managerial accountability will be held with all relevant staff. The importance of maintaining clinical supervision and professional development within the new arrangements as recognised and will be facilitated through personal development plans with continued oversight by the Director of Public Health as appropriate.

7. Governance

There will be a clear accountability for these functions through the DPH and the Chief Executive of TMBC and through the CE of NHS Greater Manchester.

- Alignment between policy (including elements that are discharged by Public Health England) and operational matters.
- Clinical supervision is in place for Public Health staff to promote professional development
- Robust processes for public health finances are in place during and after the transition to local authorities in line with the proposed ring fenced budget arrangements.

The Interim DPH will work with TMBC colleagues to deliver an effective research and intelligence function through the local information system to inform commissioning practice designed to reduce health inequalities. The arrangements will be overseen during the transition period by the Health and Well Being Board in Tameside to secure engagement across all partners including the CCG and Locality Board to improve the health and well-being of the community. The linkage to Derbyshire will be maintained through the Health & Wellbeing Board and the other collaborative arrangements in the county.

8. Proposed initial transitional arrangements

It is evident that the pace of change towards public health transition across Greater Manchester and beyond is varies and to a great degree influenced by the strength of existing relationships between LAs, public health teams and the wider PCT. For Tameside and Glossop, the prospect of an early move towards informal alignment is made possible by the strength of the existing relationship between the LAs and PCT.

With this is mind, and acknowledging wider organisation changes within the NHS, in particular the establishment of the shadow CCG in 2011, and the alignment of PCT staff to the shadow structure, it is proposed that arrangements are put in place to facilitate the transition of public health into TMBC by March 2012. Staff consultation will be an integral part of the process.

9. Next steps – timeline for action

a) Set up a transition planning group to carry out the tasks identified in the milestones listed below
b) Ensure the transition plan is submitted to the Strategic Health Authority in December and is firmly based on the guidance
c) Develop a Memorandum of Understanding to clarify and underpin terms of agreement for the early transfer of staff in advance of April 2013
d) In order to assure the key public health functions that the process of transition should be accountable to Tameside MBC CE, the Locality Board, Tameside Health & Wellbeing Board and inform Derbyshire Health & Wellbeing Board.

10. Recommendation

The Board is asked to support and endorse the proposals above to enable transition planning to commence.

Elaine Michel
Interim Director of Public Health
NHS Tameside & Glossop

Milestones for transition

Map the existing responsibilities, budgets, functions and interfaces of the public health team with Tameside MBC	October 2011
Establish a transition project group	October 2011
Produce a transition plan and submit to Strategic Health Authority	December 2011
Following response to PH consultation establish shadow budgets in relation to public health spend	December 2011
Following issue of PH HR framework clarify HR issues for PH team and organise consultation re move into TMBC	December 2011
Advertise and recruit to DPH post	Autumn 2011
Consider developments and changes in legislation and guidance, implications for PH and joint commissioning through work of NHS Manchester	Autumn 2011
Review role of public health intelligence in relation to JSNA, PHE, BI, Policy Unit, supra-district review.	January 2012
Integrate DPH and team more closely in Council management groups and functions	From March 2012
Consider relationship with emerging GM Public Health structures	Ongoing
Clarify transitional arrangements regarding Glossop	By March 2012
Continue support arrangements to HWBB	Ongoing
As shadow consortium emerges clarify PH support arrangements	Summer 2012
Understand relationship with emerging Public Health England and resource implications	Following emergence of guidance on PHE
Understand relationship with NHSCB and any transfer implications. Ensure transfer of current functions is effectively managed	Following emergence of guidance on NHSCB
Relocation of PH team to Council	By March 2012
Allocation of shadow budgets for prevention spend	April 2012
Transfer of public health budgets to Council	April 2013

Appendix 1

Public health transition: maintaining the focus on population health

Aim:

- To outline the role of the public health team in protecting and promoting the health of the population and in service improvement to improve and support population health.

- To set out the actions required to ensure that these functions are maintained throughout transition.

The functions of public health are summarised in Figure 1

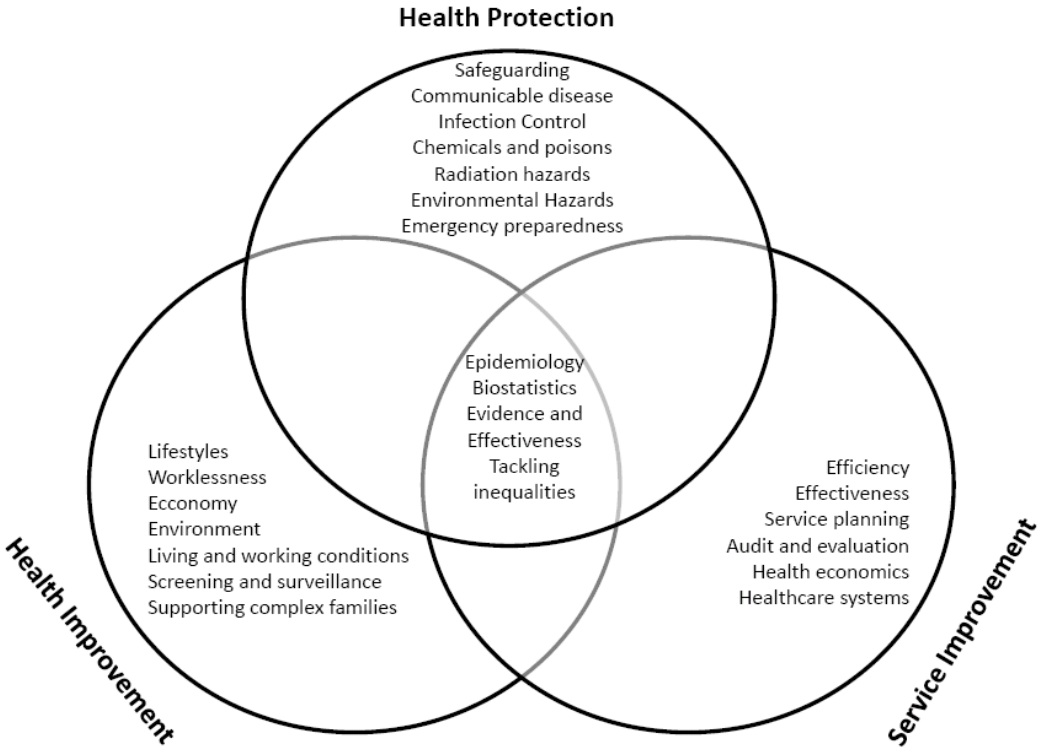
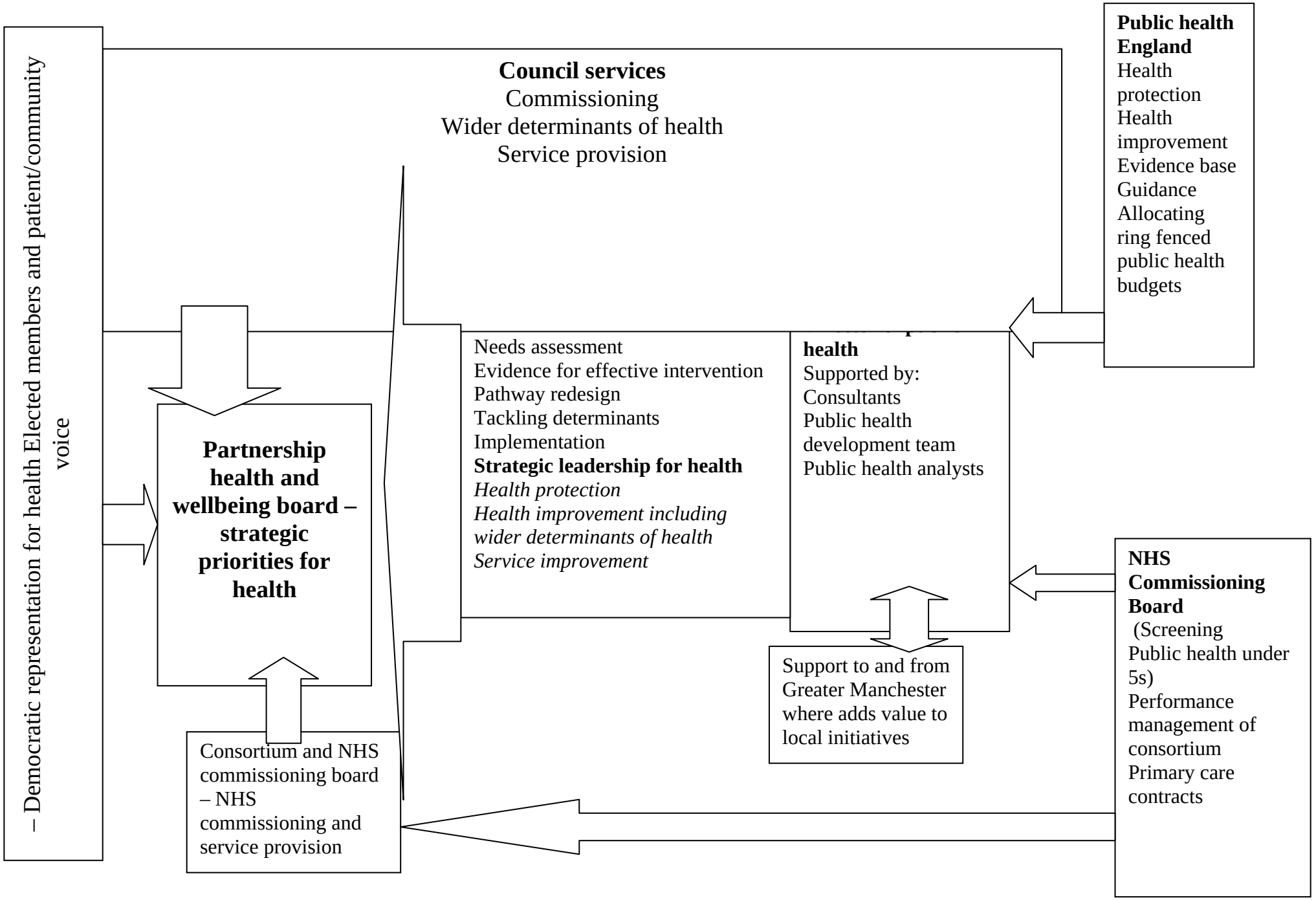


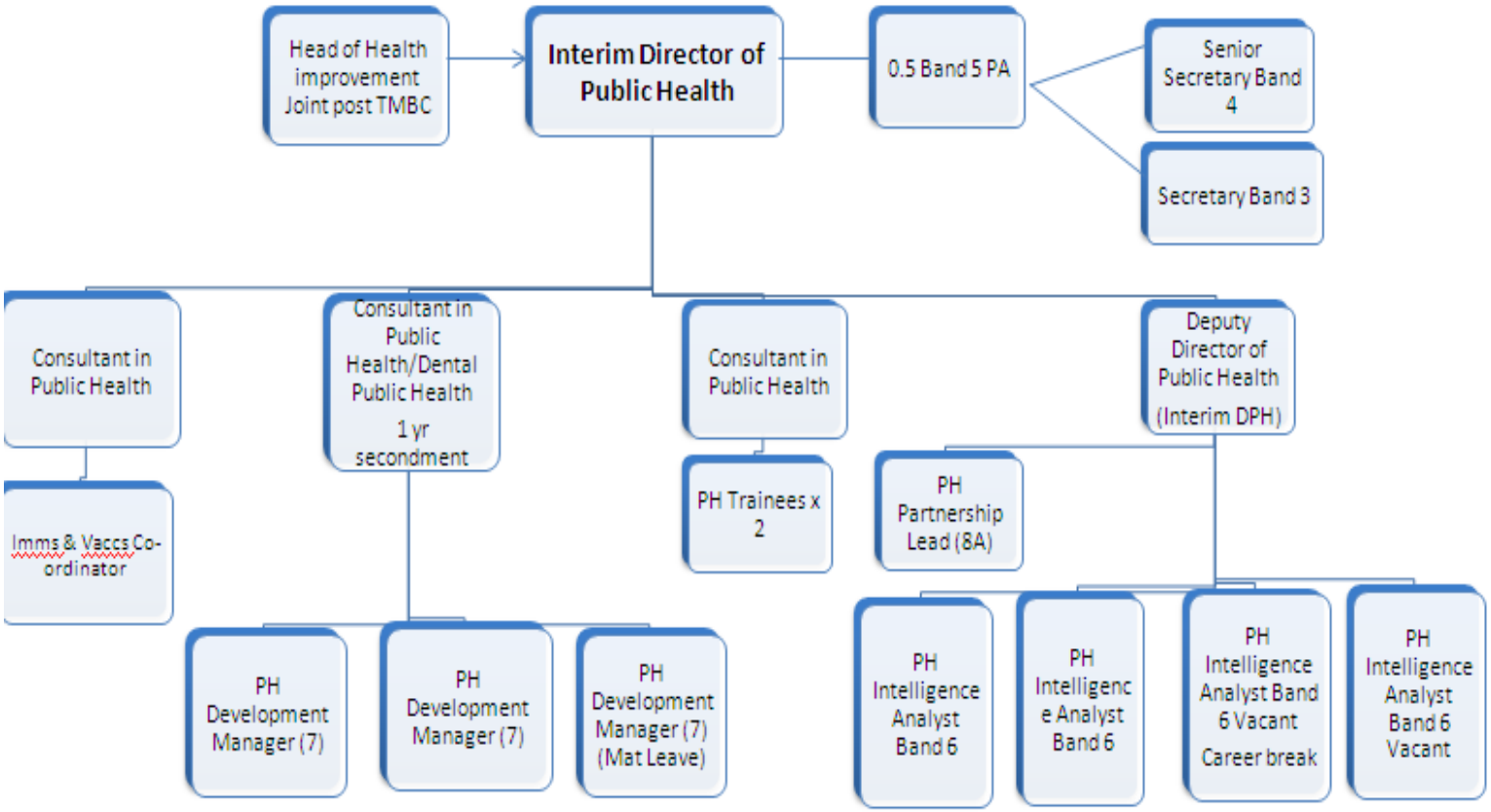
Figure 1: the functions of public health

Figure 2 demonstrates the role of public health in Tameside in supporting the formulation and delivery of strategic priorities for health through supporting the Health and Wellbeing Board, and in working with the Council and Clinical Commissioning Group in supporting commissioning, service improvement and addressing the wider determinants of health.


– Democratic representation for health Elected members and patient/community voice
Council services
Commissioning
Wider determinants of health
Service provision
Public health England
Health protection
Health improvement
Evidence base
Guidance
Allocating ring fenced public health budgets
Partnership health and wellbeing board – strategic priorities for health
Needs assessment
Evidence for effective intervention
Pathway redesign
Tackling determinants
Implementation
Strategic leadership for health
Health protection
Health improvement including wider determinants of health
Service improvement
health
Supported by:
Consultants
Public health development team
Public health analysts
NHS Commissioning Board
(Screening
Public health under 5s)
Performance management of consortium
Primary care contracts
Support to and from Greater Manchester where adds value to local initiatives
Consortium and NHS commissioning board – NHS commissioning and service provision

Appendix 2

PUBLIC HEALTH STRUCTURE



Appendix 3

MAPPING FUNCTIONS

Domain One: Health Protection

a. Blood Born Viruses
b. Emergency planning
c. Infection Prevention & Control
d. Pandemic Flu
e. Public Health On Call
f. Safeguarding
- Children
- Adults
- g. Screening
- Newborn Bloodspot
- Neonatal
- Ante-natal screening
- Diabetic Retinopathy Screening
- Abdominal Aortic Aneurysm
- Cervical
- Breast
- Colorectal

h. Vacc & Imms

Domain Two: Health Improvement

a. Affordable Warmth
b. Alcohol
c. Breastfeeding
d. Building community capacity strategy development
e. Community Safety
f. Dental Public Health
g. Domestic Violence
h. Drugs
i. Falls & Osteoporosis prevention
j. Health & Wellbeing
l. Health trainers
m. Healthy Child Programme
n. Healthy Start
o. Suicide Prevention Strategy
p. Mental Health Promotion
q. Obesity
- NCMP
- MEND

r. Oral Health
s. Physical Activity
t. Sexual Health & Teenage Pregnancy
Tobacco Control/Stop Smoking
Work, worklessness & health
Workplace Health

Domain Three: Health Services

a. Cancer
b. Cardiovascular Disease PPT
c. Chronic Disease Management Advice
d. Maternity services
e. Local quality and Outcomes Framework
f. Practice Mortality profiles

Public Health Intelligence

Public health intelligence support in relation to:
- JSNA, PNA
- Equity audit
- Health Impact Assessment
- Equality Impact Assessment
- Data collection, analysis and interpretation
- Assets assessment
-Epidemiology
- Evidence based research
- Audit & evaluation
- Outcome performance monitoring
- Health Surveys
- Needs assessment

Public Health Leadership, Advocacy, Analysis and Workforce development

- Partnership
- Strategic leadership
- Health advocacy
- Development and training
- Insight, collation and analysis of health data to address health needs
- Consideration of the wider determinants of health, health inequalities and equity
- Training Specialist Registrars