Nottinghamshire County Council

Public Health Committee

Thursday, 30 March 2017 at 14:00

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

AGENDA

1	01_Minutes of the last Meeting held on 1 Dec 2016	3 - 6
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	04_Public Health Mandatory Functions	7 - 22
5	05_Memorandum of Understanding between Public Health and CCGs in Notts	23 - 42
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7	07_Children and Young People's Mental Health and Wellbeing Transformation Plan	63 - 70
8	08_Public Health Contract Management 2016-17	71 - 80
9	09_Public Health Services Performance and Quality Report Q3	81 - 92
10	10_Work Programme	93 - 96

None

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

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

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

Nottinghamshire County Council

minutes

Meeting	PUBLIC HEALTH COMMITTEE
Date	1 December 2016 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

Joyce Bosnjak (Chair)
Glynn Gilfoyle (Vice-Chair)

Reg Adair
Steve Carroll
Mrs K L Cutts MBE
Alice Grice
David Martin
Stuart Wallace
Muriel Weisz

ALSO IN ATTENDANCE

Jo Humphries, Nottinghamshire Women's Aid
Val Lunn, Women's Aid Integrated Services

OFFICERS IN ATTENDANCE

Kate Allen, Public Health
Nathalie Birkett, Public Health
Barbara Brady, Interim Director of Public Health
Paul Davies, Democratic Services
Jonathan Gribbin, Public Health
Kay Massingham, Public Health
Gill Oliver, Public Health
John Tomlinson, Public Health
Helen Scott, Public Health

APOLOGIES FOR ABSENCE

No apologies for absence were received.

MINUTES

The minutes of the meeting held on 29 September 2016 were confirmed and signed by the Chair.

DOMESTIC VIOLENCE AND ABUSE SERVICES – PRESENTATION BY NOTTINGHAMSHIRE WOMEN'S AID AND WOMEN'S AID INTEGRATED SERVICES

Val Lunn and Jo Humphries gave a presentation on services provided since the award of the domestic violence and abuse services contract to their organisations, and answered questions from members.

RESOLVED 2016/031

That the presentation be received.

CHANGES TO THE STRUCTURE OF THE INTEGRATED CHILDREN'S COMMISSIONING HUB

RESOLVED 2016/032

That the following permanent posts be established:

1 fte Public Health and Commissioning Manager, Band D
1 fte Public Health Support Officer, Band B

in place of the deleted posts of 1 fte Strategic Performance and Needs Assessment Manager, Band D and 2 fte Integrated Community Children and Young People's Healthcare Services Programme Managers, Band D.

IMPLICATIONS FOR THE NOTTINGHAMSHIRE SUSTAINABILITY AND TRANSFORMATION PLANS FOR PUBLIC HEALTH

RESOLVED 2016/033

That the Public Health team's contribution to the development of the Sustainability and Transformation Plans and the assumptions made regarding ongoing Public Health funding for Public Health commissioned services, including the return on investment, be noted.

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015-16

RESOLVED 2016/034

That the contents of the report be noted, and the Annual Report be approved for publication.

PUBLIC HEALTH SERVICE PLAN 2016/17 – PROGRESS REPORT

RESOLVED 2016/035

That the update on progress be noted

PUBLIC HEALTH PERFORMANCE AND QUALITY REPORT FOR CONTRACTS FUNDED WITH RING-FENCED HEALTH GRANT, QUARTER 2, 2016/17

RESOLVED 2016/036

That the performance and quality information contained in the report be noted.

NHS HEALTH CHECKS IT SERVICE PROCUREMENT UPDATE

It was agreed to take the decision after consideration of the information in the exempt appendix.

WORK PROGRAMME

RESOLVED 2016/037

That the committee's work programme be noted.

EXCLUSION OF THE PUBLIC

RESOLVED: 2016/038

That the public be excluded from the remainder of the meeting on the grounds that discussions are likely to involve the disclosure of exempt information described in paragraph 3 of the Local Government (Access to Information) (Variation) Order 2006 and the public interest in maintaining the exemption outweighs the public interest in disclosing the information.

EXEMPT INFORMATION ITEM

INTEGRATED HEALTHY CHILD AND PUBLIC HEALTH NURSING PROGRAMME 0-19 YEARS – TENDER OUTCOME

RESOLVED: 2016/039

1) That the progress of the procurement exercise be noted.

2) That the contents of the exempt appendix be noted.

3) That procurement of the NHS Health Check IT Solution be abandoned, and an in-house solution be approved in accordance with the outcomes identified in the exempt appendix.

The meeting closed at 3.55 pm.

CHAIR

Nottinghamshire County Council

Report to the Public Health Committee

30 March 2017

Agenda Item: 4

REPORT OF THE INTERIM DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH MANDATORY FUNCTIONS

Purpose of the Report

1. To provide assurance for the Public Health Committee on fulfilment of mandatory Public Health functions by Nottinghamshire County Council, for noting by the Committee.

Background

2. Public Health transferred to Nottinghamshire County Council (NCC) on 1 April 2013 as part of implementing the Health and Social Care Act 2012. The Act specified a number of mandatory functions for Public Health which became the Council's responsibility. The Council also received a ring fenced allocation of Public Health grant, to support these mandatory functions along with other activities at the Council's discretion which would lead to Public Health outcomes. The ring fenced grant was expected to continue until 2018; however a recent announcement has identified that the ring fence will remain in place until 31 March 2019.

3. The grant conditions specify that grant must be used only for meeting eligible expenditure incurred or to be incurred by local authorities for the purposes of their public health functions as specified in Section 73B(2) of the National Health Service Act 2006 ("the 2006 Act"). The conditions also state that the local authority must
   - "have regard to the need to reduce inequalities between the people in its area with respect to the benefits that they can obtain from that part of the health service provided in exercise of the functions referred to in paragraph 3;
   - "have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services."

4. With regard to the use of Public Health grant for other functions of the local authority, the conditions state that "the authority must be of opinion that those functions have a significant effect on public health or have a significant effect on, or in connection with, the exercise of the functions described in paragraph 3; and the authority must be satisfied that, having regard to the contribution from the public health grant, the total expenditure to be met from the fund and the public health benefit to be derived from the use of the fund, the arrangements provide value for money."

5. The conditions provide for the Secretary of State to be able to require a further external validation to be carried out by an appropriately qualified independent accountant or auditor.

6. The Council fulfils the conditions above by completing annual returns to the Department of Health confirming that the Public Health grant has been used for the purposes specified. These returns are signed by the Director of Public Health and the Council's S151 Officer. The Public Health Committee of the Council additionally receives reports on the use of Public Health grant.

Information and Advice

7. Appendix 1 sets out in detail the mandatory functions specified in the Health and Social Care Act or added as a result of subsequent legislation, and identifies how these functions are being delivered at Nottinghamshire County Council. A brief summary is given in paragraphs 8-12 below. Discharging these duties depends on both County Council workforce and budget to commission services and the partnership working and wider integration of Public Health approaches across the County Council and the local health and care system.

8. The Director of Public Health statutory role is enshrined in the job description for the post of Director of Public Health (DPH) at Nottinghamshire County Council. The role is identified as including independent advocacy for the health of the population and as part of delivering this, the DPH produces an independent annual report. Benefits of this arrangement include: compliance with the statutory requirements; continuation of sustained Public Health leadership; and visibility within the wider health system.

9. The Health Improvement duty is delivered through a mix of commissioned services, partnership working, and staffing. The Public Health intelligence function is a significant element in this piece of work, as the production of the annual Joint Strategic Needs Assessment (JSNA) is of paramount importance in identifying where health improvements need to be made.

10. Health Protection duties are contained in the Director of Public Health job description, with delegation of specific responsibility for health protection to a named Public Health consultant, whose portfolio includes support for Public Health England (PHE) in the management of incidents and emergencies, oversight role for health protection strategy group, and health emergency planning. This Consultant is the principal link within Public Health to the emergency planning section of Nottinghamshire County Council. Additional resources are assigned at Senior Public Health and Commissioning Manager (equivalent of Group Manager) level to provide policy leadership on community infection prevention and control. Partnership working on this topic includes (amongst others) work with Public Health England, NHS England, and district councils.

11. Advice to Clinical Commissioning Groups (CCGs) is a responsibility of all of the Public Health Consultants. The Director of Public Health has overall responsibility for ensuring Public Health leadership, input and support for all CCGs across Nottinghamshire and attends the Clinical Congress meeting of the Chief Officers of all the Notts CCGs. Each of the Consultants has one or more CCGs identified for which they provide individual public health leadership and support. Consultants also attend relevant strategic management meetings of their assigned CCGs. Consultants may identify support at Senior Public Health and Commissioning Manager level for particular items of work. The Public Health intelligence function also forms part of this mandatory function, as the Public Health advice is intended to ensure that NHS commissioned services take account of health needs of the population, as identified in the JSNA.

12. Other mandatory functions, such as the National Child Measurement Programme, the NHS Health Checks programme and the sexual health service, are contained within the specifications for individual Public Health commissioned services. All of these are reported on regularly to Public Health Committee via the quarterly performance and quality reports on Public Health Commissioned Services (recently expanded to include activities funded with realigned Public Health grant). Part of the Public Health staffing establishment is focused on performance and contract management of the commissioned services, to ensure that budget control is maintained and quality of services is assured.

Other Options Considered

13. This report has been brought for information. No other options are required.

Reason for Recommendation

14. The Public Health Committee has responsibility for overseeing the Public Health grant, so that it is used for the purposes for which it was provided, including all of the specified mandatory functions.

Statutory and Policy Implications

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

Financial Implications

16. The activities described in this report are funded out of the £43.26m 2016/17 Public Health grant allocation to Nottinghamshire County Council. The staffing element within that budget is £2.388m in 2016/17.

RECOMMENDATION

That the committee

a) Notes the arrangements to ensure the mandatory Public Health functions are fulfilled by the County Council

Barbara Brady
Interim Director of Public Health

For any enquiries about this report please contact:
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Public Health Executive Officer
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Constitutional Comments (SLB 02/03/2017)
Public Health Committee is the appropriate body to consider the content of this report.

Financial Comments (DG 08/03/2017)

The financial implications are contained within paragraph 16 of this report.

Background Papers and Published Documents

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

Report to Public Health Committee 12 May 2015, Public Health Finance Plan 2015/16

Report to Public Health Committee 21 January 2016, Public Health Grant Realignment 2015/16 Progress Report

Electoral Divisions and Members Affected

- All

Annex 1
Audit of Compliance with Public Health Statutory Requirements

Conditions and mandatory functions	Basis in legislation	NCC activity to comply with functions	Assurance by Council
Statutory functions of the Director of Public Health (DPH)			
The DPH is a chief officer of their authority and the principal adviser on all health matters to elected members and officers, with a leadership role spanning all three domains of public health: health improvement, health protection and healthcare public health.	Section 73A(1) of the NHS Act 2006, inserted by section 30 of the Health and Social Care Act 2012	Employment of Director of Public Health within new PH structure. The post is managerially accountable to the Chief Executive, although it reports on a day to day basis to the Director of Adult Social Care, Health and Public Protection and Deputy Chief Executive. The post also is identified as a member of the corporate leadership team. The job description complies with national requirements and is approved by the Faculty of Public Health. DPH post has been continually filled since transfer in 2013. An interim acting-up arrangement is currently in place to ensure that the post is not left vacant. Deputising arrangements are set up whenever the DPH is absent.	The Director of Public Health post is appointed to by the Senior Staffing Sub-Committee. The Director of Public Health has an annual job plan via the EPDR process that is agreed with the Corporate Director of ASCH&PP and the Chief Executive.
Independent advocate for the health of the population and for system leadership for its improvement and protection. As such, in England this is a statutory role within local authorities with close links to the	As above	Status of the DPH as Chief Officer within the Council and input into corporate decision-making. The post is also a member of the Nottinghamshire Health and Wellbeing Board.	The Nottinghamshire HWB is chaired by the Chair of the Public Health Committee. The 2016 DPH annual

NHS and PHE. The DPH is a Chief Officer and pre-eminent advisor on health and wellbeing to the LA.		DPH is a member of the Notts Clinical Congress group of CCGs. Production of independent annual report.	report was received and approved for publication by Public Health Committee in December 2016.
All of their local authority's duties to take steps to improve public health. Any of the Secretary of State's public health protection or health improvement functions that s/he delegates to local authorities, either by arrangement or under regulations.	Section 6C of the 2006 Act, inserted by Section 18 of the 2012 Act	The DPH job description incorporates these responsibilities. Responsibility is delegated for delivery by members of the Public Health team.	The DPH agrees portfolios of responsibility and annual job plans with the Consultants in Public Health (Service Director equivalence within the Council).
Planning for and responding to health emergencies; exercising their local authority's functions in planning for, and responding to, emergencies that present a risk to public health	Section 73A(1) of the NHS Act 2006, inserted by section 30 of the Health and Social Care Act 2012	The DPH job description incorporates this responsibility. Part of the responsibility is delegated to an identified Public Health Consultant. Public Health works closely with Public Protection / Emergency Planning in carrying out this responsibility.	Responsibility is linked into the Council's risk and emergency management reporting structures and through this, to Policy Committee.
Their local authority's role in co-operating with the police, the probation service and the prison service to assess the risks posed by violent or sexual offenders	As above	Public Health is the local commissioner of domestic violence and abuse services and has an identified policy lead to work on this agenda. The DPH is a member of the Safer Notts Board.	Public Health Committee receives performance information on the DVA contract as part of quality and performance reporting.
Such other public health functions as the Secretary of State specifies in regulations	As above	Provision for additional functions is written into the Nottinghamshire DPH job description.	The DPH Job Description is subject to internal Council

			approval processes as well as externally approved by the Faculty of Public Health.
Health improvement duty			
Carrying out research into health improvement, provide information and advice (for example giving information to the public about healthy eating and exercise)	Section 12 of the 2012 Act introduced a new duty at Section 2B of the 2006 Act for all upper-tier and unitary local authorities in England to take appropriate steps to improve the health of the people who live in their areas	Public Health intelligence function. Development of JSNA. Construction of specifications for commissioned Public Health services are based on results of intelligence research. The commissioning cycle is evidence-based; proposed interventions are designed to address the identified needs.	Public Health Committee receives reports on individual specification proposals for input and approval.
Providing facilities for the prevention or treatment of illness (such as smoking cessation clinics)	As above	Commissioned services in a number of policy areas contain clinical elements to prevent or treat illness. Examples are: • Substance misuse • Tobacco control • Obesity and weight management	Performance reporting on commissioned services to Public Health Committee.
Provide assistance to help individuals minimise risk to health arising from accommodation or environment	As above	Healthy Housing contract; development of close working protocols with planners; Health Impact Assessments and input into planning process	Activity is delivered in partnership, with engagement of the Nottinghamshire HWB.

			Relevant elements are contained within the performance reporting on commissioned services to Public Health Committee
Mandated Functions Defined in part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013			
Weighing and measurement of children at Reception (age 4-5) and Year 6 (age 10-11) Parental involvement – gaining consent to carry out the measurements Submission of data to Health and Social Care Information Centre	Regulation 3 within Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013	NCMP - forms part of the 0-19 Healthy Child Programme (children's public health services) contract. The specification includes all the requirements of the mandated function.	Performance reporting on commissioned services to Committee as described above.
NHS Health Checks: To provide, or secure the provision of, health checks to be offered to eligible persons in its area and ensure that all eligible persons are offered an NHS Health Check every 5 years and in accordance to the specified content detailed within the Regulations. LAs are required to make an offer to all eligible persons, but a proportionate universalism approach is supported. This means that local authorities are free to target a	Regulations 4 and 5 within Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013	Direct award to GPs for provision of Health Checks; IT support procured separately. The specifications include all the requirements of the mandated function. Annual budget 2016/17 £859K.	Performance reporting on commissioned services to Committee as described above. Committee has also received additional update presentations on performance, most recently on 17 March 2016.

greater extent of their resource towards higher risk and vulnerable communities, whilst keeping a universal offer to all eligible persons.			
Open access sexual health services The mandated function requires each local authority to provide, or secure the provision of, open access sexual health services in its area including: preventing the spread of sexually transmitted infections (STIs); treating, testing and caring for people with STIs and partner notification. Local authorities should provide contraceptive services including advice on, and reasonable access to, a broad range of contraceptive substances and appliances; advice on preventing unintended pregnancy. Local authorities do not need to provide sterilisation or vasectomy services other than the giving of preliminary advice on availability and as an appropriate method of contraception for the person concerned.	Regulation 6 within Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013	Integrated Sexual Health Services Contract – specification includes open access services covering both contraceptive services and STI treatment in line with regulations. Approach to out-of-area GUM provision – payment for out of area provision on supply of backing data confirming home address postcode within Nottinghamshire; standard operating procedure in place. Annual budget 2016/17 £6.2m	Committee receives regular updates on the sexual health contract as part of the quarterly quality and performance in commissioned services report. On 14 July 2016, Committee received a report on quality assurance in commissioned services which gave examples related to the provision of sexual health services.

Local authorities are not required to offer services for treating or caring for people infected with Human Immunodeficiency Virus.			
Public health advice to CCGs There is a statutory duty on upper tier and unitary local authorities to give NHS commissioning a population focus to make maximum impact on population health. This is described in regulations as: "each local authority shall provide or shall make arrangements to secure provision of a public health advice service to any CCG whose area falls wholly or partly within the authority's area and further, that the service consists of provision of such information and advice to a CCG as the LA considers necessary or appropriate with a view to protecting or improving the health of people in the LA's area." The local authority Public Health advice service is intended to support CCGs in carrying out their duty and it is specified that this service should be free of charge. The regulations also make it clear that the provision of the public health advice service	Regulation 7 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 in exercise of powers conferred in Sections 6C (1) to (3) of the NHS Act 2006 (as amended by the HSC Act 2012). These duties are further described in DH Guidance "Healthcare Public Health Advice Service to CCGs" issued in June 2012. In addition the Act gives each CCG a duty to obtain	Delivered through the Public Health staff team, including includes provision of intelligence and analysis through the Public Health information team, production of the JSNA, contributions to STP advice, representation on the CCG Boards which plan health service delivery. Public Health staff have assigned responsibilities – PH consultants each have one or more identified CCGs for which they provide Public Health leadership, advice and support. The Public Health intelligence function provides additional support through the provision of intelligence and research to support decision-making in the CCGs, to ensure that services are based on demographic need. There is a Memorandum of Understanding between the Council and the CCGs. This was originally agreed for 2013-2016 and then reviewed during 2016. The revised version sets out the	The most recent MoU with CCGs is being brought to Committee seeking approval in March 2017.

should: • have regard to the CCG's needs • be agreed between the LA and the CCG; and • be kept under review	advice appropriate for enabling it effectively to discharge its functions from persons who (taken together) have a broad range of professional expertise in: a) the prevention, diagnosis and treatment of illness; and b) the protection or improvement of public health	service to be provided up to 31 December 2020. This meets the requirement for the provision of public health advice to have regard to the CCGs' needs, be agreed between the LA and CCG(s), and be kept under review. Initial guidance stated that the provision of advice to CCGs was expected to account for 40% of staff time. Further guidance (citation needed) proposes 'a rough coverage' of 1 whole time equivalent accredited specialist (i.e. Consultant) per 270,000 people. Within Nottinghamshire, this would equate to 3 FTE Consultants.	
Protecting the health of the local population Covers the provision of information and advice to relevant parties within the area in order to promote the preparation of, or participation in, health protection arrangements against threats to the health of the local population	Regulation 8 within Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013	CIPC service through Section 75 agreement with CCGs. Small contract £81K with NHS for community infection and prevention control service until March 2017, after which the activity will become the responsibility of the NHS. Public Health staff assignment as health protection policy lead. PH staff time and engagement with partnership arrangements, links to emergency planning.	PH Committee approved the S75 arrangement on 26 November 2014. Responsibility is linked into the Council's risk and emergency management reporting structures and through this, to Policy Committee.
Oral health Local authorities are statutorily	Amendment to Water Industry Act	Water fluoridation Oral health promotion programmes	Committee receives regular updates on

required to provide or commission oral health promotion programmes to improve the health of the local population, to an extent that they consider appropriate in their areas. They are also required to provide or commission oral health surveys. The oral health surveys are carried out as part of the Public Health England (PHE) dental public health intelligence programme (formerly known as the national dental epidemiology programme).	1991 by the Health and Social Care Act 2012	through contract Assess or secure the provision of oral health surveys to assess and monitor oral health needs: funding for this activity is still with NHS England and so since 2014, NHS England have been undertaking this work. Discussions are underway about the future.	contract performance as part of the quarterly quality and performance in commissioned services report.
Non mandated "conditions of public health grant"			
Have regard to need to improve take up and outcomes of drug and alcohol misuse treatment services	Health and Social Care Act 2012. New condition in 2015/16 public health grant announcement. Core expectation of the government's Drug Strategy	Substance Misuse Contract – recovery focus. Performance monitoring of contract takes into account requirements.	Committee receives regular updates as part of the quarterly quality and performance in commissioned services report.
Children and Young People's 0-19 services	Transfer of 0-5 Health Child Programme commissioning responsibility from NHS England on 1 October 2015	Children's public health nursing and Healthy Child Programme contract	As above.
Requirement to commission 5 universal health visitor reviews to at least the level provided at point of	Transfer of 0-5 Healthy Child Programme	Contained in specification for recommissioned 0-19 Healthy Child Programme	As above.

transfer – for 18 months following 1 Oct 2015	commissioning responsibility from NHS England on 1 October 2015		

Nottinghamshire County Council

Report to Public Health Committee

30 March 2017

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

THE MEMORANDUM OF UNDERSTANDING BETWEEN NOTTS COUNTY COUNCIL PUBLIC HEALTH AND THE CLINICAL COMMISSIONING GROUPS IN NOTTINGHAMSHIRE

Purpose of the Report

1. To seek agreement to the proposed Memorandum of Understanding (MoU) 2017-2020 between Public Health in Nottinghamshire County Council and the local Clinical Commissioning Groups (CCGs).

Background

2. As a result of the Health & Social Care Act 2012, the responsibility for some aspects of Public Health transferred from the NHS to the Local Authority. The Health and Social Care Act set out a number of Public Health functions which were defined as mandatory, one of which was to ensure that CCGs receive Public Health advice. This provision is sometimes referred to as the core offer.

3. Local authorities have a duty to provide specialist Public Health expertise and advice to NHS commissioners to support them in delivering their objectives to improve the health of their population. This service is to be funded from the Public Health budget allocated to local authorities at no cost to CCGs.

Information and Advice

4. A Memorandum of Understanding (MoU) has been in place to cover the period 2013-2016.

5. The proposed new MoU will cover 2017 -2020 and is attached at Appendix 1. It is based on the previous version with updates to reflect changes such as the development of the Sustainability and Transformation Plans (STPs).

6. The previous MoU was approved by Public Health Committee on 16 April 2013. The previous MoU was developed in partnership with the CCGs and the NHS Commissioning Board.

7. Main changes are as follows:

    a. General – the document was simplified by amalgamating where possible to reduce duplication.

b. Principles - References to cross-charging and to agreement of additional investment have been removed, and a reference added to Sustainability and Transformation Plans which are new since the last MoU was agreed.
c. Table 1 – Strategy. Updates were made to reflect the current operating environment, referencing the Sustainability and Transformation Plan and the current Health and Wellbeing Board structures.
d. Table 2 – Health Improvement. Updates were made to reflect changed working arrangements around quality assurance and clinical governance.
e. Table 3 – Health Protection. This table has been changed to reflect the fact that Community Infection Prevention and Control services are now delivered by agreement by the CCGs. Updates were also made to reflect the current operating arrangements with regard to sexual health services and health protection functions.
f. Table 4 – Population Healthcare. This table has been consolidated to remove duplication. An additional line has been added to reference engagement with spatial planning.
g. Table 5 – Locally Agreed Elements. This table was removed in favour of a single, standard MoU for agreement with all CCGs. A reference is included to Section 256 agreements which exist outside of the MoU for delivery of separate children's services.
h. Dispute resolution appendix – this section is practically unchanged.

8. The CCGs have been consulted on the proposed MoU via the Clinical Congress of all Nottinghamshire CCGs and through direct consultation with the Chief Operating Officer of Bassetlaw CCG. The CCGs will use their own, individual governance processes to secure final endorsement from their individual governing bodies.

9. Public Health capacity within NCC has reduced since 2013, however it remains important that the core offer of Public Health advice to CCGs is maintained. Guidance[1] identifies 'a rough coverage' of 1 whole time equivalent accredited specialist per 270,000 or so people to provide this function. Applying the 'rough coverage' of 270,000/1wte to the Nottinghamshire population of 805,800 would mean 3 accredited specialist Public Health staff specifically for this core offer.

10. The majority of the Public Health advice to the CCGs is largely invisible to members of the Committee. In view of that, the following is intended to provide some examples of the support provided since 2013. Examples are presented under four categories: strategy, health protection, health improvement and population health care.

11. Strategy:

a. Support for the development of both STPs. (Information has already been provided to the Public Health committee on this particular aspect of work at its December 2016 meeting).
b. Director of Public Health Annual report 2015 and 2016.
c. Joint Strategic Needs Assessment program of work including refreshing chapters e.g. Diet, Physical Activity, and mental illness.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216835/Healthcare-Public-Health-Advice-Service-Guidance-FINAL.pdf

12. Health Protection:

a. Public Health commissioned services are required to demonstrate adherence to best practice regarding blood borne viruses.
b. Public Health commissions community based Infection Prevention Control service in conjunction with Nottinghamshire CCGs
c. Leadership of the sexual health framework which includes issues such as tackling sexually transmitted infections

13. Health Improvement

d. Leadership for policy areas such as Tobacco which supports work to reduce smoking at time of delivery, a CCG performance measure.
e. Work with primary care to maximise their contribution to disease prevention – for example by taking every opportunity to address smoking, alcohol, obesity in their patients

14. Population Health Care

a. Input to CCG service reviews
b. Provision of Public Health information and modelling to support CCG initiatives, such as the revision of the Musculoskeletal pathway (related to muscle or joint problems)
c. Each of the Consultants in PH supports one or more of the CCGs, proving professional advice and guidance to clinical forums and or the governing body as appropriate
d. Appraise the evidence and provide support to appropriately respond to individual funding requests

Other Options Considered

15. Provision of public health advice by the County Council to CCGs is a statutory requirement as contained in the Health and Social Care Act. The option proposed is to maintain the statutory requirement at the level specified.

Reason for Recommendation

16. The Public Health Committee is responsible for the Public Health function and for ensuring that Public Health grant is used for the purposes specified.

Statutory and Policy Implications

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

Financial Implications

18. The costs of providing Public Health advice to CCGs, in line with the requirements of the Health and Social Care Act 2012, are contained within the Public Health staffing budget.

Recommendations

Members of the Public Health Committee are asked to:

1) Agree the Memorandum of Understanding (2017-2020) between Public Health in Nottinghamshire County Council and the Clinical Commissioning Groups covering Nottinghamshire.

Barbara Brady
Interim Director of Public Health

For any enquiries about this report please contact:
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Director of Public Health,
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Constitutional Comments (SLB 21/02/2017)

Public Health Committee is the appropriate body to consider the content of this report.

Financial Comments (DG 08/03/2017)

The financial implications are contained within paragraph 18 of the report.

Background Papers and Published Documents

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

Report to Public Health Committee, 16 April 2013, Memorandum of Understanding for Public Health Advice to Nottinghamshire County Clinical Commissioning Groups

Memorandum of Understanding for Public Health Advice to Nottinghamshire County Clinical Commissioning Groups 2013-2016

Nottinghamshire County Council

THE CORE OFFER FOR PUBLIC HEALTH ADVICE TO CLINICAL COMMISSIONERS

MEMORANDUM OF UNDERSTANDING

BETWEEN

CLINICAL COMMISSIONING GROUPS AND

NOTTINGHAMSHIRE COUNTY COUNCIL

2017 - 2020

VERSION CONTROL

Author	Creation Date	Version	Status
Barbara Brady	5.09.2016	1.0	Draft
Changed by	**Revision Date**		
Kay Massingham	12.10.2016	1.1	Draft
Kay Massingham	25.10.2016	1.2	Draft
Kay Massingham	9.02.2017	2.0	Final

This document is based on the previous MOU 2013-16

Purpose of the Memorandum of Understanding (MoU)

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

2. The MoU shows the full range of interdependencies with other statutory commissioners in the local health and wellbeing system. Actions are identified in the document for other agencies such as NHS England, but this is to provide brief information on how the organisations interface rather than to be a definitive list of all actions undertaken by other partners.

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

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

Context and rationale

5. From April 2013 PH responsibility transferred to the Local Authority or Public Health England (PHE) www.dh.gov.uk/health/2012/06/act-explained. One of the mandatory responsibilities of the Local Authorities is to ensure that CCGs receive the public health advice they need (**the core offer**).

Principles

6. A number of principles have been agreed between the CCGs and PH. These are:
    - Putting the needs of patients and citizens first;
    - Public and citizen involvement in decision making;
    - Sharing of risks and benefits in order to secure improvement in outcomes for our local population;
    - Mutually supportive;
    - Open and transparent, sharing information and committing to 'no surprises';
    - Clear accountability and governance arrangements;
    - Joint working to ensure delivery against Health and Wellbeing priorities and our Sustainability and Transformation Plans (Nottinghamshire and Bassetlaw /South Yorkshire)

Diagram A

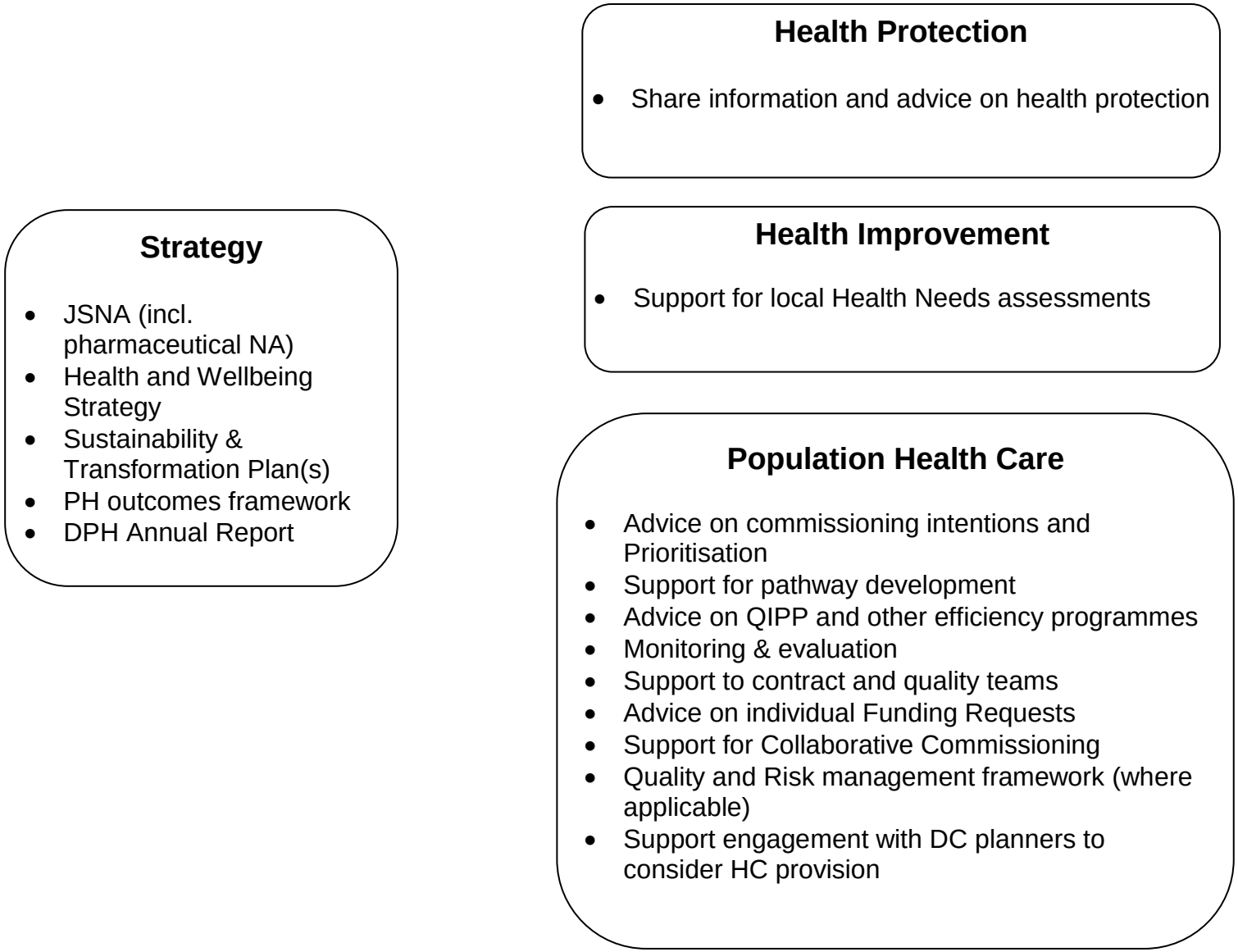
Health Protection
Share information and advice on health protection
Strategy
JSNA (incl. pharmaceutical NA)
Health and Wellbeing Strategy
Sustainability & Transformation Plan(s)
PH outcomes framework
DPH Annual Report
Health Improvement
Support for local Health Needs assessments
Population Health Care
Advice on commissioning intentions and Prioritisation
Support for pathway development
Advice on QIPP and other efficiency programmes
Monitoring & evaluation
Support to contract and quality teams
Advice on individual Funding Requests
Support for Collaborative Commissioning
Quality and Risk management framework (where applicable)
Support engagement with DC planners to consider HC provision

Table 1: Strategy

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
Director of Public Health (DPH) with a multi-disciplinary expert team of Consultants in Public Health and Public Health Managers including experts in knowledge and information	Lead the co-ordination, collaboration and production of the **JSNA** based on provision of timely, robust evidenced based information and actionable intelligence, gathered from across the health and social care community.	Contribute data, information and capacity to the production of the JSNA. Active participation in the JSNA Steering Group and its work programme.	Share relevant information including that not available through current information systems. Commissioning plans aligned to JSNA. Lead elements of JSNA as appropriate.	Contribute data, information and capacity to the production of the JSNA. Active participation in the JSNA Steering Group and its work programme.
	Support the development of the **Health and Wellbeing Strategy (HWS)** informed by the JSNA Produce and lead action plans as appropriate that target deprived areas and inequalities as appropriate.	Executive level and public/patient contribution to developing the strategy Commissioning plans directly relate to JSNA and HWS, targeting inequalities and pockets of deprivation. Lead elements of HWS as appropriate.	Executive level and public/patient contribution to the strategy	Lead elements of the HWS as appropriate.

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
	Support the development of the **Sustainability and Transformation Plans (STP)** to ensure that they are needs led and reflect evidence of cost effectiveness and good practice	To work as part of a wider Health and wellbeing system to secure a sustainable solution for our local citizens	Executive level and public/patient contribution to the STP	
DPH and consultant team	The **DPH Annual (independent) report** will vary dependent on national and local topical issues.	Contribute to report where necessary and support the implementation of recommendations of the report.		
Appropriately trained and qualified PH workforce	Provide evidence that all PH staff meet the national and statutory training and qualification requirements Continue to be a training location for SpRs in PH (and other specialties on request) and FY2 doctors. Develop annual Training Network Report for Health Education East Midlands (HEEM) and respond to any HEEM quality visit recommendations. Involvement in Clinical Governance Structures of CCGs where required as appropriate. Delivery of departmental learning and development to meet future workforce competency assurance. E.g. revalidation of PH professionals and professional appraisal in accordance with national requirements.	Support statutory professional appraisal and revalidation arrangements as appropriate		Support statutory professional appraisal and revalidation arrangements

Table 2: Health Improvement

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
PH consultant leads with support from PH managers	Develop and refresh **plans for each PH policy area** to reduce inequalities and promote equality Present reports to the governance groups of the STP and HW Board as requested to provide **assurance against delivery and performance targets**	Provide a named lead and/or lead CCG for each policy area Support locally driven public health campaigns Provide input, support and critical review of progress	Develop commissioning and delivery plans that directly relate to local strategic plans	Align wider determinants of health to Health & Wellbeing Strategy (HWS) and implement the policy in relation to employed staff and commissioned services with respect to tier 1 and tier 2 responsibilities e.g. housing
PH consultant leads with support from PH managers and contract and Performance Team	Lead the **commissioning of services** for which PH are the responsible commissioner ensuring appropriate delivery systems in order to integrate into the wider system Ensure that CCGs receive timely, good quality information about GP referrals to core prevention services and their outcomes	Contribute to commissioning process where appropriate (eg service reviews, consultation process, feedback on progress with new services)(remove) Ensure timely feedback to PH re-emerging issues. Support development of programmes and increase uptake of prevention activity including commissioned services and within the workforce across the wider system. Encourage GPs to signpost and refer to core prevention services	Support development of programmes and increase uptake of prevention activity including commissioned services within the workforce across the wider system.	Contribute to commissioning process where appropriate (eg service reviews, consultation process, feedback on progress with new services) Ensure timely feedback to PH re-emerging issues. Support development of programmes and increase uptake of prevention activity including commissioned services and within the workforce.

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
PH consultant leads with support from PH managers, quality lead and contract and Performance Team DPH or nominated deputy member of the Quality Surveillance Group	**Share data from monitoring** of PH commissioned activity with relevant commissioners and local partners. Ensure relevant **quality and safety policies** and processes are consistent with guidance and best practice as issued by PHE, NHSE and Care Quality Commission (for example serious incident management guidance, safeguarding guidance etc.) Member of QSG. Regular **performance and risk reporting, including specific incident reports** to the Public Health Clinical Governance Panel with upward reporting to LA committees, NCC Risk Safety and Emergency Management Board, and Quality Surveillance Group as appropriate	Quality leads share information and learning as appropriate. Provide input, support and critical review of progress Ensure timely feedback to PH re any emerging issues Member of QSG	Quality reports at local level shared with PH Access and oversight of Serious Incident Management (STEIS). Information shared with PH as appropriate. Professional leadership across the system Lead the QSG	Share local information to drive up quality Member of the QSG

Table 3: Health protection

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
PH consultant leads for substance misuse and sexual health	Where PH are the responsible commissioner, ensuring effective interventions for high risk areas/groups e.g. Sexually transmitted infections and Blood Borne Viruses	Commissioning plans reflect PH requirements	Commissioning plans and promotion of best practice across the workforce and in care settings	Promotion of best practice
PH consultant lead for sexual health	Lead the development and implementation of a sexual health framework for action across the local health economy. Where PH are the responsible commissioner, ensuring effective interventions for high risk areas/groups	Commissioning plans reflect PH requirements Active participation in the Sexual Health Strategic Advisory Group (via County HWB sexual health champion)	Commissioning plans and promotion of best practice across the workforce and in care settings Active participation in the Sexual Health Strategic Advisory Group (via County HWB sexual health champion)	Promotion of best practice
PH consultant lead for community Infection control of HCAI	Lead the development and implementation of arrangements to address community infection control needs	Lead and facilitate the Notts IC Stakeholder group	Commissioning plans and promotion of best practice	Commissioning plans and promotion of best practice across the workforce and in care settings
PH consultant lead for health protection	Ensure that the local population and health and social care system has adequate arrangements for protecting the health of the population and that individuals and organisations have timely access to expert advice (Aspects of this are provided to the DPH via PHE)	Active participation in the LHRP and the Health Protection Strategy Group	Active participation in the LHRP and the Health Protection Strategy Group	Active participation in the LHRP and the Health Protection Strategy Group

Table 4: Population Healthcare

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
Designated PH consultant **per CCG**	Support CCG committees and structures (to be determined locally) in order to provide advice on commissioning intentions and prioritisation	Develop and implement Commissioning plans and promotion of best practice in line with HWS.	Provide strategic oversight of the commissioning system across Derbys/Notts and South Yorkshire in line with local HWS.	Develop and commission services in partnership to meet the objectives of the Council and HWS
Designated PH consultant lead on each **priority area** supported by PH information and intelligence Support systems including the licence for Scenario Generator.	Advice on pathways, service specifications and action plans for delivery using evidence based intelligence e.g. NICE, Support QIPP and other efficiency programmes by analysing information and the evidence base Contribute to development of clinical case for change Produce predicative modelling and case for change evidence Produce Health Equity Audits	Develop and implement Commissioning plans and promotion of best practice in line with HWS.	Lead the Strategic Commissioning Collaboration, providing oversight to the system. Sharing best practice for quality Aligning commissioning for QIPP and other efficiencies across large geographical areas	Where appropriate lead integrated commissioning groups with membership from across the health and social care community Share developments and agree joint pathways for commissioning in line with the HWS. Lead partnerships with other LAs to maximise quality and value for money commissioning Implement local plans (tier 2)

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
Designated PH consultant for **collaborative commissioning** function	Support Collaborative commissioning working across Nottinghamshire	Commissioning plans and promotion of best practice	Provide strategic oversight of the commissioning system across Derbys/Notts and South Yorkshire	Develop and commission services in partnership to meet the objectives of the Council and HWS
PH consultant membership of contracting team	Lead/assist prioritisation plans to inform commissioning Provide consultant input into prioritisation panels	Lead prioritisation and commissioning intentions process Validate prioritisation plans for commissioning Produce commissioning intentions based on prioritisation	Produce commissioning intentions based on prioritisation	Produce commissioning intentions and implementation plans
PH consultant lead for Individual Funding Request (IFR) group	Provide specialist technical and PH support and evidenced based reports to the IFR process to CCGs	Manage and lead the local IFR process Produce and implement the outcomes of the IFR process	Lead/support IFR process based on PH evidence base Implement outcomes	Use information from IFR process as 'lessons learned' and application to NHS Share learning and processes
PH consultant lead on all policy and priority areas supported by specialist team including PH information and intelligence	Share plans and commission for PH areas identifying possible impact on other parts of the system Provide and share performance and quality monitoring against the mandatory functions and local targets Produce reports showing the evidence for change	Provide named leads for PH commissioning areas where appropriate Agree commissioning plans	Agree commissioning plans	Provide commissioning support and scrutiny against delivery

PH inputs	Local Authority Public Health offer and accountability	CCG actions and accountability	Actions NHSE	Actions LA tier 1 & 2 (County and Districts)
PH consultant lead on planning including PH information and intelligence	Develop an engagement protocol between planners, CCG's, healthcare providers and public health so that healthcare infrastructure is considered in major developments.	Provide named leads for planning	Provide named leads as appropriate	Healthcare provision is considered and planned for during the planning process.

Note: For locally agreed children's services, there are separate S256 agreements with five of the CCGs already signed up to for 2016/17 and no funding arrangement with Bassetlaw CCG, so this arrangement sits outside the MOU.

Appendix 1

DISPUTE RESOLUTION PROCEDURE

1. NEGOTIATION

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

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

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

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

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

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

2. MEDIATION

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

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

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

3. EXPERT DETERMINATION

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

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

3.3 Where the Parties have not agreed upon an expert, or where that person has not confirmed his willingness to act, then either Party may apply to the Centre for

Effective Dispute Resolution (CEDR) for the appointment of an expert. The request must be in writing, accompanied by a copy of the Expert Determination Notice and the appropriate fee and must be copied simultaneously to the other Party. The other Party may make representations to CEDR regarding the expertise required in the expert. The person nominated by CEDR will be appointed as the Expert.

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

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

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

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

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

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

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

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

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

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

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

3.13 All information, whether oral, in writing or otherwise, arising out of or in connection with the expert determination will be inadmissible as evidence in any current or subsequent litigation or other proceedings whatsoever, with the exception of any

information which would in any event have been admissible or disclosable in any such proceedings.

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

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

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

Nottinghamshire County Council

Report to the Public Health Committee

30 March 2017

Agenda Item: 6

REPORT OF THE INTERIM DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH SERVICE PLAN 2017/18

Purpose of the Report

1. This report outlines the approach to Service Planning to be undertaken for 2017/18, for noting by the Committee.

Background

2. As part of ASCH&PP, Public Health has an operational-level Service Plan covering its activities each year.

3. The Public Health Service Plan for 2016/17 was received by Public Health Committee on 16 May 2016. A mid-year update on progress against the Plan was reported to Public Health Committee in December. A final report on performance against the 2016/17 Service Plan will be brought to Public Health Committee in June 2017, once all performance information has been collected for the period up to 31 March 2017.

Information and Advice

4. Annex 1 to this report contains the Public Health Service Plan for 2017/18 in the Council's standard Service Plan format. Service Plans are monitored internally with a mid-year report to the corporate performance team. It is also proposed to bring update reports on progress against the Service Plan to the Public Health Committee at after six months and at year-end.

5. As well as the update report on the Service Plan actions, Public Health performance is regularly reported to Committee in the form of the quarterly contracts and performance report on commissioned services, expanded to encompass performance on all the areas supported through Public Health grant, including the realigned Public Health grant supporting activity in other parts of the Council.

Other Options Considered

6. This report has been brought for information. No other options are required.

Reason for Recommendation

7. In May 2016, the Public Health Committee received the Public Health Service Plan for 2016/17 and agreed to receive update reports on progress. Service Plans are prepared annually.

Statutory and Policy Implications

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

Financial Implications

9. There are no direct financial implications for this report.

RECOMMENDATION

1) That Committee notes the Public Health Service Plan for 2017/18
2) That Committee agrees to receive periodic updates on progress against the 2017/18 Service Plan.

Barbara Brady
Interim Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (SLB 02/03/2017)
Public Health Committee is the appropriate body to consider the content of this report.

Financial Comments (DG 08/03/2017)
The financial implications of this report are contained within paragraph 9.

Background Papers and Published Documents

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

Report to Public Health Committee, 16 May 2016, Public Health Departmental Plan 2015/16 and Service Plan 2016/17

Electoral Divisions and Members Affected

- All

Nottinghamshire County Council

Service Planning 2017-18

Name of service	**Public Health**		
Completed by	**Kay Massingham**	**Date**	**15 March 2017**
Approved by	**Barbara Brady**	**Date**	**16 March 2017**

Service Plan

1. Outcomes

a. What outcomes does the service aim to deliver for its customers?

The Council has a set of mandatory functions and duties related to Public Health enshrined in the legislation of the Health and Social Care Act 2012. The main outcomes the Public Health service aims to deliver for its customers are:

- Health and wellbeing in the population is improved
- Health inequalities are reduced
- The health of the population is protected

It delivers these outcomes through activity in three main headings:

- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

In 2017/18 the Council will receive a ring-fenced Public Health grant allocation of £42.194m. The Council has a duty to ensure that this grant is spent effectively and for the purpose for which it has been provided, i.e to deliver prescribed services, and for other activity which contributes to Public Health outcomes, as set out in the national Public Health Outcomes Framework (PHOF).

The national PHOF covers overarching indicators such as life expectancy and healthy life expectancy, and indicators linked to specific Public Health issues such as smoking prevalence, low birth weight, excess winter deaths, diagnoses of particular illnesses etc.

The requirement to demonstrate effective contract performance in relation to eventual Public Health outcomes needs to be embedded in all contracts for commissioned services and in service level agreements or similar in respect of realigned Public Health grant to other parts of the Council.

Most of the Public Health function is delivered through commissioned services. Elements of health protection and health improvement are undertaken through partner collaborations. Advice and support to the Clinical Commissioning Groups (CCGs) is provided in line with a Memorandum of Understanding (MoU). This is due to be submitted to Public Health Committee for approval on 30 March 2017.

b. How do they support / contribute to the Council's strategic outcomes? and the outcomes of other local organisations and partnerships?

ie The Strategic Plan, Redefining Your Council, Key Strategies etc

NCC's Strategic Plan 2014-18

This Plan sets out the overall vision for Nottinghamshire to be a better place to live, work and visit. It contains two specific outcomes related to Public Health (extracts in tables below taken from NCC Strategic Plan document):

Supporting safe and thriving communities

Outcome	***How will we measure progress***	***Role of the Council***
The health and safety of local people are protected by organisations working together	*A multi-agency plan is agreed to lead a response across partners to health emergencies from infectious diseases, environmental, and chemical hazards*	*We will provide leadership across partner organisations to protect the health and safety of local people. We will contribute to planning for health emergencies.*

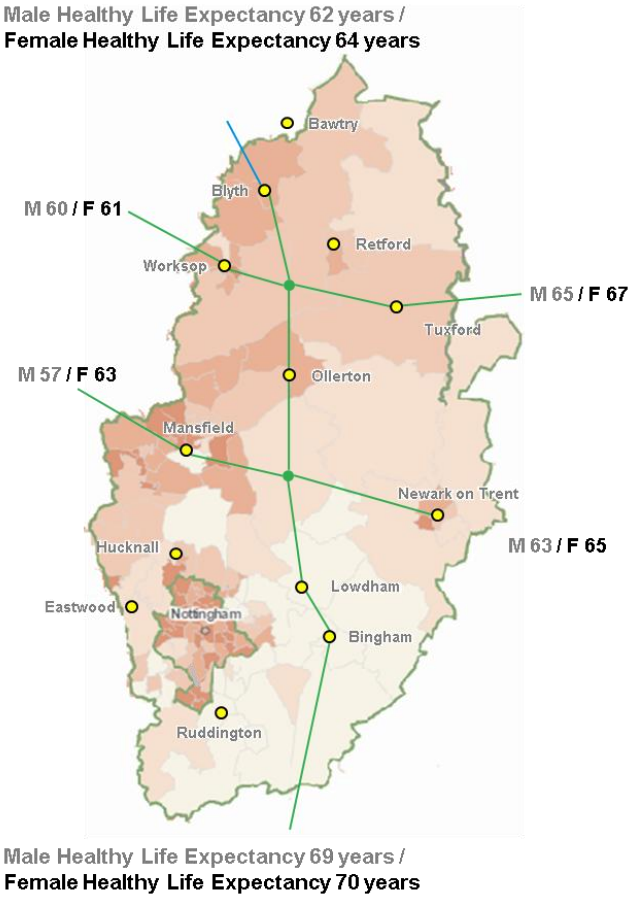
Health protection is one of the statutory functions of Public Health and we will continue to provide leadership within the Public Health arena and contribute to planning for health emergencies.

Providing care and promoting health

Outcome	***How will we measure progress***	***Role of the Council***
The health inequalities gap is narrowed, improving both health and wellbeing	*Effective health and wellbeing interventions are targeted to where they are most needed*	*We will work in partnership to maximise the use of resources to target the areas of greatest need, highest demand and tackle inequality*

Public Health addresses health inequalities by targeting resources on areas of need. Service specifications for commissioned services are written to achieve this, and advice to CCGs is provided to inform the commissioning of healthcare services in response to population need.

The Director of Public Health Annual Report 2016 particularly focused on health inequalities. The graphic below is taken from that report and uses a "road map" of Nottinghamshire to illustrate the health inequalities within Nottinghamshire: the differences in healthy life expectancy between different areas of the County.



The recommendations within the 2016 DPH Annual report focus on some of the health inequalities identified in the Marmot report of 2010. The 2017 DPH Annual Report intends to focus on a different set of health inequalities as identified in the Marmot report.

Redefining Your Council

Redefining Your Council is the overarching strategic context for developing Nottinghamshire County Council as an organisation. Through this strategy, the Council seeks to integrate its functions more closely in order to deliver services more effectively. During 2016/17, a staffing restructure within Public Health took place as a further step towards integration. This brought all staff within the division onto NCC terms and conditions into a structure designed to be consistent with other parts of the Council, within the ASCH&PP department. In 2017/18, Public Health will seek to work across the Council to integrate public health considerations into the work of the Council.

Public Health contributes to the Council's values, as identified in Redefining Your Council, as follows:

Treating people fairly - through the use of Public Health analysis of data to develop evidence-based service commissioning.
Value for Money - performance management and contract monitoring within Public Health focus on cost effectiveness, delivery of outcomes, achievement of efficiencies, and ensuring that resources are used for the purpose for which they were provided.
Working together – Public Health works through the Health and Wellbeing Board to improve the health and wellbeing of the people of Nottinghamshire. Through the provision of advice to CCGs, Public Health contributes to the commissioning of other health services based on population need.

Health and Wellbeing Strategy

The Health and Wellbeing Board (HWB) is the primary body overseeing overall Strategy for Health & Wellbeing in Nottinghamshire. A key action for Public Health in 2017/18 is to support the Health and Wellbeing strategy refresh.

2. Objectives

a. What are the key objectives of the service for 2017 - 18

1. **To work towards the Council becoming an organisation with health and wellbeing at its core, in line with the vision for Public Health previously approved by Public Health Committee**

    - Develop a health and wellbeing self-assessment tool for use within the Council
    - Use the findings of the self-assessment exercise to develop an improvement plan

2. **To work effectively with partners to improve health and wellbeing in the population and to address health inequalities identified in the Marmot Report.**

    - Refresh the Health and Wellbeing Strategy by March 2018
    - Work with Health and Wellbeing partners, both inside and outside the Council, to implement the recommendations of the 2016 Director of Public Health Annual Report
    - Implement year 2 of the 3-year Young People's Health Strategy Action Plan by the end of 2017/18
    - Publish the 2017 DPH Annual Report, focusing on other Marmot recommendations

3. **To identify and plan to address indicators within the Public Health Outcomes Framework where Nottinghamshire outcomes are significantly worse than England.**

    - Identify areas within the PHOF where Nottinghamshire outcomes are significantly worse than England or where trends are deteriorating over time
    - Devise a plan to address this

4. **To plan for a reducing level of Public Health resource announced in the Chancellor's Budget Statement of 2015 whilst ensuring that maximum value is secured from use of resources.**

    - Achieve budgetary savings required during 2017/18
    - Begin planning for the recommissioning of services as contracts expire from 2018/19 including evaluation of commissioned services, return on investment and assessment of risk, to inform future recommissioning plans

3. Pressures and Challenges

a. What pressures specific to the service may impact on service delivery or achievement of the service objectives in 2017 - 18

1. Four year forward projections for Public Health were announced in the Government's comprehensive spending review announcement of November 2015, which showed a diminishing level of future resource. 2017/18 is the third consecutive year of reductions. Stakeholders were engaged in planning for future reducing resources in 2016; mitigation includes use of reserves to taper impact.

2. Staffing capacity was reduced in a restructure in 2016. Capacity within the division affects ability to respond to changing environments. External demands on staff are increasing, e.g. the development of the Sustainability and Transformation Plan has implications for Public Health.

b. Based on 2016 - 17 and benchmarking in the service profile are there any areas of performance or cost to be addressed in 2017 - 18?

1. The 2017/18 Public Health budget is linked to the nationally determined, ring fenced allocation of Public Health grant. Public Health reserves will be used to balance the budget in 2017/18 as the grant is reducing faster than expenditure can be reduced, owing to contractual commitments.

2. Local Public Health Outcomes Framework (PHOF) information shows some poor or deteriorating Public Health outcomes for Nottinghamshire. Consideration needs to be given to how to address these. An action is included in the Service Plan.

4. Actions for 2017 - 18

What are the key actions required to deliver the 2017 - 18 objectives

Using objectives and challenges identified above what are the key actions for the service will do over the next year to achieve its objectives, improve outcomes & service quality and deliver options for change to reduce costs. Are there any risks associated with the action and have these been considered? Will any of the planned changes impact on service users/customers? If it will have an adverse impact on any particular group an Equality Impact Assessment should be completed

Actions to be completed in 2017-18 (also include actions from any relevant Council strategies or Options for Change)	Risks / Impact	Responsible Officer	Timescale	
			Start	Finish
1. Develop a health and wellbeing self-assessment tool for use within the Council and use the findings to inform an improvement plan	Impact: improved integration of health and wellbeing; opportunities for synergy and addressing wider determinants of health with impact on local population. Risk: insufficient resources to address findings.	DPH	April 2017	March 2018
2. Refresh the Health and Wellbeing Strategy by the end of the 2017/18 financial year	Impact: potential to engage partners and drive action by others. Risk: reducing capacity of HWB members to contribute to and implement strategy.	DPH	April 2017	March 2018
3. Implement the recommendations of the 2016 Director of Public Health Annual Report, working with HWB members, external partners, district Councils, and other parts of the County Council	Impact: potential to engage partners and drive action by others. Risk: Insufficient resources of partners to address all recommendations.	Consultants in Public Health	April 2017	November 2017
4. Publish the 2017 DPH Annual Report focusing on Marmot recommendations covering children & young people and economic wellbeing.	Impact: potential to engage partners and raise the profile of health and wellbeing in other parts of the system. Risk: reducing capacity of partners to contribute to and implement strategy.	DPH	July 2017	November 2017

5. Implement year 2 of the 3-year Young People's Health Strategy Action Plan.	Impact: improved health and wellbeing among young people; increased awareness of issues faced by the target group Risk: lack of budget to implement recommendations and action plan limit scope for implementation; partners' ability to contribute may also be limited.	Consultant in Public Health	April 2017	March 2018
6. Identify areas within the PHOF where Nottinghamshire outcomes are significantly worse than England or where trends are deteriorating over time, and devise a plan to address this	Impact: increased awareness of outcome indicators. Risk: lack of budget to address deterioration; partners' ability to contribute may also be limited. Mitigation: ability to target resources.	Consultants in Public Health	April 2017	March 2018
7. Achieve budgetary savings required during 2017/18	Impact: Restrictions on budget constrain service offer. Risk: Ability to respond to cost pressures. Potential mitigation by use of reserves, if needed.	DPH	April 2017	March 2018
8. Begin planning for the recommissioning of services as contracts expire from 2018/19 including evaluation of commissioned services, return on investment and assessment of risk, to inform future recommissioning plans	Impact: advance planning to enable transition and identification of efficiencies. Risk: Identified need may not be able to be met with available resource.	Consultants in Public Health	April 2017	March 2018

Is this a critical service?	**Y**	**- Critical - does the service have a business continuity plan in place?**	**Y**
		- Non critical - has the service undertaken a Business (Continuity) Impact Assessment?	**Y / N**

5. Measures

How will you know if the actions are making a difference, that the service is achieving its outcomes and that you are providing a quality service?

How can we measure if our customers/service users are better off?

Outcome measures	Baseline (2016-17)	Target					or Range		Responsible officer
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual	Lower	Upper	
Improvement relative to PHOF measures (Action 6)	Contained in PHOF reports					Improvement compared to previous year / Improvement on relative position compared to CIPFA neighbours			PH SLT
£ financial savings achieved compared to last year's budget (Action 7)	£1,066m reduction on Public Health grant compared to previous year; partly offset by use of reserves					Reserves use is within limit planned (£512K to balance budget)			Barbara Brady

How will you measure, benchmark and compare the quality of the service?									
Quality measure	Baseline (2016-17)	Target					or Range		Responsible officer
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual	Lower	Upper	
Submission of health quality and performance reports to Public Health Committee containing detailed performance data on commissioned and realigned services (Actions 6 and 8)	Quarterly reporting schedule	1	1	1	1				Nathalie Birkett

What other measures will help you to plan and manage the service?									
Deliverable/quantity/cost measures	Baseline (2016-17)	Target					or Range		Responsible officer
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual	Lower	Upper	
Self-assessment is completed by all departments by 31 March 2018 (Action 1)	Planned time schedules				Self assess-ments comp-lete				Barbara Brady
The refresh of the health and wellbeing strategy is completed by the end of March 2018 with sign off by all partners and for implementation starting 1 April 2018 (Action 2)	Existing HWB strategy			Refresh undertak en	Partner sign off.				Barbara Brady
Recommendations within the 2016 DPH Annual Report are implemented by 30 November 2017 (Action 3)	List of recommen dations		Action plans in place	Actions impleme nted in line with action plans					PH SLT
2017 DPH Annual Report is published to timeframe (Action 4)	Last year's publication schedule			Report publishe d					Barbara Brady
Year 2 of the Young People's Health Strategy Action Plan is implemented by the end of March 2018 (Action 5)	Action Plan previously agreed	Ongoing manage ment of website by Schools		Refresh of action plan	Identified actions complete d	Annual audit of service user access to			Kate Allen

		Health Hub				Health4teens website			
A plan is in place for the recommissioning of services from 2018 onwards (Action 8)	Known contract expiry dates				Commissioning plan complete				Jonathan Gribbin

Notes:

If performance is monitored at intervals other than quarterly (e.g. monthly, termly) alter column headings or add columns as needed.

Additional Guidance should be followed on the use and reporting of measures/indicators and setting targets. Please discuss with your Performance Business Partner.

Nottinghamshire County Council

Service Profile
2017-18

The Service Profile template provides additional information that has previously been contained with service plans or sought as part of the service review process. The following questions about your service's customers and resources should provide you with a tool

- for identifying needs and opportunities for your service as part of the development of your service plan for 2017-18 and
- for sharing those needs with enabling services and transformation programmes such as ways of working so that they can understand your requirements and plan support for your service and
- to provide information for service reviews and future budget development as part of the redefining your council framework and to support the overall the strategic management of the Council.

A. Customers

i. Who are your customers and service users?

Although PH commissions services at a population level, it is the commissioned providers who deliver these services to relevant target or client groups.

Public Health primarily works with organisations, either commissioned service providers, or with partners engaged in delivery of the statutory health protection role, provision of advice to CCGs, and delivery of health improvement functions.

Public Health has an influential role in bringing the key stakeholders together within forums to enable whole system planning, and from a population and health inequality perspective. For Nottinghamshire this is a core remit of the Health and Wellbeing Board.

ii. How and where do they access the service?

For commissioned Public Health services – through arrangements set up by the contracted organisations in accordance with service specifications. This may include access via GP referrals or via community pharmacies. Individuals could find out about services through libraries, charitable or third sector organisations, or the internet. Alternatively, other parts of the Council that deliver services directly may provide information on lifestyle initiatives, for example the NCC Contact Centre.

Partners can access Public Health services through various partnership working and collaborative arrangements. Identified Public Health Consultants provide links to CCGs and sit on partnership and transformation boards.

iii. What feedback have you had from users about their needs and quality of current service? And how does this compare with others?

Include or reference benchmarking data

For commissioned services: Service specifications for commissioned services are all drawn up with extensive input in terms of needs assessment and analysis, consultation, including with potential service users, and soft market testing. Benchmarking data is always part of the development of services. Evidence is gathered as part of the planning process before any soft market testing is started. This information is used to determine the level of need and the most effective approaches to service delivery, which set the scene for all re-commissioning exercises. This stage also involves analysis of data, such as predicting anticipated growth in disease and uptake of services using various limiting factors, for example, differences in level of disease and alternative treatment pathways.

Engagement with current and potential service users takes place throughout the intelligence gathering and soft market testing phases through equity audit, evaluation and needs assessment. Consultation with relevant stakeholders (which includes providers) follows to ensure that the preferred models defined by the gathered evidence are the right ones for the community. PH works to the required standards set out by the Council on all consultations to ensure that service changes are properly consulted, fair and transparent. PH will consider all the responses to consultation in finalising their plans for procurement.

For partnership activity and policy leadership: Partnership working involves maintaining relationships with partner bodies and through the development of joint and agreed Memorandum of Understanding, Strategies and Action Plans, working together on mutually agreed programmes of work and in line with agreed working methods. Review of these documents provides an opportunity to seek feedback and judge overall satisfaction of partners.

B. Service Design

i. What are the main activities that the service is commissioned to deliver

Commissioned services:

Three of the prescribed functions (NHS health checks, sexual health, National Child Measurement Programme) are directly commissioned, along with the following Public Health services:

- Tobacco control including smoking cessation
- Combating substance misuse
- Tackling obesity and promoting healthy weight
- Domestic violence and abuse
- Oral health and water fluoridation
- Healthy Child programme for ages 0-19 (includes some elements which are mandatory)

Health protection

The local authority statutory health protection role covers the provision of information and advice to relevant parties within their area in order to promote the preparation of, or participation in, health protection arrangements against threats to the health of the local population. It is delivered partly by agreement with NHS (Infection Control service) and partly through partnership working and collaborative roles (e.g. Public Health links to emergency planning).

Health improvement

Public Health works closely with health and other statutory and voluntary stakeholders to support providers and commissioners to engage with Nottinghamshire's populations main illness/premature mortality concerns (including cancer, stroke, CVD, dementia), through a whole system, population approach, enabling NICE evidence, and demographic, financial and equity elements to be incorporated in local services and activity.

Public Health organises a range of behavioural and lifestyle initiatives, some of which are to address cancer and long term conditions, and some of which are targeted at older people, such as to reduce excess deaths as a result of seasonal mortality and to reduce admissions to hospital caused by falls.

Advice and Support
Provision of advice to the CCGs is a mandatory function. Advice to the Clinical Commissioning Groups (CCGs) is delivered through a Memorandum of Understanding (MoU) – this includes provision of population health advice, information and expertise to support the commissioning of evidence-based, cost-effective health services.

ii. Do these contribute to or fulfil any statutory requirements or duties

The activities listed above demonstrate that Public Health delivers its identified mandatory functions, which are as follows:

- NHS health checks,
- Open access sexual health services,
- National Child Measurement Programme
- Health protection statutory role
- Provision of Public Health advice to CCGs
- Statutory functions of DPH
- Healthy Child Programme. Delivery of the HCP is a statutory requirement of LAs, in particular the 5 Department of Health mandated development checks within it

In addition, the Council is required to use the Public Health grant to support activities which contribute to Public Health outcomes as set out in the national Public Health Outcomes Framework. These cover overarching indicators such as life expectancy and healthy life expectancy, and indicators linked to specific Public Health issues such as smoking prevalence, low birth weight, excess winter deaths, diagnoses of particular illnesses etc.

iii. To what extent is there scope to reduce the costs of the service through the re-engineering of business processes (eg use of LEAN+)

Service redesign for re-commissioning services includes identification of value for money efficiencies. Commissioned services account for 81% of Public Health spend. Contract design and payment mechanisms are performance-related and drive positive outcomes from commissioned services. Existing commissioned services have staggered end dates to enable effective workload management. Review of service specifications will focus on cost reduction to take account of diminishing budgets.

iv. What anticipated changes in service design will be implemented in 2017/18? What is the anticipated impact?

Budget reductions affecting commissioned services – pressure on contracted services to achieve savings.

Reductions of elements of realigned Public Health grant - impacts on other parts of the Council. Reserves will be used to mitigate the impact of some reductions in 2017/18.

C. Resources - Financial

i. What is the service budget?

*Actual Expenditure 2016/17 (excluding redundancy costs):**

Employees £000	*Running Costs £000*	*Capital Charges £000*	*GROSS EXP £000*	*Grant Income £000*	*Other Income £000*	*NET EXP £000*
			0			**0**

Revenue Budget 2017/18:

Employees £000	*Running Costs £000*	*Capital Charges £000*	*GROSS BUDGET £000*	*Grant Income £000*	*Other Income £000*	*NET BUDGET £000*
2,414	40,603		**43,017**	-42,194	-823	**0**

Current Budget Pressures & Agreed Savings in MTFS:

	2018/19 £000	*2019/20 £000*	***TOTAL £000***
Budget Pressures			0
Agreed Savings			0
Projected Budget Changes	0	0	0

*Note: outturn figures for actual expenditure in 2016/17 to be added when available.

ii. Does the service generate or rely on any external income? What is the expected income for 2017/18?

Public Health is principally funded through Public Health grant, which has been announced at £42.194m for 2017/18.

Other funding is received in respect of specific items e.g. funding from CCGs to support costs of Children's Integrated Commissioning Hub; funding from PCC office as contributions to substance misuse and domestic violence contracts.

There are some small contributions from other organisations e.g. Public Health England, Health Education East Midlands, in respect of specific allowances or activities delivered by staff. Additional resource is also transferred in from CFCS in respect of Family Nurse Partnership.

The budget for 2017/18 set out above is in respect of the core Public Health function only, and anticipates transfer from reserves of £512K to balance planned expenditure.

iii. How does the cost of the service compare with others?

Include or reference benchmarking data

Public Health expenditure relates to the ring fenced, nationally allocated Public Health grant. These allocations are determined at a national level by the Department of Health, using an ACRA formula that takes account of population, need, health inequality and local service costs.

National allocations for 2017/18, together with details of all the allocations made to upper tier Local Authorities in England, are available at https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2016-to-2017

A benchmarking exercise was undertaken in January 2017 to compare the utilisation of the grant in Nottinghamshire with that of other authorities, using the expenditure reported in the RO returns for

2015/16 and comparing spend per 1000 population. The comparison was with CIPFA neighbours and with all other Public Health local authorities.

With the exception of expenditure in the children's public health and substance misuse categories, Nottinghamshire was similar to its CIPFA neighbours.

Higher spend on children's public health can be explained by the realignment of Public Health grant to support children's centres in Nottinghamshire. Higher spend on substance misuse can be explained by pooling of all the historical drug and alcohol budgets (as well as pooling non-substance misuse-specific historical budgets too). The Nottinghamshire substance misuse contract includes substance-related GP services, prescribing and pharmacy costs, and inpatient detox costs. All of these may be contracted separately in other areas. Elements of the Council's supporting people budget and community care for residential rehabilitation were also subsumed into the substance misuse contract. Other local authorities may include some of these costs within social care categories in the RO, and not in Public Health.

D. Resources - Workforce

i. How many FTE staff provide the service as at 1 April 2017?

35.71 FTEs within the core Public Health division
Up to 3 hosted staff on NHS rotational training arrangements (Registrars (in training to become Consultants in Public Health) and FY2 s (trainee doctors) on short term placement).
7.42 FTEs within the CCG-funded Children's Integrated Commissioning Hub.
4.11 FTEs providing business support to the Public Health division from the corporate business support service and funded out of PH grant.

ii. Are there any known workforce needs or issues during 2017/18?

Staffing capacity was reduced in a restructure in 2016. Capacity within the division affects ability to respond to changing environments. External demands on staff are increasing, e.g. the development of the Sustainability and Transformation Plan has implications for Public Health.

E. Resources - Technology

i. What use is currently made of ICT in the provision of your service?

Hot-desking workstations in standard NCC office accommodation
Remote working through a mix of Get Connected and Lenovo tablet devices. Some individuals have laptops instead of tablets.
Mobile telephony - principally Nokia phones.
Some individuals have fixed workstations owing to the presence of adapted equipment or special software to meet either access to work needs or to support specific areas of work.

ii. What planned developments are there for the increased use of ICT?

Replacement of Lenovo tablets and Get Connected facilities with lightweight laptops for flexible working staff.

F. Resources - Property

i. Which properties are currently used in the provision of your service and what are the current staff-to-desk ratios?

Third floor riverside south wing at County Hall (36 workstations to 49 staff members) and two shared bays on ground floor of Meadow House (15 workstations; 11 PH staff; bays are shared with staff from CFCS). Staff use these spaces flexibly according to home and meeting locations.

ii. Are these properties suitable for the service's needs? Could service delivery be improved or costs reduced by co-locating with any other local organisations or service?

PH has already reduced its office utilisation at Meadow House (12 workspaces given up for reallocation during 2015/16; co-location with TETC team within CFCS in 2016/17).

Nottinghamshire County Council

Report to Public Health Committee

30 March 2017

Agenda Item: 7

REPORT OF THE INTERIM DIRECTOR OF PUBLIC HEALTH

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING TRANSFORMATION PLAN

Purpose of the Report

1. The purpose of this report is to update the Public Health Committee on the implementation of the Nottinghamshire Children and Young People's Mental Health and Wellbeing Transformation Plan.

Information and Advice

Progress to date

2. In October 2015, a five year transformation plan for children and young people's mental health was developed. The plan aimed to deliver the recommendations from a national taskforce report into children and young people's mental health, *Future in Mind* (March 2015, Department of Health), and to deliver the findings of the Nottinghamshire child and adolescent mental health services (CAMHS) pathway review that was undertaken in 2013/14. To support delivery of the plan, an additional £1.5m of national monies was made available to the six Nottinghamshire clinical commissioning groups (CCGs) in order to fund a community eating disorder service for children and young people, and to build capacity and capability in the workforce supporting children and young people's emotional and mental health and wellbeing. CCGs hold the commissioning responsibility for community CAMHS, with NHS England responsible for commissioning inpatient CAMHS.

3. In October 2016, the plan was refreshed and combined with the equivalent plan for Nottingham City, in order to align with the Sustainability and Transformation Plan footprint. The broad priorities remain the same, but with some specific additional actions being added to the plan.

4. The priority actions to be delivered are grouped under the *Future in Mind* themes:

   a. Promoting resilience, prevention and early intervention: acting early to prevent harm, investing in early years and building resilience through to adulthood.
   b. Improving access to effective support – a system without tiers: changing the way services are delivered to be built around the needs of children, young people and families.
   c. Care for the most vulnerable: developing a flexible, integrated system without barriers.

d. Accountability and transparency: developing clear commissioning arrangements across partners with identified leads.
e. Developing the workforce: ensuring everyone who works with children, young people and their families is excellent in their practice and delivering evidence based care.

5. A summary of the plan can be found as Appendix 1. Implementation of the plan is overseen locally by the multi-agency Children and Young People's Mental Health Executive, which reports through the Children's Trust Board into the Health and Wellbeing Board, as per national requirements. Quarterly monitoring reports are also submitted to NHS England as part of the CCG's Improvement and Assessment Framework.

6. Key achievements in delivering the plan to date include the following:

- Academic resilience programmes are to be delivered to more schools in Bassetlaw, and a contract has been awarded to Each Amazing Breath to provide programmes in Mansfield and Ashfield, and Newark and Sherwood. The procurement process to establish a Provider for the contract to deliver academic resilience programmes in the south of the county is complete, and a preferred Provider has been identified. At the time of writing this report, NCC is in the 10 day standstill period and the successful bidder will be announced imminently. Both contracts are due to commence on 1st April 2017. An evaluation of the impact of the different approaches to developing academic resilience programmes on outcomes for children and young people will be undertaken by the educational psychology service.

- The Healthforteens website went live in Nottinghamshire in January 2017, providing information, advice and guidance for young people about a range of health issues including emotional and mental health. Young people can also see what services are available and how to access them. The website will be kept up to date by the schools health hub, who are now fully recruited to. This team will also support schools in advice and guidance around policies, evidence based interventions and training, including around emotional health. They will work closely with the primary mental health service within child and adolescent mental health services (CAMHS), whose remit it is to act as a link between CAMHS and schools, through providing case consultation, advice and training. They also provide this role for GPs and school nurses.

- In January 2017, Kooth.com became available to Nottinghamshire children and young people. The service provides online counselling to young people up to the age of 25.

- The expansion of CAMHS and integration of tiers 2 and 3 into one community service has positively impacted on waiting times for children waiting for assessment or treatment. Whilst there is some variation across teams, the average wait from referral to treatment in the county is now 6.61 weeks (snapshot of those waiting on 10 January 2017).

- The pilot Crisis and Intensive Home Treatment Service for young people in mental health crisis established in January 2016 has now been recurrently funded, and is providing timely access for children and young people who require a community assessment due to their acute mental illness. The service also provides in-reach mental health assessments to young people attending acute hospitals, and intensive home treatment to try and support young people to be able to remain in the community.

- The new therapeutic service for children and young people who have experienced sexual abuse and/or exploitation provided by the Children's Society is now fully mobilised.

Priorities for 2017/18

The transformation plan spans the five years to 2020, and is in its second year of implementation. Key priorities for the next year are as follows:

- Involving children and young people in the on-going development of the transformation plan, including vulnerable groups.

- Increasing the number of children and young people with diagnosable mental health needs who have timely access to evidence based interventions. This will be achieved through the development of a joint agency workforce plan, which will consider both the capacity within the CAMHS workforce, but also the skill mix in the CAMHS and wider children's workforce.

- Ensuring that children and young people who have an eating disorder are able to access timely evidence based assessment and treatment in the community, in line with national standards.

- Further develop the support to young people in mental health crisis, including those who may also have social care needs, and those who attend accident and emergency.

- Ensure that looked after children have equitable access to emotional and mental health support, whatever placement they are in, including unaccompanied asylum seeking children and young people.

- Assessing whether the emotional and health needs of care leavers are being effectively met.

- Develop a collaborative commissioning plan with NHS England Specialised Commissioning, to ensure that young people requiring inpatient admission receive treatment in the most appropriate setting, close to home.

- Embedding data collection and reporting across all services supporting children and young people's emotional and mental health, including the use of routine outcome

measures, so that there is transparency over access to services and impact of interventions.

Whilst significant progress has been made in the first year of the transformation plan, there remains a significant amount to do across the Children's Trust to achieve these priorities, and thus improve children and young people's outcomes in relation to emotional and mental health.

Other Options Considered

9. None. This report is for noting only.

Reason/s for Recommendation/s

10. This report is for noting only.

Statutory and Policy Implications

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

Safeguarding of Children and Adults at Risk Implications

Implications for Service Users

The transformation plan will improve outcomes for children and young people experiencing mental health difficulties.

RECOMMENDATION/S

1) That Members of the Committee note the progress in implementing the Children and Young People's Mental Health Transformation Plan.

2) That Members of the Committee are invited to comment on the report and to discuss the future developments.

Barbara Brady

Interim Director of Public Health

For any enquiries about this report please contact:

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Constitutional Comments (LMcC 06/03/17)

Not required – the report is for noting only.

Financial Comments (DG 08/03/2017)

There are no financial implications the report is for noting only.

Background Papers and Published Documents

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

Nottinghamshire Children and Young People's Mental Health Strategy 2015-2020

Nottinghamshire CAMHS Pathway Review update to Children and Young People's Committee, 12 January 2015

Future in Mind. Department of Health. March 2015.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

Five Year Forward View for Mental Health.

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire Child & Young People's Mental Health and Wellbeing Plan 2015-2020

What we want to achieve:

- more young people to have good mental health, including those in vulnerable groups such as children looked after, children subject to child protection plans, children with disabilities and young offenders
- more children and young people with mental health problems to recover
- more children and young people to have a positive experience of care and support
- fewer children and young people to suffer avoidable harm
- fewer children and people to experience stigma and discrimination

Our commitment to children, young people and families:

- We will support children and young people to be actively involved in the design, delivery and evaluation of children and young people's mental health services
- We will provide clear information about the range of services available, so that children, young people and families know who does what and how to access help
- We will commission and provide services in a joined up way, so that money is spent well, on evidence based interventions
- We will monitor the effectiveness of services as we strive for continuous improvement
- We will support and encourage the education, training and development of the local workforce
- We will value mental health equally with physical health

Update January 2017

- Kooth.com is now live, providing online counselling to 11-25's in Notts.
- Healthforteens.co.uk is also live, providing advice and guidance about health issues including emotional health and signposting to local services.
- Academic resilience programmes will be in schools across the county from April, building on those already in place in the north of the county
- CAMHS Crisis team now mainstreamed.
- Work started to improve the interface between the Early Help Unit and CAMHS single point of access, to improve access to the right service, quickly.

Our priorities for 2015-2017:

- Promoting Resilience, Prevention and Early Intervention
  - Provide better information for children and families about how to help themselves and when to seek support
  - Develop online or telephone support for young people who need emotional support
  - Increase the numbers of children and young people able to take part in programmes to build resilience in schools
- Improving Access to Effective Support
  - Have one community child and adolescent mental health service (CAMHS) rather than two separate services, with more practitioners working in it, so children do not have to wait so long to get the support they need
  - Introduce Primary Mental Health Workers to provide advice, consultation and guidance to schools and GPs about children's mental health issues
  - Set up a crisis team to respond quickly to young people who have a mental health crisis
  - Improve the access arrangements for CAMHS so that children in need of support get prompt access to the right service
- Care for the most vulnerable
  - Develop specialist support for children who have been sexually abused and/or exploited
  - Review services for children and young people with learning disabilities and neurodevelopmental disorders
- Accountability and transparency
  - Make sure that we get the most out of the money that is spent on children's mental health and wellbeing, and that services are making a difference to children and young people's lives
- Developing the workforce
  - Improve and make more training available to professionals working with children, young people and families where there are emotional or mental health difficulties.

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Progress Update
20 January 2017

Nottinghamshire County Council

Report to the Public Health Committee

30th March 2017

Agenda Item: 8

REPORT OF DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH CONTRACT MANAGEMENT 2016/17

Purpose of the Report

1. This report provides an update on the work of the Public Health Contract and Performance Team for the Public Health Committee in 2016/17.

Background Information

2. There is no definitive definition of Contract Management as it encompasses so many different disciplines. However, one definition could be that contract management is a systematic approach to securing maximum value from contracts by overseeing and managing:
    - contract creation, execution and analysis to maximize operational and financial performance, all while reducing financial risk;
    - supplier performance, used to measure, analyze, and manage the performance of a supplier in an effort to cut costs, alleviate risks, and drive continuous improvement;
    - supplier relationship, a systematic creation and capture of post-contract value from key business relationships; and
    - quality management, to ensure services and providers are consistently of good quality, embed safe practices and achieve desired levels of excellence.

3. There is a real tangible value to managing contracts properly. This means:
    i) ensuring the provider performs its obligations; and
    ii) the Authority delivers on its own obligations.

    If the former is not managed, the Authority cannot properly evidence that it is receiving value for money through the delivery of services to the required level of quality and cost. If the latter is not monitored it can lead to extra costs being incurred or limits the ability of the Authority to hold suppliers to account.

4. The first stage in ensuring obligations on both sides are delivered is to understand what those obligations are and that means ensuring the contract is fit for purpose and is understood.

5. The second stage is establishing formal processes for monitoring contractual and wider obligations.

6. The third stage is devoting resources to monitoring each contract requirement with a sensible and proportionate degree of auditing and challenge which is aligned to the risk and value of each contract.

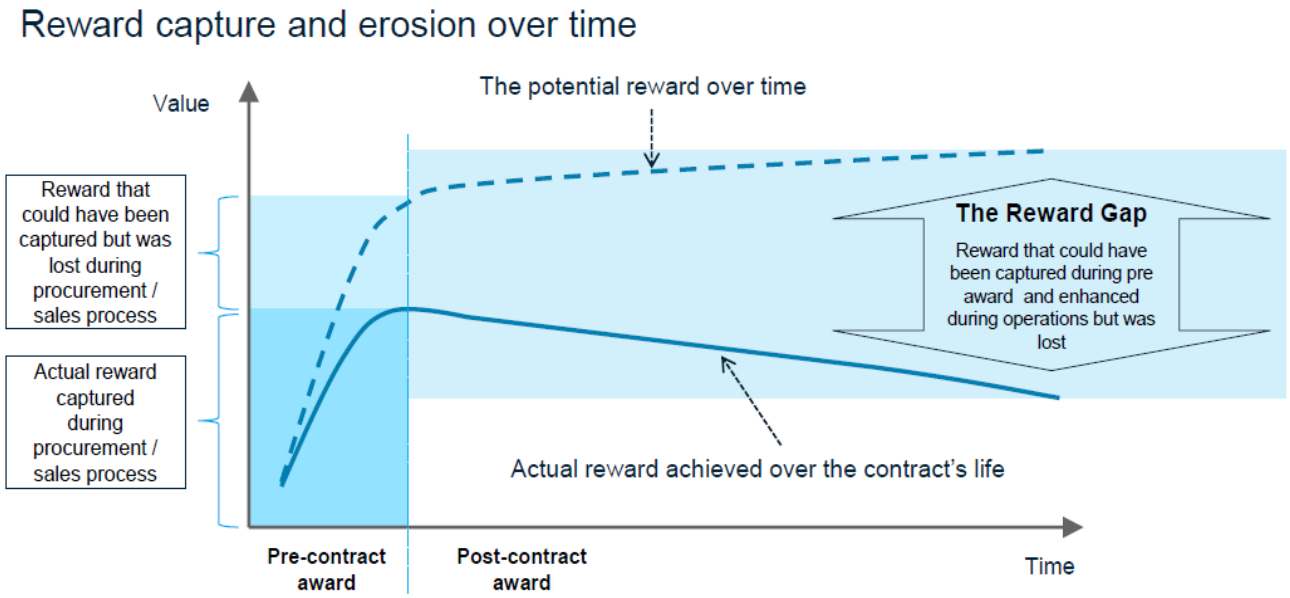
7. Robust contract management improves services and reduces costs. It is not simply delivering the deal that was agreed when the contract was signed. The Local Government organisation's research has found that local authorities obtained savings of between 3 and 15 % on the value of contracts over their duration.[1]

8. The savings made by the PH contract and performance team are real and significant: some are quantifiable and can be verified, others are hard to quantify but are of no less value. An example of the latter is contained in the report on Locally Commissioned Public Health Services (LCPHS) in Appendix 1.

9. The PH contract and performance team robustly reviews and monitors the performance and quality of providers of services commissioned directly by PH. The commissioned contracts are outcomes focused and to that end, PH have identified what matters to residents and relevant stakeholders and clearly and consistently communicate this to providers at every interaction including regular contract review meetings, quality visits and performance monitoring requests.

10. The closely managed relationship with providers and the flexibility of the contract ensures the outcomes that really matter to both organisations are delivered. This creates a true partnership approach.

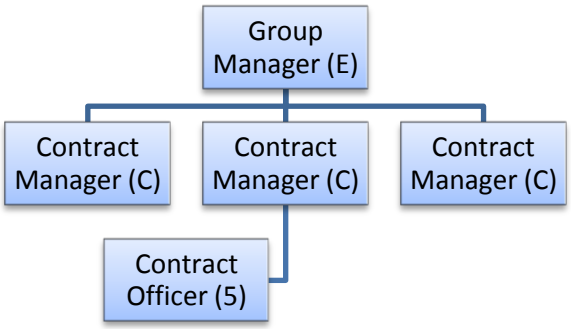
11. The diagram below illustrates the reward gap the team have captured and has not been lost to the Authority in 2016/17. In direct savings this amounts to **£526,533.34.**



[1] Making savings from Contract Management LGA November 2013

Information and Advice

12. The Contract Management and Performance Team was formed in 2014. The team is structured as set out in the diagram below:



13. The team is completely integrated into the wider PH Team and interacts closely with Policy Colleagues, Finance, Procurement and Legal Services.

14. In 2016/17, the Public Health Contract and Performance Team directly contract managed 15 key providers as well as the hundreds of GPs and community pharmacies in the LCPHS. The cost of these directly managed services amounts to over £20m.

15. All public health services have been re-procured since public health came into the Authority in 2013 and savings of approximately 8% have been made across the PH spend as part of this re-procurement process.

16. In the 2016/17 financial year alone, direct cash savings of 2.6% have been made across the services directly managed by the team. (This is the first year these savings have been documented.)

17. Further savings that cannot be easily quantifiable have been achieved through smarter working practices resulting in more efficient use of staff time and more efficient use of other resources such as printing, paper, postage and space.

18. The Public Health team try to ensure that public health contracts are drafted and managed in line with the Government's response to the findings of the National Audit Office following their review of central government services. To that end, the following elements have been key to successful contract management:

19. A number of key PH contracts have commercial incentives to improve and services including incentive reward payments which form a percentage of the total 100% budget envelope. Open-book accounting clauses are also included to ensure public money is being spent properly.

20. Performance and reporting schedules contain strong performance indicators and provider data is scrutinised and questioned vigorously on a quarterly basis at contract review meetings.

21. Risk is monitored robustly with key providers reporting quarterly on both service level and organisational risks. Any shortfalls in performance are addressed, challenges are discussed and action plans put in place to try and turn performance around. The quality review meetings are a further mechanism to assure the Authority that good quality, safe services are being provided.

22. A rigid system of incident reporting further assures the Authority that we are aware of incidents that occur and that all relevant parties can ensure services are improved from the lessons learned.

23. Better scrutiny of payments and understanding of the contract has prevented overbilling and/or overpayment.

24. The main lessons learned from this approach to contract management includes:
    a) the Authority's responsibility does not end when a contract is signed- value is achieved over the life of the contract;
    b) the contract must be flexible, fit for purpose, understood, referred to and followed;
    c) services can be improved;
    d) value can be unlocked, costs can be reduced and savings realised.

25. Proper contract Management ensures value for money and whilst some contractors may not behave well, the Authority has an obligation to proactively stop providers behaving badly.

Statutory and Policy Implications

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

Financial Implications

27. Robust performance and quality reporting ensures that financial implications are monitored and reviewed effectively to minimise financial risk to the council.

RECOMMENDATION/S

The recommendations are:

1) That the Public Health Committee receives the report and notes the performance information provided.

Barbara Brady
Interim Director of Public Health

For any enquiries about this report please contact:

Nathalie Birkett
Group Manager, Public Health Contracts and Performance

Constitutional Comments

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

Financial Comments

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

Background Papers and Published Documents

None

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

LOCALLY COMMISSIONED PUBLIC HEALTH SERVICES (LCPHS) ANNUAL REPORT – APRIL 2017

1.0 Background

Nottinghamshire County Council became responsible for the commissioning of LCPHS in 2013. Many of the systems and processes were inherited and in need of streamlining to ensure appropriate payment arrangements and performance management processes were in place to deliver efficiencies and ensure that services reflect population need and are safe, of high quality, are value for money and are evidence based.

2.0 LCPHS Services provided on behalf of Nottinghamshire County Council

In Nottinghamshire, sexual health services serve a large and diverse population, improving the sexual health of the population remains a public health priority for the Authority.

Emergency Hormonal Contraception Service (EHC)

Emergency contraception has the potential to reduce unintended pregnancy rates, thereby reducing the number of abortions. The equitable provision of and easier access to emergency hormonal contraception via pharmacies has the potential to improve the effectiveness of this contraceptive method by reducing the time interval between unprotected intercourse and initiation of treatment.

Long Acting Reversible Contraceptive (LARC)

Long acting reversible contraceptive methods have been shown to be more effective than other hormonal methods and condoms in preventing pregnancy. Recommendations of the 2005 NICE guidelines for long-acting reversible contraception state that women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception methods and that contraceptive service providers should be aware that all currently available LARC methods are more cost effective than the combined oral contraceptive pill even at one year's use and increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies.

In Nottinghamshire heart and circulation related diseases are the second most common cause of death and of hospital admissions, and account for the greatest difference in life expectancy between the most and least deprived communities.

NHS Health Check Programme

The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. The aims of the NHS Health Check programme are to reduce morbidity, mortality and hospital admissions due to cardiovascular disease and to reduce health inequalities, including socio-economic, ethnic and gender inequalities, through delivery of a cardiovascular disease risk assessment and management programme.

3.0 Main Challenges to Provision

Emergency Hormonal Contraception Service (EHC)

- Nottinghamshire County Council inherited a complicated system, with duplication and cost implications regarding paperwork for claims and audit, this was time consuming for both the Authority and for Pharmacies.
    - Paperbased systems and Electronic systems for claiming did not align
    - Carbon copied packs were used for consultations, printed by NCC and requiring Pharmacies to complete, upload onto an electronic system and then send via post to NCC for auditing and storage purposes.
    - Packs for consultations were distribution on request at a cost to the Authority in printing, postage and worker time.
    - There were risks to service provision when Pharmacies ran out of packs before re-ordering which meant they were unable to deliver the service.
    - The responsibility for ensuring Pharmacies were fully competent and had read and signed a number of individual forms to allow service delivery to take place was an administrative challenge and posed risks to the Authority in the event of any incidents.
- Communication issues
    - some branches operate/communicate through a head office or area manager, some directly through corporate email addresses, some via personal emails.
    - Information did not always get through to the relevant person and service delivery was delayed.
    - Individual Pharmacists with competency to deliver moving bases without the Authority being made aware.
    - Changes in ownership of Pharmacies not communicated to the Authority.
- A lack of up to date literature and signposting information

Long Acting Reversible Contraceptive (LARC)

- GP's, Practice Managers, unsure about accreditation and what commissioners require
- Competencies running out before GPs are aware they need to re-apply resulting in a delay in service provision.
- The burden of proof that the GPs were competent to carry out the service the responsibility of the Authority with several competency requests to be met. This was a complicated, time consuming administrative task which carried risk to the Authority if not kept up to date.
- All paperwork individualised creating a time consuming system with worker cost implications to NCC.

NHS Health Check Programme

- Different people dealing with different sections of health checks, the inputter not necessarily the person uploading the claims creating issues with incomplete/incorrect data.
- Changes in paperwork, read codes not always understood by the practice again creating incorrect information.
- No standardisation of templates, some practices using their own
- A complex, time consuming IT system to process claims and track performance accurately.

4.0 What we did

Emergency Hormonal Contraception Service (EHC)

- Liaised with Local Pharmaceutical Committee (LPC) and City Commissioners to develop/learn from best practice
- Developed a delivery declaration sheet to eliminate complicated paperwork and put the responsibility of proof onto the Pharmacies for competency for delivery, reducing the risk to the Authority.
- Aligned paper based and electronic systems
- Removed the need for carbon packs of consultation sheets by introducing a single form to be photocopied by the Pharmacies for use, saving printing, postal and administration costs, this also ensures service provision is not delayed awaiting new packs to be sent/received.
- Established a system for Pharmacies to sign to declare they will keep signed copies of the consultations for 10 years with the proviso that the Authority can request access to them at any time for auditing purposes, this guarantees the onus is on the Pharmacist to ensure the paperwork is complete and fully compliant, this reduces administration costs and storage to NCC and also reduces administration and postal costs to Pharmacies.
- Communicated through as many routes as possible to ensure any information is disseminated to the correct people through successful engagement and involvement of the LPC, individual pharmacist and head office contacts.
- All information from Pharmacies is now being captured to give a complete understanding of ownership and changes within the system and open communication routes have been established to keep this information up to date.
- Established a robust checking system to ensure claims are not processed unless all the relevant paperwork has been received, ensuring the Authority only pays for services provided within the correct procedures.
- Collated information regarding referral routes for Pharmacists to share with patients.

Long Acting Reversible Contraceptive (LARC)

- Developed an Accreditation information guide clearly outlining the Authorities requirements.
- Put the onus back onto the GPs for ensuring they have the relevant qualifications by creating an accreditation declaration form for signature and return.
- Developed a system managed by a single point of contact who gives GP Practices an early warning notification that competencies need to be updated in order to continue service provision.
- Streamlined systems and processes to update contract variations and associated paperwork to reduce worker time/administration costs to NCC and to the GP practices.

NHS Health Check Programme

- Communicated with all involved in the checks to ensure information is disseminated throughout the practice, contacting practices who are not performing well to assist with any service provision barriers or ascertain if there is a problem.
- Standardised templates being devised with training offered to ensure their correct use.
- An internal IT system is being developed to reduce cost to NCC, new processes are being discussed to ensure this provision is also more user friendly which will reduce worker time from both NCC and from GP practices and give correct up to date information on performance.

5.0 Outcomes

- The new systems and processes have reduced the paperwork for Nottinghamshire County Council, GP practices and Pharmacies, resulting in major efficiencies for both the Authority and for Providers by ensuring:
    - Less worker hours needed for processing smaller amounts of paperwork
    - Less cost from printing, paper and postage
    - Less storage needed by NCC for paperwork
    - Less risk to the authority for any service provision issues

- Requesting the providers store the paperwork themselves with the proviso that Nottinghamshire County Council can request this at any time for auditing purposes, the onus for proof in the event of an incident is now the responsibility of the provider, this is again of cost benefit to the Local Authority in worker hours keeping organised files of constant/changing information and with the changes to business support functions lessens the concern of responsibility for Nottinghamshire County Council.
- Relationships with GPs and Pharmacies have been improved through successful engagement and open and honest communication.
- Customers will benefit significantly from the improved continuous provision of services by the reduction of administrative obstacles previously faced by Pharmacies and GPs.

5.0 Key actions

- Develop the Making Every Contact County (MECC) approach with GPs and Pharmacists.
- Use case studies and patient journeys to show GPs what can be achieved through referring to appropriate services.
- Set up system for services to communicate back (through the contract team) successful referral outcomes to show effectiveness
- Advertise the services more widely in the community in areas people would see the information e.g. colleges, libraries.

Sharon Davis-Gough, Contracts and Performance Officer
April 2017

Nottinghamshire County Council

Report to the Public Health Committee

30 March 2017

Agenda Item: 9

REPORT OF DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH PERFORMANCE AND QUALITY REPORT FOR CONTRACTS FUNDED WITH RING-FENCED PUBLIC HEALTH GRANT

QUARTER 3 of 2016/17

Purpose of the Report

1. This report provides an update on performance for the Public Health Committee in respect of contracts that are commissioned directly by Public Health (PH) and services that are either in whole or in part funded with ring-fenced PH grant, for the period October to December 2016.

Background

2. The Authority has a duty under the Health and Social Care Act 2012 to take appropriate steps to improve the health and wellbeing of the local population.

3. The NHS Act 2006 and Part 2 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 (SI 2013/351) provides for certain mandatory functions to be provided by the Authority, including:
    - **Regulation 3** requires local authorities to provide for the weighing and measuring of certain children in their area (including age and school type).
    - **Regulations 4 and 5** relate to the duties of local authorities to provide or make arrangements to provide for health checks for eligible people.
    - **Regulation 6** requires local authorities to secure open access sexual health services in its area.
    - **Regulation 8** imposes a duty on local authorities to provide information and advice to certain persons and bodies with a view to promoting health protection arrangements.

4. The PH contract and performance team robustly reviews and monitors performance and quality data received from the providers of services commissioned directly by PH.

5. PH grant is used to fund services commissioned by other teams and departments of the Authority.

6. Whilst the PH contract and performance team do not directly contract manage the services commissioned by other teams, we have endeavoured to engage with the commissioners and providers to ensure PH grant is spent on PH outcomes and in accordance with the grant conditions and guidance that governs the use of the PH grant.

Information and Advice

7. This report provides the Committee with an overview of performance for public health directly commissioned services and services funded either in whole or in part by PH grant, in Quarter 2 (July to September 2016) against key performance indicators related to public health priorities, outcomes and actions within:

   i) the Public Health Service Plan 2016-2017;
   ii) the Health and Wellbeing Strategy for Nottinghamshire 2014-17; and
   iii) the Authority's priorities following the adoption of the Strategic Plan 2014-18.

8. A summary of the performance measures is set out at **Appendix A**.

Key Issues in Performance in Quarter 2 of 2016-17

9. The majority of Public Health commissioned services are on track and performing well. For those contracts where performance against plan is an issue or actual performance is not fully explained by the numbers, more detail is provided below.

10. Health check numbers are down which could be a reflection of the failure of some practices uploading their data on time albeit there is an acknowledgement that figures are falling as GPs are increasingly stretched. Those GP practices that appear to have lower or decreasing numbers are being targeted to ascertain how uptake can be improved.

11. The tobacco control and smoking cessation provider is still not performing to plan. Whilst there was an expectation that performance would improve in the third quarter due to national campaigns such as Stoptober, this has not translated into smoking quitters. The Public Health team are working closely with the provider to maximise performance however, it is unlikely the annual target will be met. The provider is keen to ensure that numbers of smoking quitters improve as this is a pbr contract.

12. The Obesity Prevention and Weight Management provider is performing to plan in a number of key areas and overall is exceeding target. However, whilst the numbers are improving for the children's and maternity services and in post-bariatric reviews, the numbers are still below target. Action plans have been provided to address these issues and the public health team will continue to robustly monitor this.

13. The number of people attending training courses provided by the Healthy Housing service has fallen in the County. This is being addressed in the final quarter with the provider focusing their efforts to scheduling training sessions in Broxtowe, Gedling and Rushcliffe and ensuring more accurate information is received from venues as to numbers of attendees.

14. The number of illicit cigarettes seized has reduced in the last quarter. This was expected due to time being taken up by prosecutions which means officers are not available to organise raids. Performance has exceeded targets previously as individual shopkeepers have been caught and are now being successfully prosecuted. The landscape is changing however, with more organised crime being involved. Robust discussions will have to take place to agree how this service evolves.

15. The numbers of people moving on in a planned way in the Supporting People: Homelessness Support service is underperforming due in part to circumstances out of the provider's control as there is not the accommodation available for service users to be moving on to. As one of the contracts not commissioned and managed by public health, further discussions are planned to provide assurance that best value for money is being attained.

Statutory and Policy Implications

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

Financial Implications

17. Robust performance and quality reporting ensures that financial implications are monitored and reviewed effectively to minimise financial risk to the council.

Public Sector Equality Duty implications

18. Monitoring of the contracts ensures providers of services comply with their equality duty. Equality performance is a standing agenda item of review meetings and providers are asked to provide case studies celebrating success and showing how complaints, if applicable, are resolved.

Implications for Service Users/Safeguarding of Children and Vulnerable Adults

19. The performance and quality monitoring and reporting of contracts is a mechanism for providers to assure commissioners regarding patient safety and quality of service.

RECOMMENDATION/S

The recommendations are:

1) That the Public Health Committee receives the report and notes the performance and quality information provided together with the mitigating and monitoring actions of Public Health officers.

Barbara Brady
Interim Director of Public Health

For any enquiries about this report please contact:
Nathalie Birkett
Group Manager, Public Health Contracts and Performance

Constitutional Comments

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

Financial Comments

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

Background Papers and Published Documents

None

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

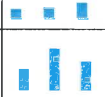
PUBLIC HEALTH CONTRACT QUALITY & PERFORMANCE REPORT QUARTER THREE 2016/17

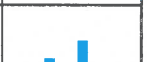
Nottinghamshire County Council

Annual Financial Value of Contract Range	Category
More than or equal to £1,000,000	High
£100,000 to £999,999	Medium High
£20,000 to £99,999	Medium
Less than or equal to £19,999	Low

⇧	Change from previous month > 5%
⇔	Equal to previous month by +/- 5%
⇩	Change from previous month < 5%

Service, Provider and Outcome	Contract Value Category	Public Health Outcomes Indicator	Performance Indicators	Q1	Q2	Q3	Q4	2016/17 Total Achieved	Annual Target	% of target met	Notes	Trend
National Child Measurement Programme To achieve a sustained downward trend in the level of excess weight in children by 2020	**Medium High**	**2.06**	% of children in Reception with height and weight recorded	Academic year 2016+C16/17 published end of Nov/Dec by HSCIC		95.22%		95%	n/a	n/a		
			% of children in Year 6 with height and weight recorded	Academic year 2016+C16/17 published end of Nov/Dec by HSCIC		89.37%		89%	n/a	n/a		
			Parents/Carers receive the information regarding their child within 6-weeks post measurement	Academic year 2016+C16/17 published end of Nov/Dec by HSCIC		99.46%		99%	n/a	n/a		
NHS Health Check Assessments To reduce early mortality and improve quality of life for individuals with Long Term Conditions (LTC) **County & Bassetlaw GP's**	**Medium High**	**2.22**	No. of eligible patients who have been offered health checks	8539	⇔ 8539	⇩ 8310		25388	51,497	49%		
			No. of patients offered who have received health checks	5299	⇔ 5292	⇩ 4738		15329	33,988	45%	Submitted to PHE - 7583(53%), practices late in uploading data	
			No. of patients who have been identified as high risk and referred to other services as a result of a health check	291	⇔ 250	⇩ 148		689	n/a	n/a	No target as there is no 'good' or 'bad' direction	
	Doncaster and Bassetlaw Hospitals											
	High	**2.04, 3.02, 3.04**	Total number of filled appointments	2431	⇔ 2426	⇔ 2431		7288	Baseline	n/a		
			Total number patients who receive full sexual health screen	527	⇧ 622	⇩ 489		1638	TBA	n/a		
			Number and % new service users accepting a HIV test	613 (30%)	⇩ 498 (44%)	⇩ 386 (49%)		41%	60%	68%		
			% 15-24 year olds in contact with the service accepting a chlamydia screen	68%	⇧ 77%	⇔ 80%		75%	75%	100%		
			Number and % screens with a positive Chlamydia result	88 (9%)	⇔ 79 (8%)	⇩ 65 (7.4%)		8%	7.50%	108%		
			% of women aged 15-24 receiving contraception who accept LARC	42%	⇔ 44%	⇔ 44%		43%	30%	144%		
			Number of women accessing Emergency Hormonal Contraception accept LARC	25	⇧ 43	⇧ 70		138	Baseline	n/a		

Integrated Sexual Health Services Promotion of the prevention of Sexually Transmitted Infections including HIV Increased knowledge and awareness of all methods of contraception amongst all groups in the local population	**Sherwood Forest Hospital Trust**											
	High	**2.04, 3.02, 3.04**	Total number of filled appointments	5763	⇔ 5964	⇩ 5615		17342	Baseline	n/a		
			Total number patients who receive full sexual health screen	1344	⇔ 1388	⇩ 1292		4024	TBA	n/a		
			Number and % new service users accepting a HIV test	1363 (36%)	⇧ 1424 (30%)	⇩ 1318 (30%)		32%	60%	53%		
			% 15-24 year olds in contact with the service accepting a chlamydia screen	56%	⇩ 44%	⇔ 44%		48%	75%	64%		
			Number and % screens with a positive Chlamydia result	355 (18%)	⇩ 251 (12%)	⇔ 242 (12.6%)		14%	7.50%	189%		
			% of women aged 15-24 receiving contraception who accept LARC	49%	⇔ 47%	⇔ 45%		47%	30%	157%		
			Number of women accessing Emergency Hormonal Contraception accept LARC	29	⇧ 45	⇧ 53		127	Baseline	n/a		
	Nottingham University Hospital											
	High	**2.04, 3.02, 3.04**	Total number of filled appointments	3043	⇧ 7653	⇧ 8516		19212	Baseline	n/a		
			Total number patients who receive full sexual health screen	1089	⇧ 1312	⇔ 1314		3715	TBA	n/a		
			Number and % new service users accepting a HIV test	1272 (74%)	⇔ 1352 (76%)	⇔ 1395 (82%)		77%	60%	129%		
			% 15-24 year olds in contact with the service accepting a chlamydia screen	55%	⇔ 58%	⇧ 64%		59%	75%	79%		
			Number and % screens with a positive Chlamydia result	11 (12%)	⇩ 6 (6%)	⇧ 25 (12%)		10%	7.50%	133%		
			% of women aged 15-24 receiving contraception who accept LARC	33%	⇔ 34%	⇧ 40%		36%	30%	119%		
			Number of women accessing Emergency Hormonal Contraception accept LARC	55	⇧ 81	⇩ 76		212	Baseline	n/a		
	Community Pharmacies - Nottinghamshire County & Bassetlaw LCPHS - Emergency Hormonal Contraception (EHC)											
	Medium	**2.04, 3.02, 3.04**	Number of women under the age of 20 accessing EHC from Community Pharmacies within the county	63	⇧ 97	⇧ 210		370	n/a	n/a		
	GP's - Nottinghamshire County & Bassetlaw LCPHS - Sub Dermal Implants/Long Acting Reversable Contraception (LARC)											
	Medium High	**2.04, 3.02, 3.04**	Total number of LARC insertions	1014	⇩ 768	⇧ 826		2608	n/a	n/a		
Alcohol and Drug Misuse Services Reduction in Alcohol related admissions to hospital Reduction in mortality from liver disease Successful completion of drug treatment **Change Grow Live**	**High**	**1.05, 1.03, 1.15, 1.04,2.18, 1.13**	Number of successful exits (ie planned)	285	⇩ 242	⇔ 242		769	April-Dec Target 642	120%	Targets set quarterly	
			Number of new treatment journeys	1456	⇧ 1647	⇔ 1619		4722	n/a	n/a		
			Number of unplanned exits	144	⇧ 167	⇧ 234		545	n/a	n/a		
			Total number of service users	4345	⇧ 4389	⇔ 4361		13095	10301	127%	50% 9954 year 2 50% 10,647 year 3	

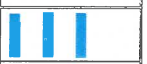
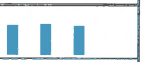
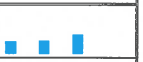
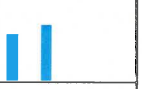
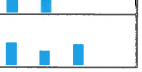
Tobacco Control and Smoking Cessation Reduce adult (aged 18 or over) smoking prevalence Behaviour change and social attitudes towards smoking **Prevalence rate of 18.5% by the end of 2015/16** **Solutions4Health**	**Four-week smoking quitter rate**											
	High	**2.9, 2.3, 2.14**	Pregnant Smokers	31	⇔ 32	⇩ 11		74	500	15%		
			Routine and Manual Workers	150	⇧ 292	⇩ 186		628	1500	42%		
			Under 18 Smokers	17	⇧ 28	⇧ 33		78	200	39%		
			Other Smokers	389	⇧ 710	⇩ 404		1503	2800	54%		
Obesity Prevention and Weight Management (OPWM) To achieve a downward trend in the level of excess weight in adults by 2020 A sustained downward trend in the level of excess weight in children by 2020 Utilisation of green space for exercise/health reasons **Everyone Health**	**Number of new assessments**											
	High	**1.16, 2.06, 2.11, 2.12, 2.13**	Adults - Tier 2	134	⇩ 68	⇔ 65		267	258	103%		
			Adults - Tier 3	222	⇩ 133	⇩ 117		472	400	118%		
			Children & Young People - Tier 2	17	⇧ 28	⇩ 10		55	108	51%		
			Children & Young People - Tier 3	15	⇔ 14	⇧ 20		49	98	50%		
			Maternity	5	⇧ 8	⇧ 10		23	104	22%		
			Post-bariatric reviews	5	⇧ 13	⇧ 18		36	60	60%		
			Adults, Children & Young People combined service users	1509	⇧ 6704	⇩ 2600		10813	6,794	159%		
Domestic Abuse Services Reduction in Violent crime Reduction in Domestic violence **WAIS & NWA**	**Medium**	**1.11**	No of adults supported	572	⇩ 392	⇧ 504		1468	2504	59%	Oct-Dec is quarter 1 for this service and they are performing well	
			No of children, young people & teenagers supported	114	⇧ 136	⇩ 119		369	776	48%		
Seasonal Mortality Reduction in excess winter deaths **Nottingham Energy Partnership - Healthy Housing**	**Medium**	**4.15**	Number of people from the target groups given comprehensive energy efficiency advice and/or given help and advice to switch energy supplier or get on the cheapest tarrif	30	⇧ 56	⇧ 117		203	288	70%		
			Number of individuals trained to deliver Brief Interventions i.e. number of people attending the training courses	19	⇧ 56	⇩ 32		107	185	58%		
Social Exclusion To improve outcomes for older people by reducing risk and health impacts of loneliness **The Friary Drop-in Centre**	**Medium**	**1.18**	Number of one-to-one specialist advice interviews undertaken	2042	⇩ 1447	⇧ 1854		5343	n/a	n/a		
			Number of emergency parcels provided	1294	⇩ 1091	⇧ 1585		3970	Baseline Q1	n/a		
Public Health Services for Children and Young People aged 0-19	**High**	**1.01, 1.02, 2.02, 2.03, 2.05, 2.06**	% of mothers who receive a face to face antenatal contact	73%	⇔ 76%	⇔ 79%		76%	75%	101%		
			Number of brief interventions offered by school nurses and delivered with children and young people by public health topic	1830	⇩ 562	⇧ 955		3347	n/a	n/a		
			% of children who received a 2.5 year review	88%	⇔ 88%	⇔ 87%		88%	95%	92%		

			% of under 18 years or low income mothers who qualify for Healthy Start that have received Healthy Start advice	75%	65%	64%		68%	75%	91%		
			% of family nurse partnership clients enrolled by 16th week of pregnancy	64%	100%	83%		82%	60%	137%		
Oral Health Promotion Services	**Medium**	**4.02**	% of service users surveyed who receive oral health advice/resources who report that it is very useful.	93%	92%	95%		93%	80%	117%		
			% of frontline staff trained who say they have gained knowledge and confidence in delivering oral health brief interventions.	100%	100%	100%		100%	80%	125%		
			% of parents/carers with a child aged 1 year who receive oral health brief advice.	74%	59%	75%		69%	75%	92%		
Suicide prevention and Mental Health Awareness Training Kaleidoscope	**Medium**	**2.23, 4.10**	Tiers 1& 2 Population based suicide prevention awareness campaign in line with national suicide prevention & Mental health community workshops focusing on building reslience & preventing mental health problems using Five Ways to Wellbeing	2	5	5		12	16	75%		

PUBLIC HEALTH CONTRACT QUALITY & PERFORMANCE REPORT QUARTER THREE 2016/17

Note: this summary contains performance information on activities being supported with Public Health grant outside of the Public Health division.

Service and Outcome	Public Health grant realignment allocation	Actual realignment expenditure 2015/16	Performance Indicators	Q1	Q2	Q3	Q4	2016/17 Total Achieved	Annual Target	% of target met	Notes	Trend
Illicit Tobacco Prevention and Enforcement Reduce adult (aged 18 or over) smoking prevalence behaviour change and social attitudes towards smoking prevalence rate of 18.5% by the end of 2015/16 **Trading Standards and Nottinghamshire Police**	**Medium High**	**2.14**	Illicit Cigarettes seized	242760	226620	7240		476620	Increase on 15/16 >575,045	42%		
			Estimated retail value: counterfeit seized products (Based on retail value of £9 cigs and £18 HRT)	£168,840	£116,541	£4,050		£289,431.00	Increase on 15/16 >£296,091	98%		
Healthy Ageing Schemes Improve health related quality of life for older people	**Handy Person's Adaptation Scheme (contribution)**											
	Medium	**2.24, 4.14**	Number of adaptations undertaken	850	958	898		2706	Maintain volume	Achieved		
	Stroke Association											
	Medium	**4.04**	Number of clients	61	88	112		261	320	82%		
	Older Person's Early Intervention Scheme (contribution)											
	Medium High	**4.13**	Age UK - Total number of Short term and Brief intervention units of support provided	1323	3298	4325		8946	7665	117%		
			Metropolitan - Total number of Short term and Brief intervention units of support provided	2912	3096	2183		8191	7374	111%		
			NCHA - Total number of Short term and Brief intervention units of support provided	1491	1720	1197		4408	3363	131%		

	Notts Help Yourself											
	Medium	**4.03, 4.13**	Website hits (millions)					0	1.5	0%	Reported annually	
			% satisfaction in user surveys					n/a	n/a	n/a	Reported annually	
Children's Centres To improve school readiness among children, contribute to targets around dental health, breastfeeding, healthy weight, smoking, hospital admissions for non-accidental injury	**High**	**2.05**	% of children under five registered with a children's centre	95%	⇔ 96%	⇔ 96%		96%	95%	101%		
			Parents completing evidence based parenting programme	1359	⇩ 856	?		2215	2,000	111%		
			% of children achievinig a good level of development at end of the Early Years Foundation Stage	65%	⇔ 67%	⇔ 67%		67%	69%	97%		
Family Nurse Partnership Improve breastfeeding initiation rates and prevalence; contribute to outcomes around smoking status at time of delivery, birth weights, hospital admissions for non-accidental injury	**Medium High**	**2.02**	Percentage of clients enrolled by 16th week of pregnancy	64%	⇧ 100%	⇩ 83%		82%	60%	137%		
			Percentage of mothers initiating breastfeeding	44%	⇧ 61%	⇩ 55%		53%	70%	76%		
Young People's Sexual Health: C-Card scheme Reduce teenage conceptions	**Low**	**2.04**	Number of young people returning to use the scheme	542	⇧ 561	⇩ 284		1387	1700	81%		
			No of new sites established	9	⇩ 7	⇩ 6		22	20	110%		
Young People's Substance Misuse Services Successful completion of drug treatment. Reduce numbers of young people not in education, employment or training	**Medium High**	**2.15**	% of planned exits	96%	⇔ 95%	⇔ 99%		97%	80%	121%		
Supporting People: Homelessness Support Reduction in statutory homelessness, impacts on alcohol related admissions to hospital	**High**	**1.15**	Total Number of Individual Service Users Receiving Support	317	⇔ 328	⇩ 306		951	n/a	n/a		
			People moving on in a planned way	68	⇧ 89	⇩ 54		211	75%	22%		
			Utilisation of accommodation	99.8%	⇦ 100.4%	⇦ 101.9%		100.7%	n/a	n/a		
Mental Health Self reported wellbeing, Adults in contact with secondary mental health services who live in stable and appropriate accommodation **CoProduction**	**Medium**	**4.09**	% Improvement in mental health and wellbeing from entry and at 12 months (based on WEMWBS) - mean WEBWBS score	50%	⇧ 80%	⇩ 51%		60%	increase over year	achieved		
			% of clients with improvement in WEMWBS scores	50%	⇧ 80%	⇩ 64%		65%	increase over year	achieved		
			% of clients in stable accommodation	100%	⇔ 100%	⇔ 100%		100%	increase over year	Achieved		
Reduction in statutory homelessness Adults in contact with mental health services who live in stable and appropriate accommodation **Moving Forward**	**Medium**	**1.15**	Number of clients entered the service by quarter	134	⇧ 142	⇧ 207		483	n/a	n/a		
			Number and % of entry clients completing WEMWBS on entry in to the service	78 (58%)	⇧ 100 (70%)	⇩ 96 (46%)		64%	Q1 40% Q2 60% Q3 75% Q4 80%	Q1 58% Q2 70% Q3 46%		
			Number of clients exited the service by quarter	218	⇩ 140	⇧ 202		560	n/a	n/a		

	Complaints relating to Health Contracts			Summary of Serious Incidents (SI's)			Freedom of Information
Public Health Area	**No.of new Complaints in period**	**No.of Complaints under investigation in period**	**No.of Complaints concluded in period**	**No.of new SI's in period**	**No.of SI's under investigation in period**	**No.of SI's concluded in period**	**Freedom of Information Requests relating to Public Health Functions and Health Contracts**
Alcohol and Drug Misuse Services				3	1		3
Pharmacy							
Mental Health							1
Information relating to management functions							
Sexual Health							
Cross Departmental							
Obesity Prevention							
NHS Health Checks							
Tobacco Control							
CYP						2	
Domestic Abuse							3

Public Health Outcomes Framework 2016–2019
At a glance

VISION

To improve and protect the nation's health and wellbeing and improve the health of the poorest fastest

Outcome measures

Outcome 1) Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life

Outcome 2) Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities)

Alignment across the Health and Care System

* Indicator shared with the NHS Outcomes Framework.

** Complementary to indicators in the NHS Outcomes Framework

† Indicator shared with the Adult Social Care Outcomes Framework

†† Complementary to indicators in the Adult Social Care Outcomes Framework

1 Improving the wider determinants of health

Objective

Improvements against wider factors which affect health and wellbeing and health inequalities

Indicators

1.01 Children in low income families

1.02 School readiness

1.03 Pupil absence

1.04 First time entrants to the youth justice system

1.05 16-18 year olds not in education, employment or training

1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H) **(NHSOF 2.5ii)*

1.07 Proportion of people in prison aged 18 or over who have a mental illness

1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services **(i-NHSOF 2.2) ††(ii-ASCOF 1E) **(iii-NHSOF 2.5i) †† (iii-ASCOF 1F)*

1.09 Sickness absence rate

1.10 Killed and seriously injured casualties on England's roads

1.11 Domestic abuse

1.12 Violent crime (including sexual violence)

1.13 Levels of offending and re-offending

1.14 The percentage of the population affected by noise

1.15 Statutory homelessness

1.16 Utilisation of outdoor space for exercise / health reasons

1.17 Fuel poverty

1.18 Social isolation † *(ASCOF 1I)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

2.01 Low birth weight of term babies

2.02 Breastfeeding

2.03 Smoking status at time of delivery

2.04 Under 18 conceptions

2.05 Child development at 2 – 2 ½ years

2.06 Child excess weight in 4-5 and 10-11 year olds

2.07 Hospital admissions caused by unintentional and deliberate injuries for children and young people under 25

2.08 Emotional well-being of looked after children

2.09 Smoking prevalence – 15 year olds

2.10 Self-harm

2.11 Diet

2.12 Excess weight in adults

2.13 Proportion of physically active and inactive adults

2.14 Smoking prevalence – adults (over 18s)

2.15 Drug and alcohol treatment completion and drug misuse deaths

2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison

2.17 Estimated diagnosis rate for people with diabetes mellitus

2.18 Alcohol-related admissions to hospital

2.19 Cancer diagnosed at stage 1 and 2**(NHSOF 1.4v 1.4vi)*

2.20 National Screening Programmes

2.22 Take up of the NHS Health Check programme – by those eligible

2.23 Self-reported well-being

2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

The population's health is protected from major incidents and other threats, whilst reducing health inequalities

Indicators

3.01 Fraction of mortality attributable to particulate air pollution

3.02 Chlamydia diagnoses (15-24 year olds)

3.03 Population vaccination coverage

3.04 People presenting with HIV at a late stage of infection

3.05 Treatment completion for TB

3.06 Public sector organisations with board approved sustainable development management plan

3.08 Antimicrobial Resistance

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities

Indicators

4.01 Infant mortality* *(NHSOF 1.6i)*

4.02 Proportion of five year old children free from dental decay** *(NHSOF 3.7i)*

4.03 Mortality rate from causes considered preventable ***(NHSOF 1a)*

4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*

4.05 Under 75 mortality rate from cancer* *(NHSOF 1.4)*

4.06 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*

4.07 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*

4.08 Mortality rate from a range of specified communicable diseases, including influenza

4.09 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5i)*

4.10 Suicide rate***(NHSOF 1.5iii)*

4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*

4.12 Preventable sight loss

4.13 Health-related quality of life for older people

4.14 Hip fractures in people aged 65 and over

4.15 Excess winter deaths

4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

Nottinghamshire County Council

Report to Public Health Committee

30 March 2017

Agenda Item: 10

REPORT OF CORPORATE DIRECTOR, RESOURCES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme for 2016/17.

Information and Advice

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

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

4. As part of the transparency introduced by the revised committee arrangements in 2012, committees are expected to review day to day operational decisions made by officers using their delegated powers. It is anticipated that the committee will wish to commission periodic reports on such decisions. The committee is therefore requested to identify activities on which it would like to receive reports for inclusion in the work programme.

Other Options Considered

5. None.

Reason/s for Recommendation/s

6. To assist the committee in preparing its work programme.

Statutory and Policy Implications

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

RECOMMENDATION/S

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

Jayne Francis-Ward
Corporate Director, Resources

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

Constitutional Comments (HD)

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

Financial Comments (NS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to Committee on operational activities and officer working groups, will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Public Health Committee Work Programme 2016 - 17

Meeting Dates	PH Committee	Lead Officer	Supporting Officer
8 June 2017	Public Health Service Plan 2016/17 – Final performance report	Barbara Brady	Kay Massingham
20 July 2017	Public Health Services Performance and Quality Report for Health Contracts - Jan-Mar 2017	Nathalie Birkett	
September 2017	Public Health Services Performance and Quality Report for Health Contracts - April-June 2017	Nathalie Birkett	

Updated: March 2017