Nottinghamshire County Council

Public Health Sub-Committee

Thursday, 06 June 2013 at 14:00

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

AGENDA

1	Appointment of Chair and Vice-Chair To note the appointment by the County Council of Councillor Joyce Bosnjak as Chair of the Sub-Committee and Councillor Glynn Gilfoyle as Vice-Chair	
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	Minutes of the last meeting held on 16 April 2013	3 - 6
5	Membership and Terms of Reference	7 - 10
6	Presentation on the Health and Social Care Act 2012 and Public Health Reforms by Dr Chris Kenny	
7	Health and Wellbeing Integrated Lifestyle Service	11 - 28
8	Use of Public Health Grant to Commission Comprehensive Sexual Health Services in Nottinghamshire	29 - 34
9	Resource from Public Health Grant to Fund Gaps in Prevention and Management of Excess Weight Pathway	35 - 38
10	Public Health Contract Peformance and Quality Management	39 - 82
11	Work Programme	83 - 86

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) Reports in colour can be viewed on and downloaded from the County Council's website (www.nottinghamshire.gov.uk), and may be displayed at the meeting.

(4) 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.

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

Nottinghamshire County Council

minutes

Meeting	PUBLIC HEALTH SUB-COMMITTEE
Date	16 April 2013 (commencing at 2.00 pm)

Membership
Persons absent are marked with `A'

COUNCILLORS

Martin Suthers OBE (Chairman)
Joyce Bosnjak
Steve Carroll
Ged Clarke
John Doddy
June Stendall
Stuart Wallace
Liz Yates
Vacancy (Liberal/Democrat)

A Ex-officio (non-voting): Councillor Mrs Kay Cutts

OFFICERS IN ATTENDANCE

Barbara Brady, Public Health Consultant
Paul Davies, Democratic Services Officer
Dr Chris Kenny, Director of Public Health
Adrian Pearson, Public Health Manager
Lindsay Price, Senior Public Health Manager
Anne Pridgeon, Public Health
Cathy Quinn, Associate Director of Public Health
Helen Scott, Senior Public Health Manager
Penny Spring, Public Health Consultant
John Tomlinson, Deputy Director of Public Health

MINUTES

The minutes of the last meeting held on 11 February 2013 were confirmed and signed by the Chairman.

DECLARATIONS OF INTEREST

There were no declarations of interest.

AGENDA ORDER

The Chairman agreed with the consent of the Sub-Committee to take the following item out of order.

SUBSTANCE MISUSE

RESOLVED: 2013/007

(1) That approval be given to the expenditure in the report;

(2) That progress reports on the projects be received in due course.

PUBLIC HEALTH SERVICE DEVELOPMENTS

The Chairman moved an amended recommendation, which was unanimously agreed, as set out below.

RESOLVED: 2013/008

(1) That each of the Public Health service developments set out in the report be recommended for approval by Policy Committee.

(2) That a further report on the Innovation Fund/Risk Reserve and Summary Finance Plan be presented to a future meeting, following agreement of the final NHS contracts for 2013/14.

OVERWEIGHT/OBESITY PREVENTION AND WEIGHT MANAGEMENT SERVICES

RESOLVED: 2013/009

(1) That approval be given to a review of the existing overweight/obesity prevention and weight management services across Nottinghamshire County with a view to decommissioning existing services and commissioning new services no later than 31 March 2015.

(2) That a further report be presented in six months time to outline progress made and on the commissioning of the new services.

PUBLIC HEALTH TRANSITION

RESOLVED: 2013/010

That the progress being made on the transition of Public Health from the NHS to the County Council be noted.

MEMORANDUM OF UNDERSTANDING FOR PUBLIC HEALTH ADVICE TO CLINICAL COMMISSIONING GROUPS

RESOLVED: 2013/011

That the Memorandum of Understanding be approved.

PUBLIC HEALTH DEPARTMENTAL STRUCTURE

RSEOLVED: 2013/012

That the structure of the Public Health Department be noted.

SECTION 75 ARRANGEMENTS FOR PUBLIC HEALTH SERVICES

RESOLVED: 2013/013

(1) That approval be given to entering into Section 75 agreements for Public Health services with the Clinical Commissioning Groups and the NHS Commissioning Board from 1 April 2013.

(2) That delegated authority be given to the Director of Public Health in consultation with the Chairman of the Public Health Sub-Committee to approve the necessary details to execute these agreements in line with the relevant regulations.

(3) That the Group Manager, Legal and Democratic Services be authorised to enter into any and all necessary documentation to give effect to this resolution.

(4) That the operation of this delegation be reviewed after 12 months.

The meeting closed at 4.05 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Public Health Sub-Committee

6 June 2013

Agenda Item: 5

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

MEMBERSHIP AND TERMS OF REFERENCE

Purpose of the Report

1. To note the Sub-Committee's membership and terms of reference.

Information and Advice

2. The membership of the Public Health Sub-Committee is:

   Councillors
   Reg Adair
   Joyce Bosnjak
   Kay Cutts
   Glynn Gilfoyle
   John Knight
   Alan Rhodes
   Martin Suthers
   Muriel Weisz
   Jacky Williams

3. The Sub-Committee's terms of reference are:

4. This is a sub-committee of the Policy Committee.

5. The exercise of the powers and functions set out below are delegated in relation to Public Health:

   a. All decisions within the control of the Council including but not limited to those listed in the Table below

   b. Policy development in relation to Public Health, subject to approval by the Policy Committee or the Full Council

   c. Review of performance on at least a quarterly basis

   d. Review of day to day operational decisions taken by Officers

e. Approval of consultation responses

f. Approval of relevant staffing structures as required

g. Approving all Councillor attendance at conferences, seminars and training events including any expenditure incurred, within the remit of this Committee and to receive quarterly reports from Corporate Directors on departmental officer travel outside the UK within the remit of this Committee.

6. If any report comes within the remit of more than one committee, to avoid the report being discussed at several committees, the report will be presented and determined at the most appropriate committee. If this is not clear, then the report will be discussed and determined by the Policy Committee.

7. As part of the detailed work programme the Sub-Committee will receive reports on the exercise of powers delegated to Officers.

8. The Sub-Committee will be responsible for its own projects but, where it considers it appropriate, projects will be considered by a cross-committee project steering group that will report back to the most appropriate committee.

Table
Responsibility for Public Health with the exception of functions reserved to the Health and Wellbeing Board

9. The Health and Wellbeing Board's terms of reference are in Appendix A, for information.

Other Options Considered

10. None.

Reason/s for Recommendation/s

11. To assist the Sub-Committee in its work.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) That the Sub-Committee's membership and terms of reference be noted.

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

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

Constitutional Comments

1. As the report is for noting, no constitutional comments are required.

Financial Comments

2. None.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

APPENDIX

HEALTH AND WELLBEING BOARD

TERMS OF REFERENCE

1 To prepare and publish a joint strategic needs assessment.

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

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

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

Nottinghamshire County Council

Report to the Public Health Sub-Committee

6th June 2013

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

HEALTH AND WELLBEING INTEGRATED LIFESTLE SERVICE

PURPOSE OF THE REPORT

1. This report outlines the proposal to explore the commissioning of an integrated lifestyle/wellbeing service for the population of Nottinghamshire County and presents the initial case for change.

Summary.

- People's lifestyles, whether they smoke, how much they drink, what they eat and if they exercise, are widely recognised as affecting their health and increasing their risk of dying young
- Recent Health policy whilst reducing unhealthy behaviours overall has led to an increase in health inequalities.
- People with no qualifications are five times as likely as people with higher education to engage in multiple unhealthy behaviours.
- The majority of people have multiple not single unhealthy behaviours and people have very different combinations of behaviours.
- There is a real opportunity to make a significant difference in Nottinghamshire for people with multiple lifestyle risks, whilst at the same time ensuring access for all to lifestyle services across the county by considering a more integrated, holistic approach to support people in making behaviour changes in order to improve their health

INFORMATION AND ADVICE

Background

2. People's lifestyles, whether they smoke, how much they drink, what they eat and if they exercise, are widely recognised as affecting their health and increasing their risk of dying young .

3. Less is known about how these lifestyle factors are reflected across populations over time.

4. Buck and Frosini, (The Kings Fund, Clustering of Unhealthy Behaviours, August 2012) identify that much has been achieved from 2003 to 2008 by tackling lifestyle behaviours as separate policy areas with a significant reduction in the numbers of people who have three or four unhealthy behaviours from 33% in 2003 to 25% in 2008 .

5. However, as the report also notes, closer examination of the data reveals that the reduction has not been equally distributed across society.

6. The effect of this unequal distribution has been to actually increase health inequalities, according to Buck and Frosini, **with people with no qualifications being five times as likely as people with higher education to engage in all four unhealthy behaviours in 2008, compared with only three times as likely in 2003.**

7. This is endorsed by the Lifecourse Tracker, Wave 1 Spring 2012, a baseline measure of lifestyle behaviour published in March 2013, which also identifies that households, in deprived areas and with lower levels of education tended to report more negative health behaviours. Household environment was also important, with those living with a smoker, drinker or drug user more likely to report those negative health behaviours themselves.

The Policy Context

8. Over the last ten years the government has adopted a generally target-driven approach to health policy around unhealthy lifestyle behaviours, focusing primarily on smoking and introducing a national smoking cessation service.

9. Policy and investment around the other lifestyle behaviours has not been as widespread.

10. Policies and plans have existed in siloes with little recognition of how these lifestyle risks were jointly distributed across the population or how people actually experienced them which was mostly more than one at a time.

11. The Coalition Government in 2011, building on the existing approach published separate documents on Tobacco Control, Obesity and Alcohol, although moving towards an outcome based approach rather than a target driven one.

12. The Marmott Review,(Fair Society, Healthy Lives, 2011) charged with the responsibility to identify, for the health inequalities challenge facing England, the evidence most relevant for future policy and action, recommended as one its six policy objectives, the need to strengthen the role and impact of ill-health prevention. However, although Marmott talks of the need to refocus needs assessment and the development of evidence based interventions that are effective across the social gradient he still separates out each lifestyle issue into individual areas.

13. More recently, the NHS Future Forum (2012) identified the need to Make Every Contact Count (MECC) to “build the prevention of poor health and promotion of healthy living into day- to-day business, by using every contact with patients and staff to encourage and help people to make healthier choices to achieve positive, long term behaviour change”.

14. This was adopted by the NHS Midlands and East as one of their ambitions for 2012/13 and will now be taken forward through the National Commissioning Board and Public Health England

15. MECC is a co-ordinated approach across all lifestyle areas, concentrating on giving staff the skills to have conversations around lifestyle issues and then signposting or referring as appropriate.

16. There is a real opportunity to build on this local ambition and to now develop local co-ordinated services across the lifestyle agenda.

17. From April 1st 2013 Public Health became the responsibility of the Local Authority. The move of the Public Health Directorate from the NHS to the Local Authority brings with it increasing opportunities to integrate work across Adult and Children's Health and Social Care and through this, increasing opportunities to impact upon the wider determinants of health.

18. As future standards are developed for local authorities and the NHS, and as the every contact counts policy is rolled out, commissioners need to consider that:
    - the majority of people have multiple not single risks
    - people have very different combinations of risks

The National Context

Weight management

19. In 1980 six per cent of men and eight per cent of women were classed as obese in the UK.

20. In 2002, it was estimated that the economic cost of obesity for the NHS, was between £3.3 and £3.7 billion, rising to £4.2 billion in 2007.

21. The Department of Health estimated in 2007 that obesity was responsible for more than 9,000 deaths a year in England. Being obese is also a major risk factor for developing other diseases including heart disease and cancer.

22. It is estimated that one million fewer obese people in England could mean:
    - 15,000 fewer people with coronary heart disease
    - 34,000 fewer people developing type 2 diabetes
    - 99,000 fewer people; living with high blood pressure.

Smoking

23. In England around 79,100 deaths (18% of all deaths of adults aged 35 and over) were estimated to be caused by smoking. The main causes of death are cardiovascular disease, cancers and respiratory disease (Health and Social Care Information Centre, 2012).

24. Smoking causes around 86% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema, and about 17% of deaths from heart disease.

25. More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, stomach, liver and cervix (ASH; Smoking Statistics May 2012).

26. There were approximately 1.5 million hospital admissions with a primary diagnosis of a disease that can be caused by smoking. The annual number of admissions has been rising steadily since 1996/97, when the number of such admissions was 1.1 million.

27. Around 459,900 hospital admissions were estimated to be attributable to smoking. This accounts for 5% of all hospital admissions in this age group.

28. In the UK about 8 in 10 non-smokers live past the age of 70, but only about half of long-term smokers live past 70 (ASH; Smoking Statistics May 2012)

Alcohol

29. Alcohol misuse is now estimated to cost the NHS £2.7 billion a year, almost twice the equivalent figure in 2001 and is expected to continue rising to £3.7 billion.

30. The cost of alcohol to society as a whole is even greater, estimated to stand at £20 billion, a year through its health, crime and social impacts.

31. Evidence suggests that heavy alcohol consumption can increase the risk of mortality from conditions such as cardiovascular disease and cancer, as well as suicide and injury.

The Local Context - What we do now

32. Locally implementation of the lifestyle agenda has echoed national policy, driven often by an NHS target driven top down approach. As with the national outcomes this has delivered local successes in separate areas but could be challenged on the impact upon health inequalities locally.

33. The Joint Strategic Needs Assessment for the county identifies that the All-age, all-cause mortality (AAACM) in Nottinghamshire, is falling over time, with a corresponding increase in life expectancy. However the rate of improvement varies by gender and by deprivation with the male AAACM rate improving faster than for females between 1999 and 2009 and the gap in life expectancy between the most and least deprived communities in Nottinghamshire (9 years for men and 7.6 years for women) increasing for women between 2001 and 2010, but not for men.

Key Headlines

Obesity

34. Obese people are more likely to develop diabetes, colon cancer, hypertension (high blood pressure) and heart attacks, and obesity also has an impact on psychological well-being.

35. Adult obesity is high in the areas of Mansfield, Ashfield, parts of Bassetlaw and specific wards of Gedling, Broxtowe and Rushcliffe, largely mirroring levels of deprivation.

Smoking

36. Smoking prevalence in Nottinghamshire is 20.9%. This is slightly higher than the England and East Midlands average; however this figure masks local variation as exemplified in figure 1. For example in Rushcliffe in the south of the county, smoking prevalence is 14.8% and by contrast Ashfield in the north of the county has a smoking prevalence of 29.4%.

37. Deaths through smoking related illness amount to 1,347 across Nottinghamshire County including Bassetlaw every year (English Public Health Observatories, 2012), with 200 more deaths in males than females (Nottinghamshire Public Health Informatics, 2012). Smoking related hospital admissions are also above regional and national averages in Mansfield and Ashfield; in the same way the prevalence rates are some 9% higher than the England average (English Public Health Observatories)

38. Both Nottinghamshire and Bassetlaw NHS are above the national average for women who smoke during pregnancy. For Nottinghamshire County, smoking status at the time of delivery is 17.8%. For Bassetlaw, it is 20.6% and in the East Midlands this figure is 15.7% (All data taken from the English Public Health Observatories, 2012, based on 2011/12 data).

Alcohol

39. There are an estimated 123,529 'increasing risk' [1]drinkers and 110,248 'binge'[2] drinkers over the age of 16 in Nottinghamshire.

40. The number of alcohol related admissions to hospital in Nottinghamshire has increased 56% from 9,956 in 2002/03 to 17,599 in 2011/12 [3].

41. There is a clear north/south divide across Nottinghamshire (north higher than south) in terms of alcohol related admissions in both males and females.

42. All districts are experiencing a year on year rise in increasing risk drinkers

Drugs

43. In Nottinghamshire in 2010/11, there were 3,035 adult drug users in treatment.

44. The majority of those in treatment are using heroin or crack cocaine, with cannabis and alcohol the most commonly used substances in young people.

45. There were 147 drug related deaths (age 20 and above) in the county between 2006 and 2010. The highest numbers were male and in the 30-39 age range. Alcohol use was a significant contributing factor.

[1] Increasing Risk drinkers (an increasing risk of developing alcohol related illness) are males who drink 3-4units of alcohol a day and females who drink 2-3 units of alcohol a day

[2] Binge drinking is defined as males drinking more than 8 units of alcohol at any one time and females 6 units of alcohol

[3] http://www.lape.org.uk/natind.html accessed 11.03.13

What can we do in the future and what we can achieve

46. If current policy is having a limited effect and is not evidencing a reduction in health inequalities nationally or locally, the challenge is to consider a new approach.

47. It would seem sensible as 70% of the population still have two or more unhealthy behaviours (The Kings Fund, Clustering of Unhealthy Behaviours, August 2012) to consider a more integrated, holistic approach to support people with behaviour changes in order to improve their health.

48. Nationally policy and research have not explored this area in much detail yet and evidence so far is limited, but Paiva et al (2012) and Johnson et al (2008) have shown, in separate studies, that people who have success in changing one behaviour are more likely than their peers then to be successful at changing others.

Wellness Services

49. It would seem that national and local evidence supports the development of local person centred services across a number of lifestyle issues.

50. Building upon the MECC agenda the development of a wellness service across lifestyle issues would have the potential to impact upon individual behaviours and community involvement to improve health outcomes and, if targeted appropriately, reduce health inequalities.

51. A recent briefing on wellness services issued jointly by the NHS Confederation and the Faculty of Public Health (NHS Confederation 2011) commented: 'Wellness services provide support to people to lead healthy lives. The wellness approach goes beyond looking at single-issue, healthy lifestyle services and a focus on illness, and instead aims to take a whole-person and community approach to improving health.

52. It appears therefore that there is strong support for this direction of travel at the highest level.

What are others doing locally?

53. Locally, organisations have commissioned a variety of models of integrated services from a single point of access to specialised services to a full wellness service incorporating assessment, intervention and ongoing support. These will need to be scoped in more detail if this proposal is agreed.

Bassetlaw

54. In Bassetlaw a range of holistic health & well-being interventions have been established, to include:
    - 'Holistic exercise referral for adults, commencing 2010 via a contract with the district council. Outcomes include a 4% increase in adult physic activity during 2011-12.
    - Holistic brief intervention training been established in line with the national MECC.
    - Workplace Health (the Bassetlaw Well-being at Work scheme). Aim to use the workplace as an umbrella theme for promoting the key C4L (change for life) themes across local workplaces.

- Life Education scheme; this is delivered by the Nottinghamshire Life Education Centre via a SLA with Bassetlaw CCG. They are delivering holistic life style messages (in line with the key C4L themes); to include a real focus on wider well-being, self-esteem and valuing the body. This is delivered through an interactive educational model in local schools and early years settings (age range 3-11). Outcomes include model delivered in 58 schools from most deprived areas facilitating engagement of children, teachers and wider families in the adoption of healthy lifestyles.
- Children's weight management prevention programmes such as 'inneractive' and Lets Get Moving', being delivered through local contracts. Aims to promote health and well-being, focusing on improving self-esteem of children and their families aged 5-16. Outcomes include those involved loosing 5% weight loss and increased uptake of physical activity and play.

Derby City

55. Derby City Council has commissioned an Integrated Lifestyle Service, following a local pilot, which commenced on April 1st.
    - Derby have commissioned a Lifestyle Service with a generic "hub" where referrals are received and clients and their families offered the support of a health champion/trainer who is skilled in working with them to maximise motivation and develop an individualised change plan referring then to specialist services as required through a modular programme of interventions. Appendix 1
    - Following a Public Consultation and Market Analysis Derby chose a Master Vendor model, with one lead service provider who sub commissions specialist services.
    - Following a procurement process Derby City Council Leisure Services were successful in tendering for this service and commenced on April 1st 2013.

Nottingham City

56. Nottingham City Council has also commissioned a Single Point of Access hub for Lifestyle Services since 2011.
    - The *Healthy Change* Lifestyle Referral Service provides a single referral point for patients aged 18 years and over with one or more lifestyle risk factors, and a pathway into other commissioned services and community-based suppor.t to help clients change behaviour.
    - Within Healthy Change, Health Trainers assess the individual needs and readiness to change of clients and support them to achieving behaviour change goals.

Wellness Services and Cost Effectiveness

57. In November 2010 Liverpool Public Health Observatory published a review of Wellness Services locally and nationally (Wellness Services – Evidence based review and examples of good practice).

58. The review analysed wellness services and models across the country and developed helpful guidelines and standards for future development of Wellness Services.

59. The report concluded that:
    - "In cost-effectiveness analysis there is often considerable uncertainty associated with the findings as a result of the assumptions and parameters used, therefore even when a sensitivity analysis is undertaken a degree of caution is required when reading the results.

- Nevertheless, the majority of services reviewed, that considered costs, were found to be cost-effective and have shown the potential to bring a return on investment and to save on future costs of ill-health through early intervention. They can provide significant value for money in return for the resources that they consume.

OTHER OPTIONS

60. Other options have been considered that would have the potential address the issues identified.

61. **Option 1. No Change To Current Services**
This option would maintain the current model for commissioning of lifestyle services, where these are commissioned by the separate policy teams in line with their own separate agendas.
Whilst this model would continue to address lifestyle behaviours, working in isolation from other policy areas will not address the health inequalities that this model has unintentionally created and the opportunity will be missed to work in an holistic, person centred way.

62 **Option 2. Provide an In House Assessment Service**
This option would require Public Health to establish a co-ordinated lifestyle model which can deliver an in house assessment service for people that are identified as having several unhealthy lifestyle behaviours.
Working collaboratively across the lifestyle agenda in house will be integral to the success of any proposed intervention, however, delivering this in house will not allow for the opportunity to commission for integration across the provider model with the associated efficiencies.

PROPOSAL

63 It is proposed that locally an integrated lifestyle model of delivery be explored.

64 Currently spending on Lifestyle Services across smoking and obesity alone is around 3.5m across the county and the proposal would be to use this funding more effectively through the development of the proposed model. Existing staff resource will be used to support the initiation of the programme. The project will develop a fully costed model for the new service for further consideration by the Public Health Sub-Committee in due course.

65. An example of the model in Appendix 2 gives an outline of a proposed hub approach but this would need to be explored as part of the programme.

66. Appendix 3 shows models used in other areas to support the wellness concept.

67. Subject to approval from the Public Health Sub-Committee a project plan and timescale can be drawn up with regular reporting to the Sub Committee to be agreed within this.

RECOMMENDATION

68. The Public Health Sub Committee is asked to approve the establishment of a project to explore the development of an Integrated Lifestyle/Wellness Service for Nottinghamshire County.

STATUTORY AND POLICY IMPLICATIONS

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

Chris Kenny
Director of Public Health

For any enquiries about this report please contact:
Lindsay Price, Senior Public Health Manager
Telephone: 01623 433098 or email: lindsay.price@nottscc.gov.uk

Constitutional Comments (SLB 22/05/2013)

70. The Public Health Sub-Committee is the appropriate body to consider the content of this report.

Financial Comments (ZKM 28.05.2013)

71. The financial implications of this report are outlined in paragraph 61.

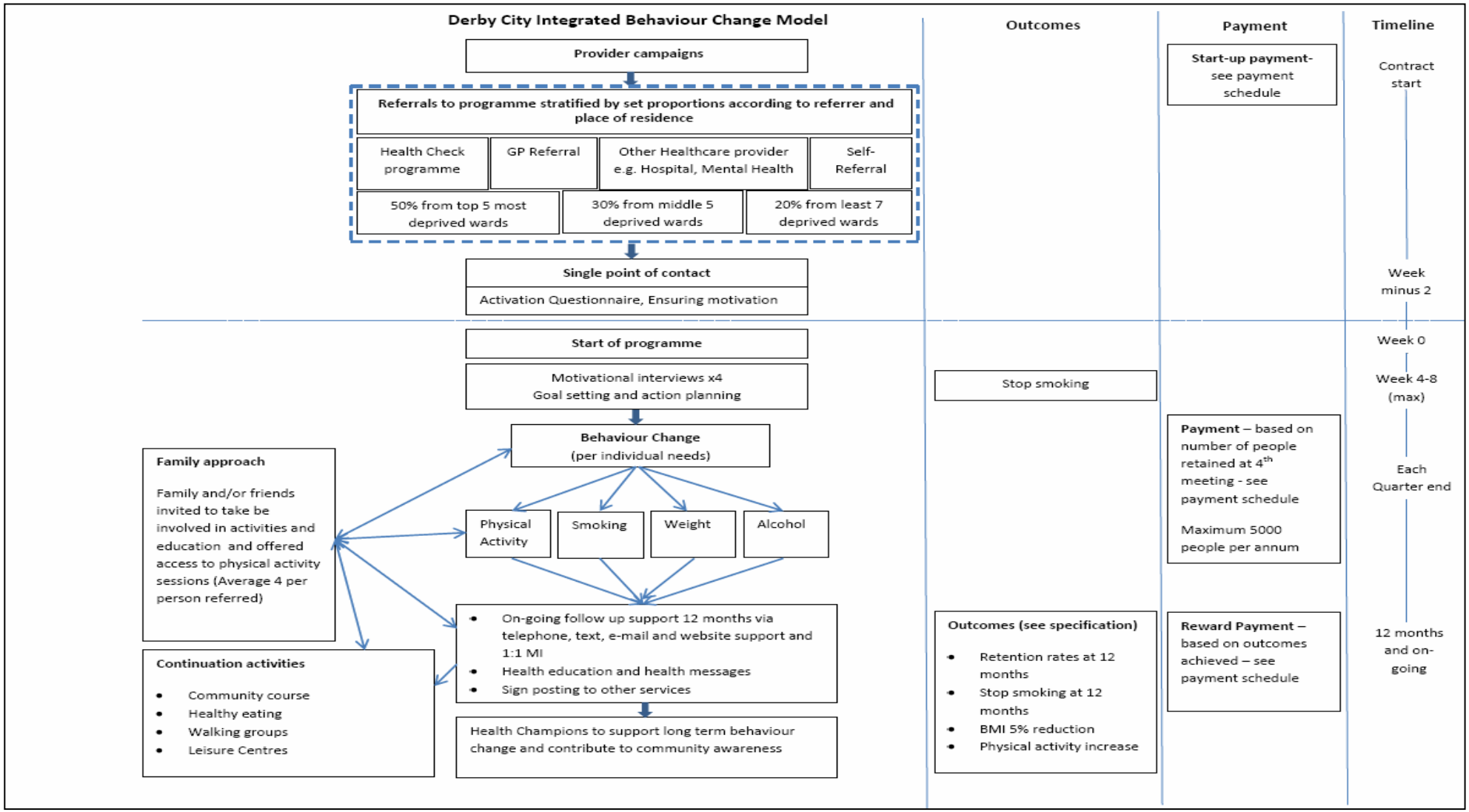
Background Papers

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

Electoral Division(s) and Member(s) Affected

All

Appendix 1


Derby City Integrated Behaviour Change Model
Provider campaigns
Referrals to programme stratified by set proportions according to referrer and place of residence
Health Check programme
GP Referral
Other Healthcare provider e.g. Hospital, Mental Health
Self-Referral
50% from top 5 most deprived wards
30% from middle 5 deprived wards
20% from least 7 deprived wards
Single point of contact
Activation Questionnaire, Ensuring motivation
Start of programme
Motivational interviews x4
Goal setting and action planning
Behaviour Change
(per individual needs)
Family approach
Family and/or friends invited to take be involved in activities and education and offered access to physical activity sessions (Average 4 per person referred)
Physical Activity
Smoking
Weight
Alcohol
On-going follow up support 12 months via telephone, text, e-mail and website support and 1:1 MI
Health education and health messages
Sign posting to other services
Continuation activities
Community course
Healthy eating
Walking groups
Leisure Centres
Health Champions to support long term behaviour change and contribute to community awareness
Outcomes
Stop smoking
Outcomes (see specification)
Retention rates at 12 months
Stop smoking at 12 months
BMI 5% reduction
Physical activity increase
Payment
Start-up payment- see payment schedule
Payment – based on number of people retained at 4th meeting - see payment schedule
Maximum 5000 people per annum
Reward Payment – based on outcomes achieved – see payment schedule
Timeline
Contract start
Week minus 2
Week 0
Week 4-8 (max)
Each Quarter end
12 months and on-going

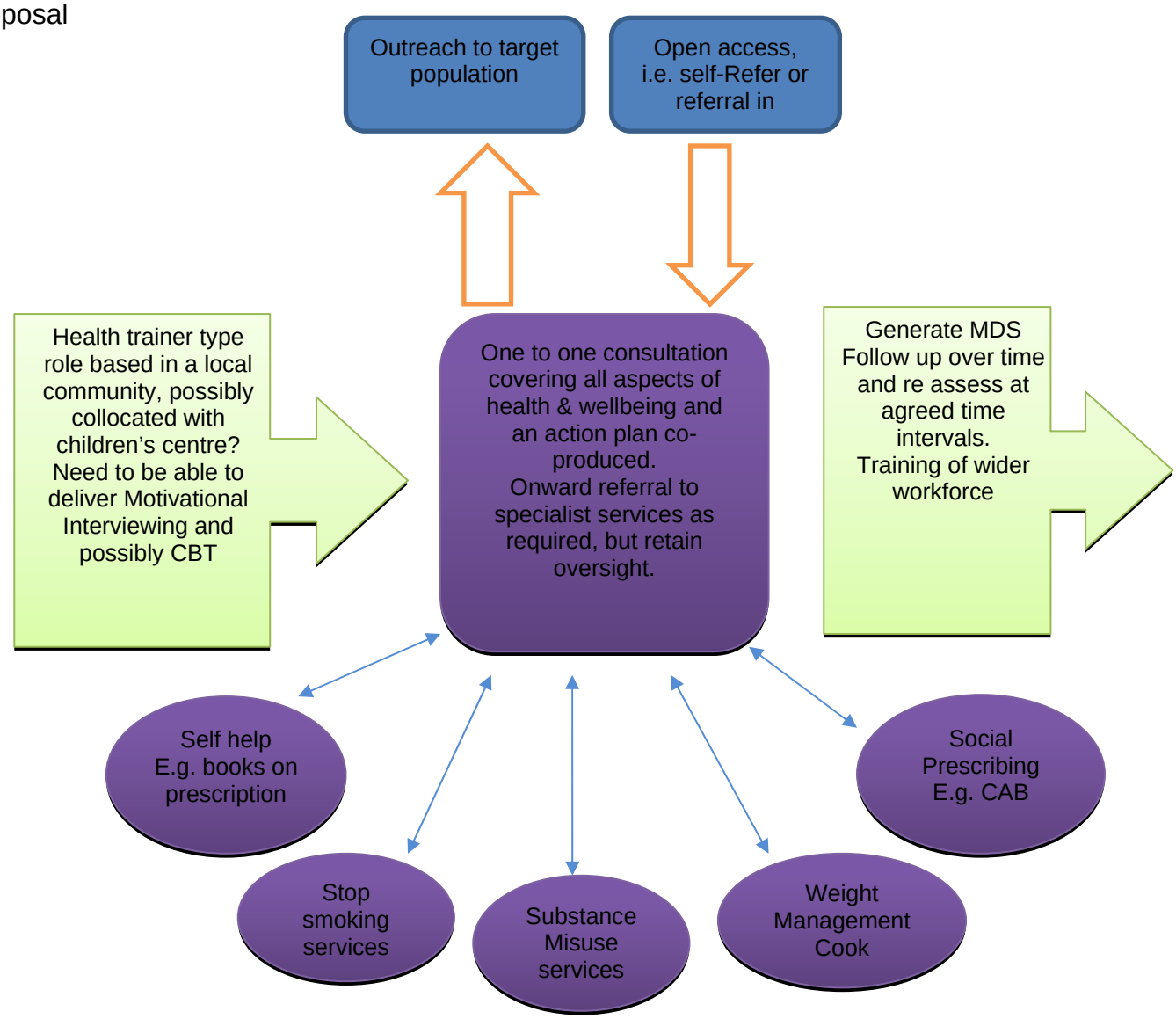
Appendix 2

Integrated Healthy Lifestyles

Rationale/Context

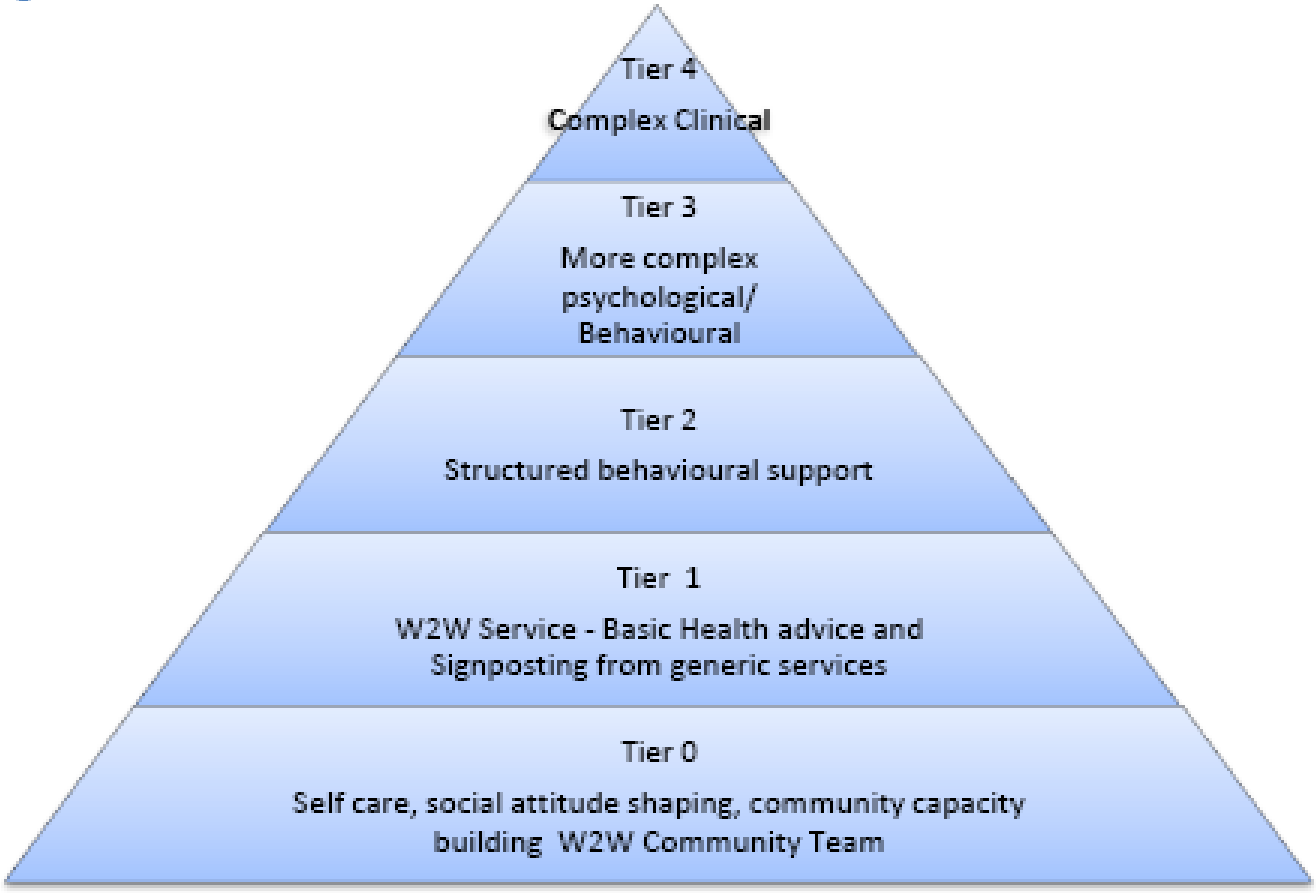
- Move of PH to LA, sickness to health and well being
- Clear mandate to reduce health inequalities
- Need to move to a person centred approach - History of silo commissioning (single issues) even though we know about clustering of unhealthy behaviours

Proposal



Appendix 3

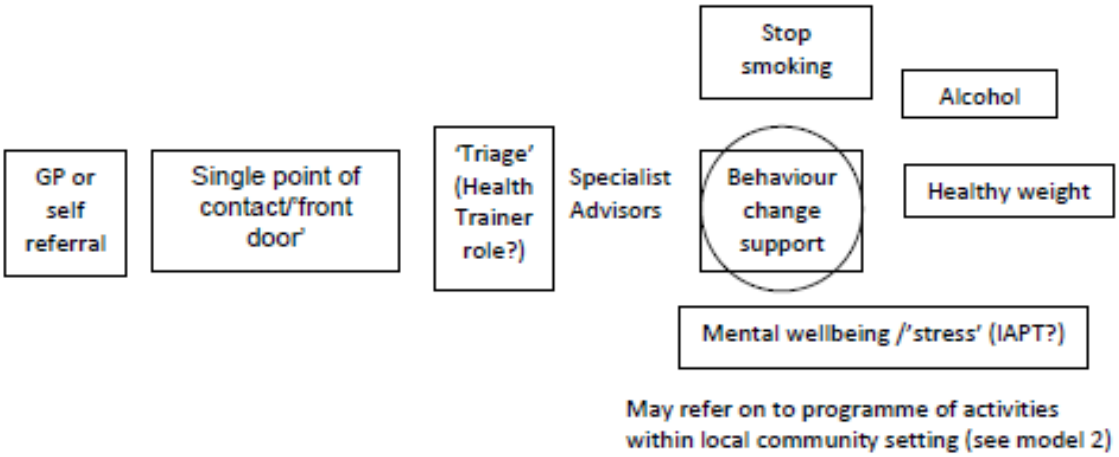
Figure 3: Model of Salford Wellness Services



Source: A Wellbeing Service for Salford[109]

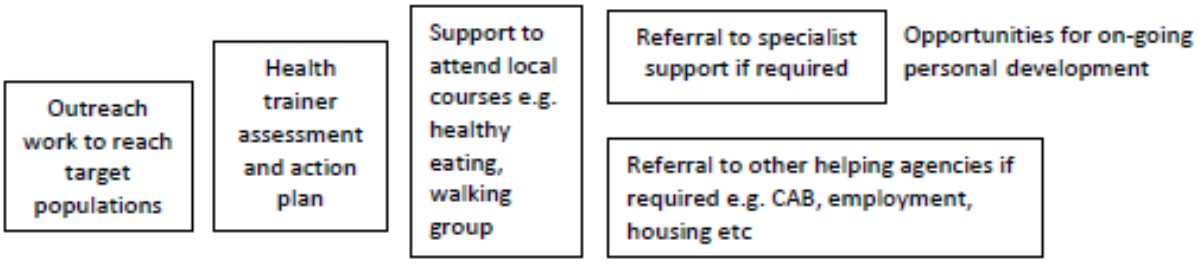
Some existing models of integrated lifestyle services to inform development of 'wellness services'

Model 1: Integrated lifestyle services (plus mental wellbeing) for individuals (clinical model)



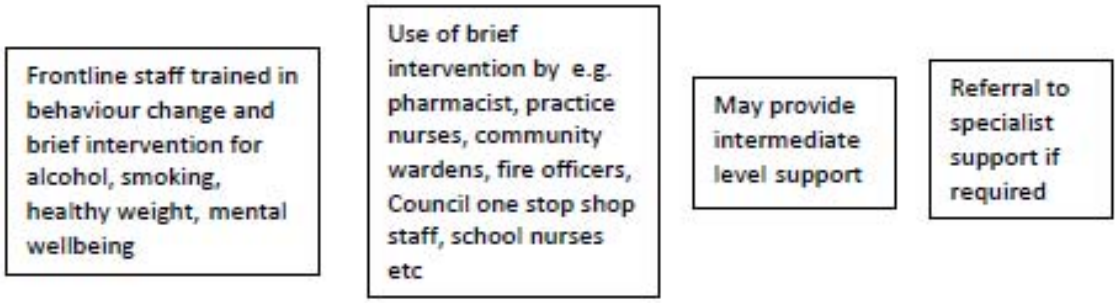
Benefits: use of GP referral enables systematic industrial scale targeting (linked to 'health check')

Model 2: Integrated lifestyle services within a community setting (community health development approach)



Benefits: family, and/or friends' approaches; peer support available; links to wider determinants; use of social marketing techniques; in the home or street level interventions
Services 'wrapped around' everyday life e.g. local shops, local champions, children's Centre, door knocking, web-based, local pubs, supermarket etc. (e.g. Wirral smoking programme)

Model 3: Basic support for lifestyle change within other service

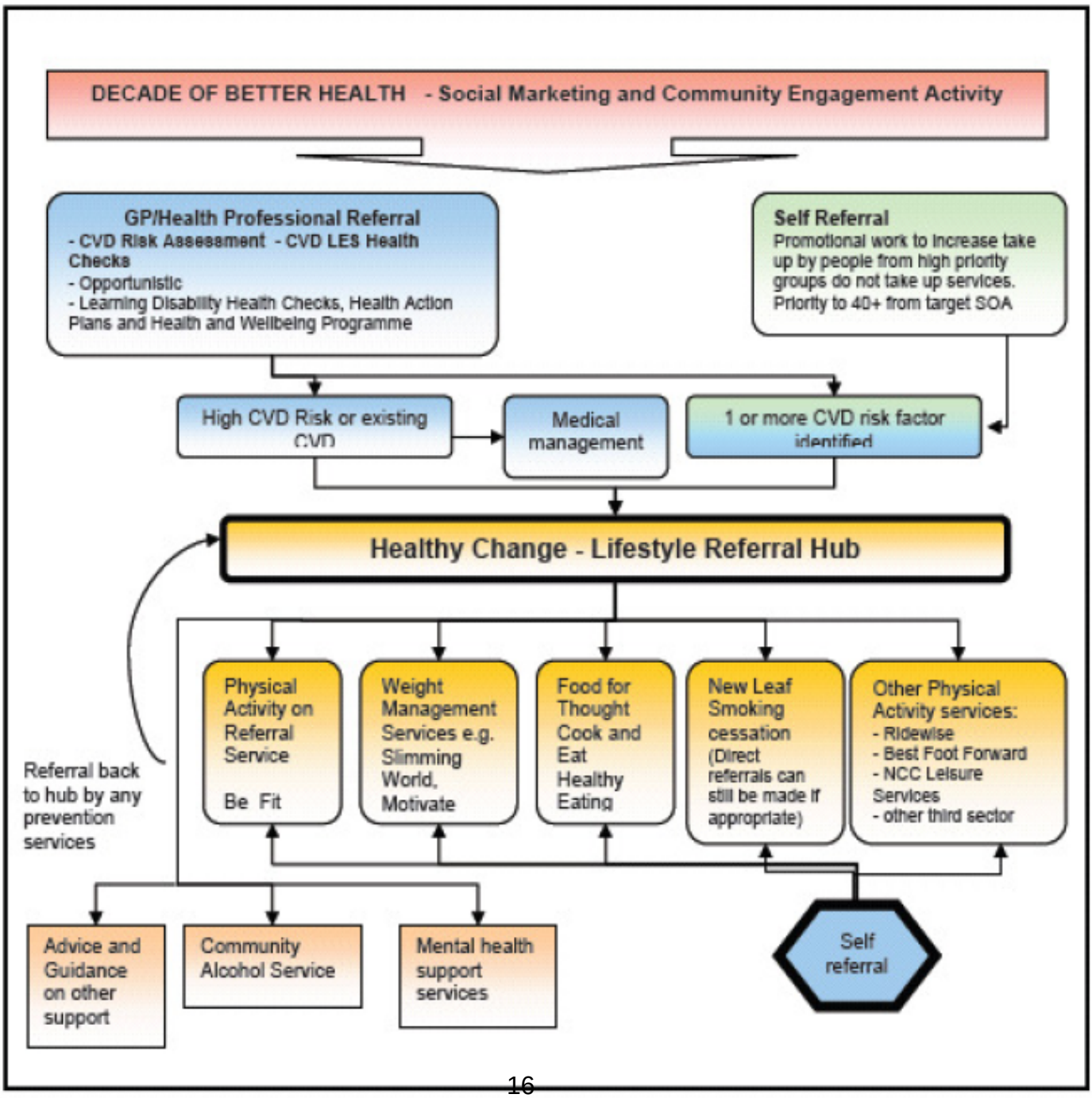


Benefits: opportunity for integration of lifestyle change into wider determinants workforce; opportunistic use with target populations; potential for further development following public health integration with local authorities

Model 4: Case management approaches (e.g. Job Centre Plus – Condition management programme)

Benefits: Lifestyle groupwork support within the context of health related worklessness; ongoing peer support helps to overcome social isolation; individual assessment of outcomes up to 6 months following programme; on-going support through programme by Case Manager (clinically trained and JC+ Personal Advisor. NB funding from JC+ ceases April 2011

Figure 1. Nottingham City CVD/LTC prevention pathway



Nottinghamshire County Council

Report to Public Health Sub-Committee

6 June 2013

Agenda Item: 8

USE OF PUBLIC HEALTH GRANT TO COMMISSION COMPREHENSIVE SEXUAL HEALTH SERVICES IN NOTTINGHAMSHIRE

Purpose of the Report

1. The purpose of this report is to provide the case and obtain agreement for additional resource from the Public Health Grant to enable the commissioning of the pre-committed, core Sexual Health services across Nottinghamshire County. The pre-committed services are those essential clinical sexual health services for which at present there is no local alternative. Young people's sexual health services are already integrated with the Children and young people's policy area and in particular with teenage pregnancy.

   This paper also highlights for information those services which had previously been agreed at the Public Health Sub-Committee and which at this stage are not pre-committed. There are considerable opportunities to review creatively and innovatively the commissioning and implementation of sexual health promotion services, however the key priority for the essential sexual health clinical services is to ensure that all sexually active residents in Nottinghamshire can access the basis services they need for sexual health, protection and safety.

Information and Advice

1. Since April 2013 local government is required by regulation to commission HIV prevention and sexual health promotion, open access genitourinary medicine and contraceptive services for all age groups.

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

3. As part of the Public Health Outcomes Framework, commissioners have a responsibility to achieve the following indicators within the framework.

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

b. Domain 3 Health Protection- Chlamydia Diagnosis (15-24years) - Untreated, between 10 and 20% of Chlamydia cases result in infertility due to pelvic inflammatory disease. Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection and over 186,000 new cases were diagnosed in England in 2011

c. Domain 3 Health Protection - People presenting with HIV at a late stage of diagnosis - The proportion of late diagnoses remained high in 2010 (50%). These individuals carry a tenfold increased risk of dying within a year of diagnosis, compared to those diagnosed. If the 3,640 UK-acquired HIV diagnoses made in 2010 had been prevented, between £1.0 and £1.3 billion lifetime treatment and clinical care costs would have been saved. Similar savings may also be attributed to social care.

4. An additional £507,000 was requested as part of the broader paper on service developments, a large proportion of which was already pre committed and for services already being delivered. Consideration of this paper was deferred by the Policy Committee as it was felt that opportunities for integration and collaborative working across the Council should be explored further before funding was committed.

5. The Sexual Health paper presented and discussed at the April 2013 meeting was supported as a large proportion of the additional funding requested was pre committed to the provision of existing services already being delivered which include Chlamydia testing, the Folkhouse young person's sexual health and contraceptive services clinic already in place, the C card condom scheme and increasing access to Long Acting Reversible Contraceptives (LARC) through the provision of accredited training for clinical staff to become qualified to fit these. In addition from April 2013 local government became responsible for commissioning population level services to prevent HIV and reduce late diagnosis. This will include all HIV testing programmes in sexual health and the commissioning of testing programmes in non-clinical settings.

6. There are two developments which are not pre-commitments.

a. The first is the extension of Sexions (young people's sexual health promotion) programme to southern Boroughs to address the gaps in current service provision and to provide equity of service across the whole county. Evidence since the launch of the SEXions in Ashfield indicates that the service has contributed to the consistent decline in teenage pregnancy rates in the district, where other areas have plateaued or increased. The reduction outperformed other comparative districts in the county. Ashfield has achieved more than two and a half times the reduction of Nottinghamshire (11.6%) and is a greater reduction than the East Midlands (11.4%) and more than three times the national reduction (9.1%). This success provides sound local knowledge on which to base future commissioning decisions.

b. The second is the implementation of a creative viral messaging programme targeted at key “at risk” groups to raise awareness about sexual health and well-being and the services available. Viral messaging has been successful in other areas at increasing access to local services is innovative and appealing to young people.

The Rationale

7. In March 2013 the Department of Health (DH) produced the document ‘Commissioning Sexual Health services and interventions – Best practice guidance for local authorities’ sets out the responsibilities for local authorities in the commissioning of sexual health interventions and services.

8. The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 covers the provision of open access health services for everyone present in their area, covering free sexually transmitted infections (STI) testing and treatment and notification of partners and free contraception, and reasonable access to all methods of contraception.

9. The new framework for Sexual Health Improvement in England produced by the DH this year states that achieving good sexual health is complex, and there are variations in need for services and interventions for different individuals and groups. It is essential that there is collaboration and integration between a broad range of organisations, including commissioning organisations, in order to achieve desired outcomes.

Expected Outcomes

10. This funding will ensure currently committed resources to services can continue and new services detailed will enable the indicators within the Public Health Outcomes Framework to be achieved by continuing to work jointly with colleagues within NCC.

Statutory and Policy Implications

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

Implications for Service Users

12. HIV testing will become more readily available within high risk populations and hence assist in removing barriers to people coming forward for testing. This will ensure early diagnosis and an improved quality of life reducing the need for multiple medications with side effects. This also reduces the chance of transmission to a HIV negative person.

13. Reduction in the negative outcomes associated teenage pregnancy .

14. Easy access to Chlamydia testing, ensuring early diagnosis and prevention of long term health effects.

Financial Implications

15. The request is for £507,000 from the ring fenced Public Health Grant to be made available for sexual health services. Documented evidence is available nationally which demonstrates cost savings.

RECOMMENDATION/S

16. That the Public Health Sub-Committee are asked to:

Agree to £507,000 being released from the ring fenced Public Health Grant to enable the current gaps in the Nottinghamshire Comprehensive Sexual Health Services to be addressed and Public Outcomes Framework Indicators to be achieved.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Penny Spring (Public Health)

Constitutional Comments

To follow

Financial Comments

To follow

Background Papers

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

To follow

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to the Public Health Sub-Committee

6th June 2013

Agenda Item: 9

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

RESOURCE FROM PUBLIC HEALTH GRANT TO FUND GAPS IN NOTTINGHAMSHIRE PREVENTION AND MANAGEMENT OF EXCESS WEIGHT PATHWAY

Purpose of the Report

1. The purpose of this report is to provide the case and obtain agreement for additional resource from the Public Health Grant to enable the commissioning of equitable weight management services across Nottinghamshire County.

Information and Advice

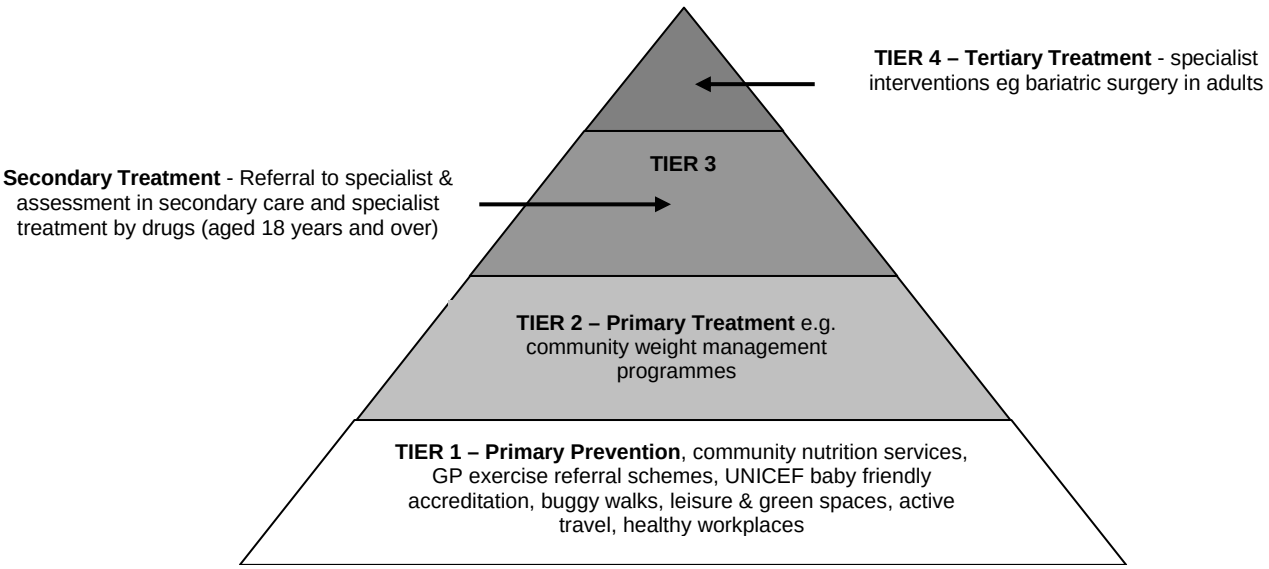
2. Excess weight threatens the health and wellbeing of individuals and has a financial burden in term of health and social care costs, on employers through lost productivity and on families because of the increasing burden on long-term chronic disability. It is responsible for an estimated 9,000 premature deaths per year in England.

3. Unhealthy diets combined with physical inactivity have contributed to an increase in excess weight in England and almost a quarter of adults and almost a sixth of children under the age of 11 are obese. It is predicted that by 2050, 60% of adult men, 50% of adult women and 25% of children may be obese. Alongside this, being overweight has become usual, rather than unusual.

4. The Nottinghamshire Health and Wellbeing Strategy has identified excess weight, this complex yet common condition, as a key priority. The complexity and interrelationships of the causes of excess weight require the need for a multi-dimensional approach to deal with it. The Nottinghamshire prevention and management of excess weight model consists of four tiers:

   - Tier 1 focuses on the prevention of excess weight for the wider population, with an emphasis on those who are more at risk e.g. lower socio-economic and socially disadvantaged groups, particularly women, people with physical disabilities, people with learning difficulties, people diagnosed with a severe and enduring mental illness and older people.

Nottinghamshire Prevention and Management of Excess Weight Model



- Tier 2 focuses on the provision of community weight management services for those who are overweight or obese
- Tier 3 focuses on the provision of a specialist multidisciplinary weight management service for those with complex obesity. This tier includes the use of anti-obesity drugs which should only be considered in adults aged 18 years and over after dietary, exercise and behavioural approaches have been started and evaluated.
- Tier 4 focuses on the provision of weight loss (bariatric) surgery for adults defined as morbidly obese, when all other measures have failed. In the East Midlands, people must have a BMI of 50 kg/m² and above may be eligible for surgery. The NHS Commissioning Board will be responsible for the commissioning of bariatric surgery from April 2013.

5. From April 2013, Public Health in the Local Authority became the responsible commissioner for obesity interventions, locally led nutrition and physical activity initiatives via funding from the Public Health ring-fenced Grant. Nottinghamshire currently invests approximately £960,000 in overweight/obesity prevention and management services through a large number of different contracts and providers.

6. An additional £540,000 was requested as part of the broader paper on service developments. Consideration of this paper was deferred by the Policy Committee as it was felt that opportunities for integration and collaborative working across the Council should be explored further before funding was committed.

7. The paper 'Public Health Service Development Costs' and 'Nottinghamshire County Overweight/Obesity Prevention and Weight Management Services' was discussed at the April 2013 meeting. The paper was supported as it met an urgent need to review the current services and improve access to equitable high quality services across the county.

8. The additional £540,000 requested as part of the service developments is required to feed into the review of services to meet the current gaps in service provision particularly around community and specialist weight management (Tiers 2 & 3) services.

9. This funding will enable the commissioning of evidence-based integrated obesity prevention and weight management services for adults (including pregnant women) and children across the whole of Nottinghamshire to ensure there is a co-ordinated approach to tackling excess weight. This is supported by the Nottinghamshire Obesity Strategy Integrated Commissioning Group which includes a range of senior strategic representatives from County Council, Borough/District Councils, Clinical Commissioning Groups and includes both a physical activity and diet expert.

The Rationale

10. In October 2011 the Department of Health issued "Healthy Lives, Healthy People: a call to action on Obesity in England". This sets out the national strategy to tackling excess weight and sets new national ambitions:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020.

11. There are parts of the Nottinghamshire overweight/obesity pathway in which there are gaps. There is **no** Tier 3 specialist weight management service in place and Tier 2 community weight management services are **only being delivered in Bassetlaw**.

Expected Outcomes

12. By having the additional resource along with the current investment will ensure that the gaps in service provision are filled and provide an equitable obesity prevention and weight management service across the whole county. This will help to reduce the need for access to higher tiers of the pathway and therefore the need for anti-obesity drugs and surgery.

Other Options Considered

13. **Maintain the status quo.** Without additional investment, the gaps in current service provision at Tiers 2 & 3 will not be addressed.

Statutory and Policy Implications

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

Implications for Service Users

15. The local population of Nottinghamshire and those at increased risk of an excess weight will be able to access high quality weight management services across the county.

Financial Implications

16. The request is for £540,000 from the ring fenced Public Health Grant to put in place weight management services (within a total budget of £1.5m) as soon as possible.

RECOMMENDATION/S

17. That the Public Health Sub-Committee are asked to:

    i. Agree to £540,000 being released from the ring fenced Public Health Grant to enable the current gaps in the Nottinghamshire weight management pathway to be filled.

Chris Kenny
Director of Public Health

For any enquiries about this report please contact: Anne Pridgeon (Public Health)

Constitutional Comments

To follow

Financial Comments

To follow

Background Papers

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

To follow

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to the Public Health Subcommittee

06 June 2013

Agenda Item: 10

REPORT OF THE ASSOCIATE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH CONTRACT PERFORMANCE AND QUALITY MANAGEMENT

Purpose of the Report

1. This report provides information on the arrangements for the Performance and Quality Management of Public Health Contracts. It asks the Public Health Subcommittee to review and consider the Quality and Risk Management Policy to Support Health Contracts and the information provided in Public Health Contract Performance and Quality Management

National and local context

2. As a result of the Health and Social Care Act 2012 (H&SCA 2012) and the new duty of upper tier and unitary local authorities to take steps to improve the health of their populations, Nottinghamshire County Council has taken forwards a range of health services, supported by a ring fenced budget for public health.

3. The new responsibility includes the commissioning of services to deliver the five priority Public Health functions and Public Health functions guided by the Public Health Outcomes Framework (PHOF), the local Joint Strategic Needs Assessment (JSNA), the Health and Wellbeing Strategy and the Local Outcomes Framework (LOF) **(refer to Appendix 1).**

4. The practicalities of implementing this new responsibility included the transition of existing health contracts that extended beyond 01 April 2013, which were transferred to Local Authorities under a transfer scheme (H&SCA 2012 section 300-302 and schedule 22 and 23). The transfer scheme transferred the contract obligations and liabilities from the current commissioning arrangements to local authorities as outlined in the transition powers of the H&SCA 2012.

5. Associated with this responsibility, Nottinghamshire County Council has three types of contracts; Associate Contracts where Nottinghamshire County Council is an associate commissioner, contracts transacted through the Public Health Services Contract (developed by the Department of Health, in partnership with local government and public health professionals) and a local abridged contract for the provision of Public Health Services with a financial value under £100,000.

6. Reflective of the promises and commitments outlined in the Nottinghamshire County Council Strategic Plan 2010 -2014, a cornerstone to the assurance process for commissioned health services is the assurance of quality, patient safety and positive patient experience.

7. The focus on quality, patient safety and patient experience is underpinned by the recommendations of the Francis Report (2013). The Francis report is the result of a public inquiry into the role of commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust between January 2005 and March 2009. It follows on from two previous inquiries into events at the Trust which uncovered a lack of basic care in many of its wards and departments. In response to the report, Health Secretary Jeremy Hunt committed to ensuring that the quality of patient care will be put at the heart of the NHS in an overhaul of the health and care system. The response by the health secretary is accompanied by a statement of common purpose signed by the chairs of key organisations across the health and care system.

8. Nottinghamshire County Council will be working in partnership with the local NHS England Area Teams to implement the Francis Report (2013) recommendations, with a particular focus on the recommendations for commissioners which form part of the 290 recommendations.

9. To support delivery of commissioning functions for health contracts a Quality and Risk Management Policy to Support Health Contracts is shared (Appendix 2) and an outline model of Performance and Quality Reports for Health Contracts (Appendix 3). The performance management of health contracts will reflect the process to be outlined in the Nottinghamshire County Council Strategic Management Framework supported by a Performance Management protocol. The strategic framework and protocol will set out key principles to support robust performance monitoring, quality standards and quality assurance measures (including patient safety) to ensure that Nottinghamshire County Council as commissioner of health services is assured that services are:
    a. fit for purpose
    b. of a high quality
    c. demonstrate the application of systems and processes that maintain patient safety
    d. deliver measurable health outcomes (health enhancement/improvement) reflective of the PHOF, LOF, JSNA and Health and Wellbeing Strategy
    e. capture service user evaluation and feedback, and
    f. reflect value for money

10. **The Quality and Risk Management Policy to Support Health Contracts,** is aligned to the Nottinghamshire County Council Corporate Risk Management Strategy and an appendix to the draft Public Health Governance Framework (06.09.2012) and has been developed to set out robust and responsive quality and risk management processes to ensure that quality standards and service user / patient safety are continually improved.

11. The policy endorses the proactive anticipation and appropriate management of risks, through clear risk reduction measures. The policy sets out the process for Serious Incident Reporting using the National Reporting and Learning System, Care Quality Commission Serious Incident Investigation and the responsibilities of the Public Health Department in the investigation and management of Serious Incidents and Complaints. The policy outlines the relationships with NHS England Area Teams, Healthwatch, Scrutiny Panels, the management of formal and informal enquires, including enquiries from members of

parliament to support effective system wide management of quality and patient safety **(refer to Appendix 2).**

12. It is envisaged that there will be the opportunity to bring some alignment of Serious Incident investigation processes for health contracts through joint working with Adult Health Social Care and Public Protection (AHSC&PP) as part of the review the AHSC &PP Risk Escalation Policy. The PHSC is asked to endorse the Quality and Risk Management Policy to Support Health Contracts and recommend it for approval to the Policy Committee.

Outline Model of Performance and Quality Reports for Health Contracts

13. A template for the Quality and Performance reports will capture performance and quality information obtained from providers in monthly, quarterly, six monthly and annual health contract returns. A summary report will be provided to the Public Health Senior Management Team (PH SMT) and the Public Health Sub Committee (PH SC) on a quarterly basis **(refer to Appendix 3) .**

14. The report will include a summary of High Impact (Red Risks) from Public Health Register, Serious Incidents, complaints and Freedom of Information requests relating to Health contracts. Table 1, below provides a timetable for Performance and Quality Reports.

Table 1 Timetable for Quality and Performance Reports

Data Reporting Period	PH SMT	PH SC
Summary of 2012-13	28.08.2013	12.09.2013
Quarter 1 2013-14	28.08.2013	12.09.2013
Quarter 2 2013-14	18.11.2013	09.01.2014
Quarter 3 2013-14	Feb 2014 date TBC	06.03.2014
Quarter 4 2013-14	April 2014 date TBC	08.05.2014

Statutory and Policy Implications

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

RECOMMENDATION/S

1. The Public Health Sub-Committee is asked to endorse the Quality and Risk Management Policy to Support Health Contracts and recommend it for approval by the Policy Committee.

2. The Public Health Sub-Committee is asked to note the information provided in Public Health Contract Performance and Quality Management and to provide feedback in relation to the format of the proposed report.

Cathy Quinn,
Associate Director of Public Health

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

16. Constitutional Comments (SLB 24/05/2013)
The Public Health Sub-Committee is the appropriate body to consider the content of this report

17. Financial Comments (ZKM 28.05.2013)
There are no financial implications arising directly from this report.

Background Papers
Draft Public Health Governance Framework September 2012

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

Electoral Division(s) and Member(s) Affected

All

List of Appendices

Appendix 1	Public Health Priority and Public Health Functions
Appendix 2	Quality and Risk Management Policy to Support Health Contracts
Appendix 3	Outline model of Performance and Quality Reports for health contracts with sample data for the Priority Public Health Functions

Appendix 1

Public Health Priority and Public Health Functions		
Functions	**Lead Consultant**	**Lead Public Health Manager**
Public Health Priority Functions		
1. The National Child Measurement Programme	Barbara Brady	Anne Pridgeon
2. NHS Health Check assessments	John Tomlinson	Jenny Charles-Jones
3. Comprehensive sexual health services (including testing and treatment for sexually transmitted infections, contraception outside of the GP contract and sexual health promotion and disease prevention)	Penny Spring	Tracy Burton
4. The local authority role in dealing with health protection incidents, outbreaks and emergencies	Jonathan Gribbin	
5. Public Health advice to Clinical Commissioning Groups (CCGs) via Memorandum of Understanding		
Public Health Functions		
6. Accidental injury prevention	Penny Spring	
7. Alcohol and drug misuse services	Barbara Brady	Tammy Coles
8. Public health services for children and young people aged 5-19 (including Healthy Child Programme 5-19) (and in the longer term all public health services for children and young people)	Kate Allen	Irene Kakoullis
9. Public health aspects of promotion of community safety, violence prevention and response	Barbara Brady	
10. Dental public health services (prevention/health promotion elements only)	Barbara Brady	Anne Pridgeon
11. Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes	Kate Allen Penny Spring	
12. Infection Prevention and Control	Jonathan Gribbin	Sally Bird

Public Health Priority and Public Health Functions		
Functions	**Lead Consultant**	**Lead Public Health Manager**
13. Public mental health services	Barbara Brady	Anne Pridgeon
14. Locally-led nutrition initiatives	Barbara Brady	Anne Pridgeon
15. Increasing levels of physical activity in the local population	Barbara Brady	Anne Pridgeon
16. Behavioural and lifestyle campaigns to prevent cancer and long-term conditions	John Tomlinson – LTC Mary Corcoran - cancer	Jenny Charles-Jones Sue Coleman
17. Population level interventions to reduce and prevent birth defects	Kate Allen	
18. Local initiatives to reduce excess deaths as a result of seasonal mortality	Mary Corcoran	Nikki Hughes
19. Public health aspects of local initiatives to tackle social exclusion	Barbara Brady	
20. Tobacco control and smoking cessation services	John Tomlinson	Lindsay Price
21. Interventions to tackle obesity such as community lifestyle and weight management services	Barbara Brady	Anne Pridgeon
22. Local initiatives on workplace health	Penny Spring	Helen Houghton

Appendix 2

Quality and Risk Management Policy to Support Health Contracts

Refer separate attachment

Appendix 3

Outline model of Performance and Quality Reports for health contracts including sample data for the Public Health Priority Functions

Refer to separate attachment

Nottinghamshire County Council

Appendix 2
PHSC 06.06.2013

Final Draft

Policy Library Pro Forma This information will be used to add a policy, procedure, guidance or strategy to the Policy Library.

Title: Quality and Risk Management Policy to support Health Contracts.

Aim / Summary: Sets out the policy for the promotion and management of quality and identification, mitigation of risk associated with health contracts commissioned by Nottinghamshire County Council.

Document type (please choose one)			
Policy	√	Guidance	
Strategy		Procedure	

Approved by:	**Version number: 1**
Date approved:	**Proposed review date:** March 2015

Subject Areas (choose all relevant)

About the Council	√	Older people	√
Births, Deaths, Marriages		Parking	
Business		Recycling and Waste	
Children and Families	√	Roads	
Countryside & Environment		Schools	
History and Heritage		Social Care	
Jobs		Staff	
Leisure		Travel and Transport	
libraries		**Public Health**	√

Author: Sally Handley and Tracy Madge	**Responsible team:** Public Health
Contact number: 0115 9772445	**Contact email:** Sally1.handley@nottscc.gov.uk

Please include any supporting documents	
1. Public Health Governance (currently draft)	
2. Risk Management Strategy.	
3. Policy for reporting and management of incidents & near misses including Serious Incidents (SIs).	
4. Procedure for reporting incidents near misses and SIs.	
5. Complaints Policy.	
6. Links to NCC Corporate Risk Management Strategy	
7. Procedure for the Management of Claims.	
8. Health and Safety Policy	
9. Performance and Quality Framework to support commissioning of Health Contracts	
Review date	**Amendments**

Quality and Risk Management Policy to support Health Contracts

Context

1. Following the implementation of the Health and Social Care Act 2012 (H&SCA 2012) and the new duty of upper tier and unitary local authorities to take steps to improve the health of their populations, Nottinghamshire County Council has taken forward a number of steps to commission services locally to meet the responsibilities and functions to secure delivery of a range of health services, supported by a ring fenced budget for public health.

2. The H&SCA 2012 required the transfer of some Public Health (PH) NHS contracts to Local Authorities. A number of these contracts include clinical commissioned services for the provision of clinical procedures for example substance misuse i.e. GP prescribing and pharmacy dispensing of controlled drugs and sexual health services that include clinical procedures. Assurance is required that any procedure undertaken by a provider is managed with due regard to appropriate clinical competencies. Assurance can be sought through adherence to the Care Quality Commission (CQC) guidance nonetheless, Nottinghamshire County Council (NCC) must have an internal assurance process to protect citizens and manage clinical risk accordingly.

3. There are three dimensions of quality, all of which must be present in order to provide a high quality services:
    a. Clinical effectiveness- high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes
    b. Safety –high quality care is care which is delivered so as to prevent all avoidable harm and risk to the individual's safety
    c. Patient experience – high quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care possible, including being treated according to what that individual wants or needs, and with compassion, dignity and respect.

4. The terms patient/service user or citizen are used interchangeable throughout the policy and refer to all residents in the County of Nottinghamshire or registered with a Nottinghamshire County General Practitioner. Resident and registered populations are both covered within this policy.

5. This policy is aligned to the Nottinghamshire County Council Corporate Risk Management Strategy and is an appendix to draft Public Health Governance Framework(*file path Q:\Corporate, Governance & Assurance\PH Governance*) and should be read alongside that document.

6. All health services commissioned by Nottinghamshire County Council as part of the PH function require robust quality and risk management processes to ensure that quality standards and service user/patient safety are continually improved and that risks are proactively anticipated and appropriately managed through the application of clear risk reduction measures.

7. The policy outlines the quality and risk structure and processes that enable the organisation

to commission and improve the quality and safety of health services that are directly commissioned by the NCC. The policy outlines internal and system wide mechanisms that provide assurance in relation to delivery of quality services, the review of quality and safety standards, processes for monitoring, reporting and escalating concerns and breeches in relation to the quality of care, quality standards and safeguards and associated risks management and mitigation. The policy explains how lessons learnt are shared and actions implemented, alongside national lessons learnt (for example Francis Report 2012).

8. The policy also outlines the risk management process relating to health contracts, how risks are managed, mitigated against, the likelihood of occurrence and their potential impact on the successful achievement of PH and NCC objectives, NCC Strategic Plan and the Health and Wellbeing Board Strategy.

Scope of this policy

9. The policy applies to all health services contracted by Nottinghamshire County Council as part of PH responsibilities.

Principles and Commitments

10. The purpose of this Quality and Risk Management Policy (to support PH Contracts) is:

- To ensure structures and processes are in place to support a culture of high quality service delivery and safety, embedding of quality standards, with a focus on continual improvement, with the assessment and management of associated risks

- To promote and support a culture of accountability for quality, safety and risk management

- To state principles of openness, transparency and candour in relation to the promotion of quality, safety and risk reduction, where lessons learnt are shared and acted upon in a timely way

- To assure the public, patients, staff and partner organisations that NCC is committed to ensuring that there is a culture of continual improvement of quality and quality standards within commissioned Public Health services, with the appropriate identification and management of associated risks

Key actions to meet the commitments set out in the policy

ACCOUNTABILITIES FOR QUALITY AND RISK

The Chief Executive

11. The Chief Executive has overall accountability for the management of risk and is responsible for:

- Continually promoting quality, safety and risk management and demonstrating leadership, involvement and support

- Ensuring an appropriate committee structure is in place, with regular reports to the Nottinghamshire County Council Policy Committee, through the Risk, Safety and Emergency Response Board (RSERB)

- Ensuring that Lead Officers with managerial responsibility for quality and risk management are clearly identified

- Ensuring appropriate policies, procedures and guidelines are in place

The Health and Wellbeing Board

11. The core functions of the Health and Wellbeing Board are set out in legislation and cover the following areas:

- The production of a Joint Strategic Needs Assessment including Pharmaceutical Needs Assessment

- The development of a Health and Wellbeing Strategy for the county that improves health outcomes

- Promotion of integrated working between the NHS, local government, the criminal justice system, as well as commissioners and providers of services

- Provision of support and advice to encourage close working relationships between the Board and commissioners and providers of health or social care services

Nottinghamshire County Council Policy Committee

12. In relation to this policy the Policy Committee is responsible for:

- The Nottinghamshire County Council Risk Management Strategy and has responsibility for monitoring and reviewing the overall performance of the Council

- Remaining statutory overview and scrutiny powers except those delegated to a health scrutiny committee

- The discharge of all functions and exercise of all powers of Nottinghamshire County Council not expressly reserved to the Full Council or to any other part of Nottinghamshire County Council by statute or by this Constitution

The Director of Public Health

13. The Director of Public Health (DPH) is one of three sponsoring Directors for Health and Wellbeing and is the lead director for quality and risk management relating to the PH contracts and is responsible for:

- Emergency Accountable Officer in relation to all PH contracts including associate contracts with the NHS and is the Medical Lead relating to these contracts

- Ensuring quality standards, safety and risk management systems relating to PH contracts are in place

- Ensuring that Serious Incidents (SIs) are reported by Care Quality Commission (CQC) registered providers to the NHS Commissioning Board (NHS CB) via the National Reporting and Learning System (NRLS)

- Ensuring that SIs from providers who are not CQC registered trigger a locally agreed

investigative process detailed in the policy

- Overseeing the management of risks as determined by the NCC Policy Committee, through the Risk, Safety and Emergency Response Board (RSERB)

- Ensuring risk action plans are put in place, regularly monitored and implemented

- Ensuring that the Public Health Directorate is a member of, RSERB and, if nominated by Nottinghamshire County Council the local Quality Surveillance Groups (QSGs)

- Providing assurance reports to the Nottinghamshire County Council RSERB

- Working with NHS CB Area Teams to provide at least an annual summary to the Policy Committee outlining NCC progress (as a commissioner of clinical services) to implement recommendations from the Francis Report (DH 2012) Mid Staffordshire NHS Foundation Trust Public Enquiry

- Ensuring the Quality and Risk Management Policy is regularly reviewed on a quarterly basis and updated accordingly

14. There are a number of specific roles and responsibilities assigned to members of PH department in relation to quality, safety and risk management. Refer **Appendix 6**

ORGANISATIONAL FRAMEWORK FOR QUALITY AND RISK MANAGEMENT ASSOCIATED WITH HEALTH CONTRACTS

15. The structure relating to the management of quality and risks is illustrated at **Appendix 1.** The following describes the roles of committees and boards within the context of managing quality

The Health and Wellbeing Board

16. The Health and Wellbeing Board provides local leadership for quality improvement, with local health and care commissioners coming together with the local community to jointly assess needs, determine a joint health and wellbeing strategy to improve outcomes. The Health and Wellbeing Board will want to be informed of any risk to quality with respect to integrated commissioning.

17. The terms of reference for the Health and Wellbeing Board are in **Appendix 2**

NCC Policy Committee

18. The NCC Policy Committee exercises powers and functions delegated by the Full Council and as set out in **Appendix 3**.

19. Corporate risks arising from PH contracts will be escalated to the Policy Committee via the Corporate Leadership Team. The Policy Committee will exercise its responsibilities relating to performance management responsibilities of Nottinghamshire County Council.

20. Corporate risks may arise from complaints or concerns relating to quality standards and safety from a Direct Award provider and from the investigation of SIs (investigated by CQC for registered CQC providers or locally for non CQC registered providers), from Patient and Public Involvement (PPI), Healthwatch and politicians **(Appendix 1).**

The Nottinghamshire County Council Risk, Safety and Emergency Response Board (RSEMB)

21. The RSEMB is responsible for risk management, health and safety, emergency planning and business continuity within the department.

22. The RSEMB acts as the departmental forum through which risk, safety and emergency management related issues are communicated and implemented and maintains an overview of corporate and legislative standards, policies and guidance.

23. In relation to **Risk Management** (the RSEMB is responsible for)

- Implement, review and maintain a departmental risk register
- Ensure coherence with the corporate risk register
- Maintain a programme of risk assessment across the department

24. In relation to **Health and Safety** (the RSEMB is responsible for)

- Instigate and review departmental health and safety improvement plans
- Ensure staff training needs are identified to enable them to carry out health and safety functions to the required levels of competence

25. Corporate risk relating to PH contracts will be escalated to the RSEMB via the Corporate Leadership Team

26. The terms of reference for the NCC RSEMB are in **Appendix 4**

Corporate Leadership Team (CLT)

27. CLT has responsibility for making informed decisions that ensure that NCC obligations in relation to quality standards, safety and risk mitigation are carried out in an effective, robust and timely way. In relation to PH contracts, corporate risks and risks that may have broader impact across health and social care are escalated to the Policy Committee.

The Public Health Senior Leadership Team (SLT)

28. The Public Health SLT undertakes the department Risk, Safety and Emergency Management function and regularly reviews quality standards, safety and risks and concerns arising from Public Health Contracts from the following sources:

- Public Health Risk Register – section for PH contracts
- Performance and Quality Summary Reports
- Investigation of SIs
- Audit and review of services to provide assurance of quality standards, safety and to clarify risk within the system

- Summary of complaints, serious incidents, audits and PPI intelligence relating to PH contracts

29. The Public Health SLT reports high impact (red) risks, serious incidents, concerns or trends and mitigation to the Public Health Sub Committee and the RSEMB.

30. The terms of reference for the Public Health Subcommittee are in **Appendix 5**

Nottinghamshire County Council Risk, Safety and Emergency Management Function

31. Each department within Nottinghamshire County Council undertakes the Risk, Safety and Emergency Management function, and has a responsibility to report any intelligence relating to quality, safety and risks associated with the Public Health Contracts to the RSEMB. Refer to **Appendix 1.**

Quality Surveillance Groups

32. There are regional and local Quality Surveillance Groups (QSG). The local QSGs act as a virtual team across the health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, commissioning and regular activities. There are two local QSGs South Yorkshire Area Team and Notts/Derby Area Team.

33. NCC has elected the DPH to be the named member of the QSGs on behalf of Nottinghamshire county Council.

Patient and Public Involvement (PPI) System Intelligence

34. As part of the broader health system intelligence and scrutiny, feedback from PPI, Healthwatch, Scrutiny Committees, complaints and relevant intelligence received through politicians and Freedom of Information (FOI) enquiries and formal questions about quality standards, safety and risk will be captured and summarised quarterly by PH Consultants as portfolio leads. High impact (red) risks and concerning trends will be shared with the Policy Committee via CLT and will be summarised within directorate Risk, Safety and Emergency Management reports.

SYSTEMS FOR MANAGING QUALITY AND RISK

Commissioning for Quality

35. A PH Performance and Quality Framework will support the commissioning of services and clearly define the requirements for quality standards, patient safety, risk management and quality and performance requirements and will include:

36. Upholding the rights of citizens and patients with due regard to the NHS Constitution, mechanisms for meaningful PPI feedback, including Picker Institute Surveys

37. A clear focus on commissioning for quality and outcomes, applying the Public Health Outcomes Framework, the Local Outcomes Framework and supporting partners to deliver against the NHS and Social Care Outcomes Framework. The partners will need assurance of delivery against the HWB Board Local Outcomes Framework and recommendations from the national Children and Young Peoples work

40. Supporting delivery to the NHS CB quality and outcomes objectives which support the health system's collective objectives in relation to quality

41. Supporting the NHS through the core offer of public health advice to secure quality and improvement against all 60 indicators included in the NHS Outcomes Framework. This core offer of advice is detailed in a Memorandum of Understanding with the NHS CB and Clinical Commissioning Groups (*file path Q:\Transition\MOU)*

42. Supporting the NHS to deliver a stretching level of ambition for each domain of the NHS Outcomes Framework

43. Supporting the NHS to address the recommendations from the Francis Report (February 2013)

44. Ensuring that requirements for CQC registered providers to report serious incidents to the NHS CB via the NRLS are upheld and monitored

45. Requirements for non CQC registered providers to report and trigger investigations into SIs

Quality and Performance Reports

46. Quality and performance schedules outline the quality and performance reporting requirements and frequency of reporting. The schedules form part of the Service Specification for all commissioned services.

47. The development of performance and quality reports will be supporedt by the Public Health Performance and Quality Framework for health contracts. The contracts set out the requirements for providers to deliver performance and quality data/reports to the Public Health Performance Team on a monthly, quarterly, six monthly and annual basis, as set out in the contract schedules and service specifications. A summary Performance and Quality Report will be provided to Public Health Subcommittee for all health contracts on a quarterly basis.

PH Risk Register - Health Contracts

48. The PH Risk Register includes a section for PH contracts and is maintained and updated by the Public Health Consultants for their lead areas and reviewed quarterly at the Public Health Sub Committee. High impact (red) risks and any concerning trends are identified and escalated to the Nottinghamshire County Council RSEMB.

Nottinghamshire County Council Risk, Safety and Emergency Response Board (RSEMB)

49. The RSEMB agrees corporate concerns escalated from each department and records these on the Corporate Risk Register which is shared with the Policy Committee and CLT.

National Reporting and Learning System (NRLS) - NHS CB Serious Incident Reporting Framework

50. Reporting to CQC of patient safety incidents involving severe harm or death as well as reporting to CQC of other incidents that indicate, or may indicate, risks to on-going compliance with the registration requirements, or that lead, or may lead, to changes in the details about the organisation in the regulator's register, is a requirement on all CQC-

registered providers. NHS providers can fulfil this requirement by reporting such incidents to the NRLS which shares relevant information with CQC. For other providers, such incidents should be reported directly to CQC.

51. The NHS CB has published a framework for the management of serious incidents in the NHS. This serious incident management framework ensures consistency in relation to definitions, roles and responsibilities and clarifies legal and regulatory requirements across the NHS and wherever possible the management of serious incidents in NCC commissioned public health care should be consistent with this framework.

52. Investigations of serious incidents under the NHS contract will follow the national guidance. Where incidents or complaints cross organisational boundaries the principle of management should any primary care element be included the investigation will be led by the NHS CB Area Team who will be responsible for the coordination of the response. If there is no primary care element but the serious incident or complaint crosses organisational boundaries, the organsiaiton where the complaint / serious incident was reported will lead the investigation and be responsible for the coordination of the response.

53. The systems-improvement approach to safety acknowledges that causes of incidents cannot simply be linked to the actions of individual people. The framework uses a system wide perspective for notification, management and learning from serious incidents. It supports openness, trust and continuous learning and service improvement. Where relevant, it highlights where engagement with relevant bodies for full investigation and identification of learning from a serious incident is needed. **Refer Appendix 7** and web link: http://www.NRLS.npsa.nhs.uk/resources/?entryid45=75173

Local Investigations of Serious Incidents (SIs)

54. Local processes will be established to investigate SIs arising from PH contracts. The Senior PH Manager for Quality will coordinate the investigations drawing on experts within PH and other directorates and the NHS CB Area Teams. A summary report of serious incidents investigated will be provided to the Public Health Sub Committee on a quarterly basis. (**Appendix 1 and 6**).

Other bodies with a remit for serious incidents

55. The NHS CB is the primary NHS organisation responsible for the collation of, and learning from serious patient safety incidents occurring in healthcare. Other bodies such as the Medicines and Healthcare Products Regulatory Agency (MHRA), Public Health England - Health Protection function, Serious Hazards of Transfusion (SHOT), National Screening Programmes, Health and Safety Executive (HSE), Monitor or Local Safeguarding Boards should be notified about incidents relevant to their remit in accordance with their reporting guidance.

56. In circumstances where several bodies are notified, these will liaise with each other, the relevant commissioning organisation and the provider organisation(s) in formulating an appropriate national response (if one is needed). Healthcare provider organisations should support investigations by other bodies as required, to facilitate national learning.

57. Local safeguarding procedures for adults and children will be followed and safeguarding alerts made whenever necessary and appropriate.

Management of complaints relating to contracted Public Health Services

58. Complaints that are received via the Nottinghamshire County Council complaints system will be investigated by PH Directorate and a summary of complaints and outcome of the investigation will be provided quarterly to the Public Health Subcommittee. Please refer to **Appendix 6.**

Patient and Public Involvement and Local Scrutiny mechanisms

59. Health system intelligence and scrutiny including feedback from PPI engagement, Healthwatch, Scrutiny Committees and relevant intelligence received through politicians and FOI enquiries and formal questions about quality standards, safety and risk. This will include feedback from provider staff surveys and patient surveys including Picker Institute Surveys.

Joint Nottingham and Nottinghamshire Health Scrutiny Committee

60. Representative Councillors from Nottinghamshire County Council and Nottingham City Council ensures accountability and a wider community engagement in health issues across the conurbation. The joint committee scrutinises developments in local NHS services and helps to ensure the delivery of local health services. The Chair alternates between the City and County each year.

RISK ASSESSMENT PROCESS

61. The Nottinghamshire County Council Risk Assessment Procedure (**Appendix 10**) is summarised as:

Risk Identification

62. Risks associated with PH contracts are identified by PH Consultants for their lead areas and recorded in the Public Health Risk Register in the section for Public Health Contract. The risks identified are those risks which may impact on citizen or patient safety, service quality /standards risks that could negatively impact on the achievement of outcomes from the:

- Public Health Outcomes Framework
- NHS Outcomes Framework
- Social Care Outcomes Framework
- Local Outcomes Framework
- Recommendations from the Children and Young People's Outcomes Group

Quantifying Risk

63. Once a risk is identified it is important to establish the likelihood of it occurring and the potential impact if it did occur. This is measured by using a risk assessment matrix and assessment of the impact of risk – shown in **Appendix 10**.

64. The risk score is determined by multiplying the score for the likelihood of an event occurring with the impact score

Reporting and Evaluation of Risk

65. Risks are escalated to the Public Health Subcommittee and in turn high impact (red) risks

and mitigation and any concerning trends from SIs, reviews and PPI intelligence are escalated appropriately including to the CLT and RSEMB who agree new strategic risks to be reported to the Policy Committee.

Recording of actions

66. Actions identified to minimise a potential risk are recorded in the Public Health Risk Register and include a time scale for expected completion of that action. When actions are complete and now form part of the controls within the system the key controls column should be updated.

Residual Risk

67. After identifying any action/plan to minimise a risk, the risk should be re assessed taking in to account the effect of implementing any action / plan.

MONITORING THE EFFECTIVENESS OF THE POLICY

68. Nottinghamshire County Council will monitor and review performance in relation to the management of quality and risk, and the continuing suitability and effectiveness of the systems and processes in place to manage risk through a programme of internal and external audit work, and through the oversight of the RSEMB

CONSULTATION AND COMMUNICATION WITH STAKEHOLDERS

69. Systems of communication with external stakeholders are in place to contribute to the minimisation of reputational risk to the organisation. These include a public website, Health and Wellbeing Board Strategy and Strategic Objectives.

REVIEW AND REVISION OF THE DOCUMENT

70. The Quality and Risk Management Policy to support PH contracts is a working document and will be reviewed by the Public Health Department, Public Health Sub Committee and RSEMB.

DISSEMINATION AND IMPLEMENTATION

71. This document will be made available to all directorates within NCC contributing to delivery of the policy and the wider health community (NHS CB Area Teams, Clinical Commissioning Groups and Healthwatch). Public Health staff involved in PH contracts will be supported by a programme of risk management training to support the implementation of this policy.

Appendix 1

Reporting structure for management of quality and risks associated with Health Contracts

Corporate Leadership Team

NCC Policy Committee/ Health and Wellbeing Board

Risk, Safety and Emergency Management Board

Public Health Sub Committee

Each department undertakes Risk, Safety & Emergency Management Group / function

Adult Social Care and Health and Public Protection

Public Health

Policy Planning and Corporate Services

Environment and Resources

Health System

Quality Surveillance Groups
NHS Commissioning Board Area Teams

Role of Patient, Public and Local Scrutiny

- Healthwatch
- Scrutiny Committees
- PPI
- Complaints via NCC
- Formal and informal enquiries including Members of Parliament

NHS CB - National Reporting and Learning System (NRLS)
Public Health England –Health Protection function

Public Health functions /processes to promote quality, safety and risk mitigation in respect of Heath Contracts

Public Health SLT

Assure robust quality and performance metrics applied to health contracts. Relating to health contracts:

- Investigate complaints and serious incidents
- Advise and recommend audit and review of provider services
- Review Quality and Performance Reports quarterly
- Review and assess associated risks and mitigation
- Summary of complaints, FOI and other requests quarterly
- Report to PH Sub Committee

Summary of Complaints

A complaints log and outcome is kept for complaints relating to Health Contracts and reported via the NCC Complaints System and investigated by PH Directorate. Shared quarterly with PH SLT and PH Sub Committee.

Public Health Risk Register for Health Contracts

Completed by PH Consultants – summary reported quarterly to PH Sub Committee

Health Contracts Quality and Performance Report

- Reviewed Monthly by PH Quality and Performance Team
- Shared with PH SLT

Public Health interface with NHS CB Area Teams

- Senior PH manager interface with NHS CB Director of Nursing (DoN)

Public Health interface with Public Health England - Health Protection Function

Develop PPI - utilising NCC systems

APPENDIX 2

Health and Wellbeing Board Terms of Reference

1. Preparing and publishing a Joint Strategic Needs Assessment of the population of Nottinghamshire.

2. Preparing a Health and Wellbeing Strategy based on the needs identified in the Joint Strategic Needs Assessment and overseeing the implementation of the strategy.

3. Ensuring that commissioning plans have due regard to the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy.

4. Promoting integrated working including joint commissioning in order to deliver cost effective services and appropriate choice. This will also include joint working with services that impact on wider health determinants.

NOTE: This Committee is in shadow form until the Health and Social Care Act's statutory powers are in place from April 2013.

APPENDIX 3

Nottinghamshire County Council Policy Committee Terms of Reference

Refer to link in the Nottinghamshire County Constitution

http://www.nottinghamshire.gov.uk/dms/Constitution/tabid/105/FolderID/5/Constitution-2012-13-Current-Version.aspx

APPENDIX 4

Nottinghamshire County Council Risk, Safety and Emergency Management Group Terms of reference

Refer to link in the Nottinghamshire County Constitution

http://www.nottinghamshire.gov.uk/dms/Constitution/tabid/105/FolderID/5/Constitution-2012-13-Current-Version.aspx

APPENDIX 5

Public Health Subcommittee Terms of Reference

Refer to link in the Nottinghamshire County Constitution

http://www.nottinghamshire.gov.uk/dms/Constitution/tabid/105/FolderID/5/Constitution-2012-13-Current-Version.aspx

APPENDIX 7

Quality Surveillance Groups

There are regional and local Quality Surveillance Groups (QSG). The local QSG (based on the footprint of the NHS Commissioning Board Area teams) will act as a virtual team across the health economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, commissioning and regular activities. By collectively considering and triangulating information and intelligence, the local QSGs will work to safeguard the quality of care that people receive. There are two local QSGs South Yorkshire Area Team and Notts/Derby Area Team.

The local QSGs will engage in surveillance of quality at a local level and consider information and intelligence, working together to take coordinated action to mitigate quality failure.

Regional QSGs provide an escalation mechanism for local QSGs, assimilating risks and concerns from local QSGs, identifying common or reoccurring issues that would merit a regional or national response.

How to Establish a Quality Surveillance Group –Guidance to the new health system January 2013 refer to web link:

https://www.wp.dh.gov.uk/publications/files/2013/01/Establishing-Quality-Surveillance-Groups.pdf

Flow diagram for reporting and investigating clinical risk and complaints

Clinical Risk or Complaint Identified through…

Service user/other alert to County Council via complaints process or other NCC department

Provider or other professional e.g. commissioner alert to Public Health Contract Team (including CQC where required)

All complaints are assessed by NCC Complaints Team as low, medium or high risk and recorded on the NCC complaints register - RESPOND.

NCC Complaints Team makes initial contact with the complainant and forwards the complaint to the Senior PH Manager Quality, who:

1. Records on the internal Public Health Complaints log
2. Commences urgent action/investigation if indicated
3. Alerts Associate Director and PH Consultant for policy lead area of complaint and the initial assessment of level of risk

Low Risk
The Senior PH Manager Quality:

1. Prepares report for Associate Director who confirms response /correspondence which is sent from PH Consultant to the service user or complainant within agreed timeframe
2. Informs provider and/or other of action plan to reduce risk and any contract penalty
3. Service user notified of outcome as appropriate
4. Source of notification informed of outcome /actions
5. Collate trends and share with QSGs as appropriate

Medium or High Risk

1. PH Consultant for policy area completes investigation and provides information /report to Senior PH Manager Quality within agreed timeframe
2. Senior PH Manager Quality links with NRLS and reports to CQC and NHS CB as appropriate

DPH reports high impact (red) risk and mitigation to CLT, which are in turn reported to Policy Committee and HWB Board as appropriate.
DPH or PH representative shares high impact risks / risk that may require system wide intelligence and triangulation to the local QSGs

Senior PH Manager Quality submits report to Associate Director within agreed timeframe

Associate Director agrees response /correspondence which is sent from either PH Consultant or DPH to service user or complainant within agreed timeframe

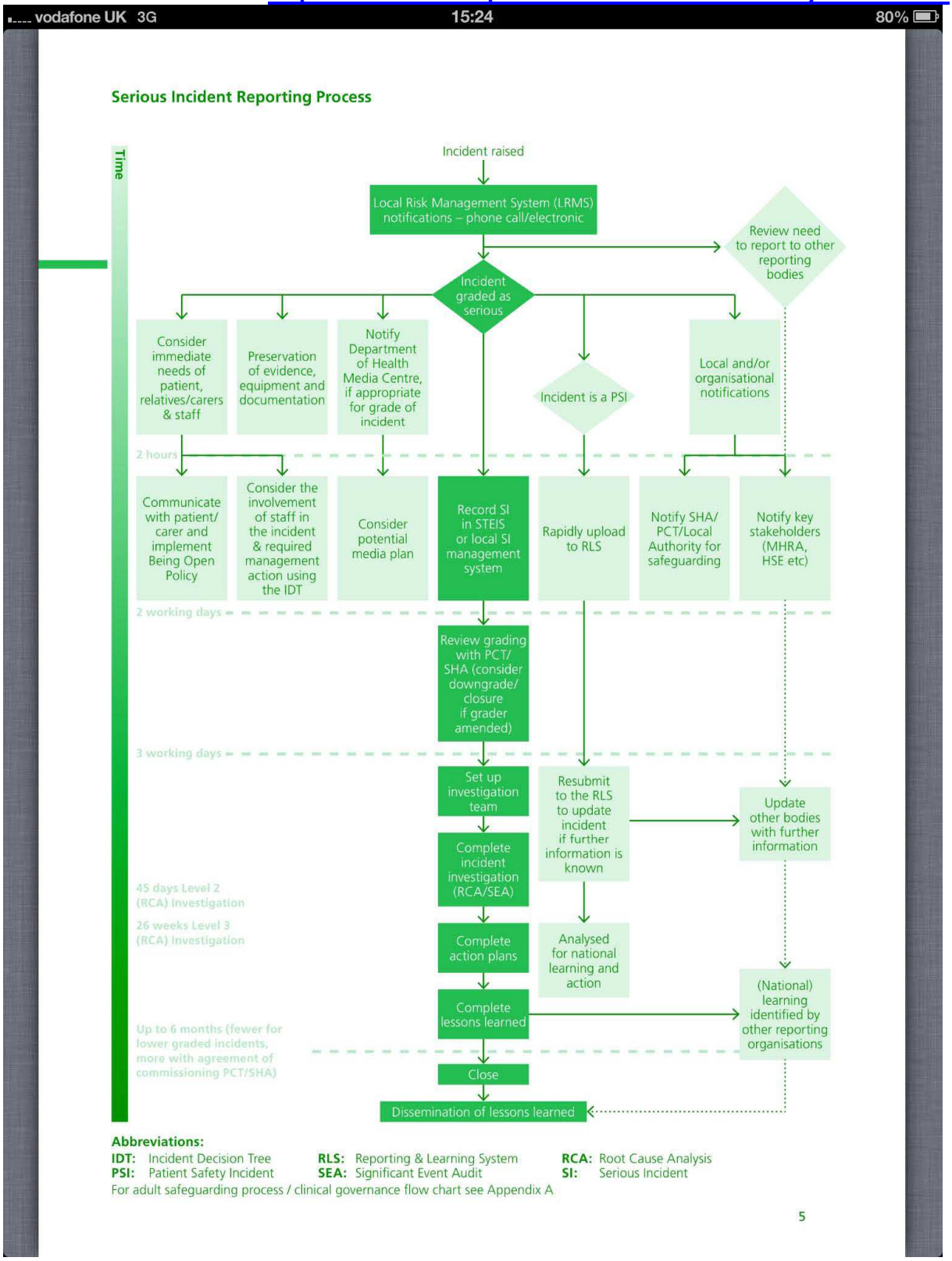
Senior PH Manager Quality:

1. Records high impact (red) risks on risk log, updates internal complaints log of outcome and signs off action plan agreed by policy lead
2. Discusses contract penalties to be applied with Procurement Lead as appropriate
3. Liaises with NHS CB and CCG as appropriate

Associate Director reports high impact (red) risks to Risk, Safety and Emergency Management Group

Date: XX.XX.2013

APPENDIX 9 Serious Incident Reporting via NHS CB NRLS
Available on Web link: http://www.NRLS.npsa.nhs.uk/resources/?entryid45=75173



Nottinghamshire County Council

Risk Management

Risk Assessment Procedure

This version: November 2011

The following guidance is designed to help managers to identify, evaluate and respond appropriately to service risks of all kinds

Risk Assessments

Introduction

Risk is an inherent feature of decision making at any time, and many managers will already be aware of the benefits of using risk management techniques in their day-to-day work. The key to successful risk management is to be in a position where you are able to take risks knowingly, not unwittingly.

The purpose of this brief paper is to offer a simple general-purpose process for assessing risks and feeding these into the County Council's risk management structure. It does not replace or preclude the use of more elaborate techniques that may be employed for complex project planning.

Objective

The objective of the Risk Assessment is to identify **key risks**, and to assess these in terms of their **likelihood** and the potential **impact** were they to occur. This process can highlight any potentially significant risks which require additional control actions.

The Overall Risk Assessment Process:

Step 1: Identify Risks
Step 2: Assess Risks
Step 3: Manage and Control Risks
Step 4: Report any high priority risks
Step 5: Review Risks

These steps are described in the following sections.

Step 1: Identify Risks

Consider services' key activities, and ask yourself ***"what if?"*** questions, and imagine scenarios. The following headings may be helpful:

- **People** – Failure to deliver services as a result of the lack of a sufficient, suitably qualified and/or skilled, valued, healthy and motivated managers and workforce
- **Property** – Failure to provide accommodation / tools / equipment that is fit for purpose
- **Pounds** – Failure to provide safe and sufficient levels of service due to financial constraints / inability to provide correct and timely payments to staff / contractors
- **Performance** – Inability to deliver effective standards of services and meet statutory requirements and effectively monitor performance
- **Partners** – Inability to maximise the benefits of partnership working.
- **Policy & Procedures** – Failure to establish and adhere to policies and procedures
- **Political** – Failure to provide timely and accurate information to Elected Members
- **Profile** – Failure to maintain the good reputation of services and/or communicate effectively with the media.

List the risks you have identified and then evaluate each one individually as follows:

Step 2: Assess Risks

It is important that the same basic process is used for assessing risks across all Council activities so that risks can be compared across services and across departments in a consistent manner.

Use a separate copy of the attached Risk Assessment Form for each identified risk.

In each case, include separate assessments of:

- the **LIKELIHOOD** of the risk materializing; and
- the severity of the **IMPACT / potential consequences** if it does occur

This is your own expert opinion, as a manager. It is subjective. There are no right or wrong answers, but it will be a useful tool to highlight topics of potential concern.

Each factor is evaluated on a sliding scale of 1-5; with 5 being the highest value i.e. highest likelihood / most severe impact / consequences. **Use the following guide** to assess these. This will also introduce a measure of consistency and comparability into the overall risk assessment process.

LIKELIHOOD:

1	Rare	0 to 5% chance
2	Unlikely	6 to 20% chance
3	Possible	21 to 50% chance
4	Likely	51 to 80% chance
5	Almost certain	81%+ chance

IMPACT: (e.g. on project costs and/or schedule)

1	Insignificant	0 to 5% effect
2	Minor	6 to 20% effect
3	Moderate	21 to 50% effect
4	Significant	51 to 80% effect
5	Catastrophic	81%+ effect

Having scored each risk for likelihood and impact, next plot the coordinates onto the following matrix and follow the guidance as appropriate. This enables risks to be categorised into Low, Medium, High and Very High Risk, which in turn can trigger different levels of response. A 5x5 matrix is used across the Council to measure risk.

Relative Impact					
Catastro… (5)	M	H	VH	VH	VH
Significa… (4)	M	H	VH	VH	VH
Moderat… (3)	M	M	H	H	H
Minor (2)	L	L	M	M	M
Limited (1)	L	L	L	L	L

Low (1)	Medium Low (2)	Medium (3)	Medium High (4)	High (5)

Relative Likelihood

Red = Very High Priority
Take urgent action to mitigate the risk.
Orange = High Priority
Take action to mitigate the risk.
Yellow = Medium Priority
Check current controls and consider if others are required.
Green = Low Priority
No immediate action other than to set a review date to re-consider your assessment.

Step 3: Manage and Control Risks

Next consider the following headings and record your findings on the attached Risk Assessment form:

- **Current Controls / Mitigation** – existing measures that will (or can be used to) alleviate any possible problems. Ask yourself what contingency plans are in place already that can be brought into action.
- **Additional Controls / Mitigation required** – new measures that can be introduced to alleviate possible problems (e.g. Business Continuity planning helps to manage risk).

It may be helpful to consider the four T's:
Risks can be – *tolerated, transferred terminated, or treated*.

Identify a person to take ownership of the risk and who will be responsible for managing the risk (the Responsible Officer). Also consider relevant timescale and line of reporting. Record all this information on the Risk Assessment form.

Step 4: Report any high priority risks

For the **RED** (Very High Priority) risks, please notify your own manager and departmental representative on the Corporate "Risk, Safety and Emergency Management Board". Send them each a copy of the relevant Risk Assessment form.

Department	Current representative
Adult Social Care, Health & Public Protection	Sue Storey
Children, Families & Cultural Services	Gill Thackrey
Environment & Resources	Tim Gregory
Policy, Planning & Corporate Services	Deborah Hinde

Step 5: Review Risks

Keep your risk assessments under continual review, especially if you feel circumstances have changed.

Any queries:
Contact Rob Fisher,
Head of Emergency Management & Registration
robert.fisher@nottscc.gov.uk
Tel. 0115 977 3681

Nottinghamshire County Council

Risk Management

Individual Risk Assessment Form

Risk (give the topic a title)							
Responsible Officer (include contact details)							
Date of risk assessment							
Next review date							
Nature of the threat (narrative description)							
Likelihood (score 1 – 5)		**Impact** (score 1 – 5)		**Risk Rating** (Multiply Likelihood x Impact)			
Current Controls / Mitigation							
Additional Controls / Actions / Mitigation required						**Action Taken** (record progress)	
Reported to (e.g. Risk, Safety & Emergency Management Board / Service Director / Group Manager)							
Review Comments / Outcomes							

Outline model of Performance and Quality Reports for health contracts including sample data for the Public Health Priority Functions Quarter 3 2012/13

Contents

Introduction & Guide to Using this Report

Introduction
This report details performance of the Public Health (PH) commissioned activity for Nottinghamshire County. It is separated in to the different functions as outlined in the table below. The function is linked to the PH Local Outcomes Framework (LOF) and priorities within the Health and Wellbeing Strategy.

Public Health Priorities:	11. Immunisation Screening & Support
1.NHS Health Check	12. Infection Control
2.National Child Measurement Programme	13. Mental Health
3.Comprehensive Sexual Health Services	14. Nutrition
4.Local Authority (LA) role in dealing with health protection incidents, outbreaks and emergencies	15. Physical Activity
5.Public Health Advice to the Clinical Commissioning Groups (CCGs) (via a MoU)	16. Prevention of cancer & long term conditions
Other Public Health Functions:	17. Reduce & prevent birth defects
6. Accidental Injury Prevention	18. Seasonal mortality
7. Alcohol & Drug Misuse	19. Social exclusion
8. Children & Young People	20. Tobacco control
9. Community Safety	21. Weight management
10. Dental Public Health	22. Workplace Health

Each Public Health function/priority is reported on, where there is current commissioned activity. Where there is no commissioned activity, this is stated.

The table below provides a key to the performance trends shown within the tables

Key to Performance Trends	
▲	Better
►	Not significantly different
▼	Worse
▬	Comparison not possible

Public Health Priority: NHS Health Checks

Public Health Local Outcomes Framework		Health and Wellbeing Strategy Priorities
Outcome	**Reference PHLOF**	- Physical Disability, Long term Conditions and Sensory Impairment - To reduce early mortality and improve quality of life for individuals with Long Term Conditions (LTC)
Recorded diabetes	PH 2.17	

Name of Providers	Number of Contracts
GPs – County-wide	96

Target and Measure	Status		Q3 – 2012/13 Plan	Q3 – 2012/13 Actual
	YTD	F/O		
% of eligible patients who have been offered health checks	R	A	19.0%	14.6%
% of eligible patients who have received health checks	R	A	13.1%	6.6%
% of patients offered who have received health checks	R	A	69.1%	45.3%

Details and Remedial Actions

Key Issues affecting delivery:

- The underperformance has been attributed to the change from the targeted approach from Year 2, whereby Programme activity was slowed down causing a number of practices to disengage.

Actions to address issues:

- Public Health and the CCGs having been working together, through the Local NHS Health Check Implementation Groups, to deliver the key message that the programme is mandatory, for a targeted population.
- All Nottinghamshire County CCG Practices have received annual targets for 2012/13, to catch up with the full national rollout of the programme.
- CCG Action Plans have been devised to improve the uptake rate and activity which, once completed, will be incorporated into CCG Communication Plans to raise awareness of the NHS Health Check Programme by:
    - Utilising CCG Patient Engagement Teams with CCG PPI Leads to assist in raising awareness.
    - Exploring opportunities to raise awareness in CCG events, for example Practice Learning or Promotional Events
    - Sourcing NHS Health Check Promotional Information leaflets/package of material for local use

Public Health Priority: National Child Measurement Programme (NCMP)

Public Health Outcomes Framework		Health and Wellbeing Strategy Priorities
Outcome	**Reference PHLOF**	To achieve a sustained downward trend in the level of excess weight in children by 2020
Excess weight ages 4-5	PH 2.6i	
Excess weight ages 10-11	PH 2.6ii	

Name of Providers	Number of Contracts
County Health Partnership	One
Bassetlaw Health Partnership	One

Target and Measure	Status		2011/12 Plan	2011/12 Actual
	YTD	F/O		
Participation rates (NHS Bassetlaw) – Reception (%)	G	G	89.05%	91.0%
Participation rates (NHS Bassetlaw) – Year 6 (%)	G	G	88.22%	89.3%
Participation rates (NHS Nottinghamshire County) – Reception (%)	A	A	91.0%	90.5%
Participation rates (NHS Nottinghamshire County) – Year 6 (%)	A	A	91.0%	89.6%
Excess Weight – overweight & obesity combined (NHS Bassetlaw) – Reception (%)			No target	24.5%
Excess Weight – overweight & obesity combined (NHS Bassetlaw) – Year 6 (%)			No target	33.2%
Excess Weight – overweight & obesity combined (NHS Nottinghamshire County)–Reception (%)			No target	20.7%
Excess Weight – overweight & obesity combined (NHS Nottinghamshire County) – Year 6 (%)			No target	31.5%
Details and Remedial Actions				

Key Findings:

- NHS Nottinghamshire County did not meet its target for numbers of reception or Year 6 children that are weighed and measured (participation rate) as part of the NCMP.
- The obesity and excess weight prevalence rate in both reception and Year 6 in Nottinghamshire County were significantly lower than the England rate.
- The percentage of obese children in Year 6 is approximately double that of Reception year children, both locally and nationally.
- Locally, there has been no significant change or difference in reception and Year 6 obesity or overweight prevalence rates between 2006/07 and 2011/12.
- There has been a significant decrease in excess weight in reception year for Nottinghamshire County but no significant change or difference in excess weight for Year 6 between 2006/07 and 2011/12.

Actions for 2013/14:

The indicators in the Public Health Outcomes Framework are based around excess weight (overweight plus obesity) in 4-5 (reception year) and 10-11(year 6) year olds. Futures targets will therefore be based around excess weight and will be countywide as opposed to being based around the two PCT areas. Targets for NCMP from 2013/14 will be developed in the near future.

Notes:

This report is based on results from the 2011/12 school year. The NCMP takes place once in a school year; therefore it will be reported on annually. The results for the 2012/13 school year will be published in December 2013.

A more detailed report has been presented to the Children's Trust.

Public Health Priority: Comprehensive Sexual Health

Public Health Outcomes Framework		Health and Wellbeing Strategy Priorities
Outcome	**Reference PHLOF**	None
None		

Name of Providers	Service	Number of Contracts
Nottingham University Hospitals	Genitourinary Medicine (GUM)	One
	GUM - community	
	Contraceptive and Sexual Health service (CaSH)	
Sherwood Forest Hospital Foundation Trust	Genitourinary Medicine (GUM)	One
	CaSH	
	Sexions	
Doncaster & Bassetlaw Hospital	Genitourinary Medicine (GUM)	One
	CaSH	
Chandos Clinic	Psycho-sexual	One
Terrence Higgins Trust	HIV Advice/support	One
Bassetlaw Health Partnership	Teenage Pregnancy Service	One
Community Pharmacists	Emergency Hormonal Contraceptive (EHC)	
GPs	Long-Acting Reversible Contraceptive (LARC, IUDs & Implants)	

Performance data is not available for all the above contracts. Work is on-going to identify what data is available that is meaningful and that gives a picture of providers performance.

Public Health Priority: Steps Local Authorities must perform to protect the health of their local populations

There is a Health Protection Strategy Group (HPSG) which feeds in to the Health and Well Being Implementation Group. It also links in with Public Health England and the NHS Commissioning Board Area Team.

The purpose of the HPSG is to provide proper assurance regarding outcomes and arrangements for the protection of the health of the population to Nottinghamshire County Health and Wellbeing Board and Implementation Group. The Terms of Reference outline the approach and governance arrangements of the HPSG.

Public Health Priority: Public Health Advice to Clinical Commissioning Groups

A Memorandum of Understanding (MoU) for Public Health (PH) advice to the Nottinghamshire County Clinical Commissioning Groups (CCG) for the period 2013 – 2016 has been developed. Each CCG has received their MoU which has been adapted to reflect local need.

This report will outline progress against the outcomes, as identified in the MoU, on a quarterly basis.

Summary Report of High Impact (Red Risks) from Public Health Register, Serious Incidents, Complaints and Freedom of Information requests relating to Health contracts for a given quarter

[The detail below is provided as an example only]

	Summary of High Impact Risks (Red Risks)		Complaints relating to Health Contracts			Summary of Serious Incidents (SI)			Freedom of Information Requests relating to Public health Functions and Health Contracts
	Relating to Public Health Functions	Relating to Health Contracts	Number of new complaints in period	Number of complaints under investigation in period	Number of complaints concluded in period	Number of new SIs in period	Number of SIs under investigation in period	Number of SIs concluded in period	
Public Health Area									
Example NHS Health Check Assessments	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	2 (Two)
Example Alcohol and Drug Misuse services	0 (Zero)	1 (One)	0 (Zero)	1 (One)	1 (One)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)
Example Infection, Prevention and Control	0 (Zero)	1 (One)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)	0 (Zero)

Nottinghamshire County Council

Report to Public Health Sub-Committee

6 June 2013

Agenda Item: 11

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Sub-Committee's work programme for 2013/14.

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

RECOMMENDATION/S

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

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

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

Constitutional Comments (HD)

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

Financial Comments (PS)

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 Sub Committee Forward Plan 2013/14

Meeting Dates	PH Sub Committee	Lead Officer	Supporting Officer
6 June 2013	Presentation of Public Health for new Members	Dr Chris Kenny	
	Public Health Contract Performance and Quality Management	Cathy Quinn	Sally Handley
	Health and Wellbeing Integrated Lifestyle Service	Barbara Brady	Lindsay Price
	Follow up report on Obesity, Nutrition & Exercise funding	Barbara Brady	Anne Pridgeon
	Follow Up report on Sexual Health funding	Penny Spring	Tracy Burton
18 July 2013	Draft PH Service Plans	Dr Chris Kenny	Cathy Quinn
	Development of the Integrated Commissioning Hub for children and young people's health services	Kate Allen	
	Public Health Nursing	Kate Allen	
	Follow up report on Community safety, violence prevention and response & public mental health funding and other PH developments	Barbra Brady / Mary Corcoran	Nick Romilly
	Follow up report on NHS Health Checks	John Tomlinson	Helen Scott
12 September 2013	Annual Performance and Finance Report for 2012-13	Cathy Quinn	Sally Handley
	Performance and Finance Report for April-June 2013	Cathy Quinn	Sally Handley
	Follow up report on substance misuse commissioning	Barbara Brady	Tammy Coles
	Follow up report on Tobacco Control funding	John Tomlinson	Lindsay Price
7 November 2013	Half Year report on prisons Substance Misuse Services	Barbara Brady	Tammy Coles

Updated: 24 May 2013

	Request for delegated authority to approve the tender results for community based SMS services (Barbara Brady) Follow up report on Obesity commissioning TBC Follow up report on Sexual Health funding & Work Place Health	Barbara Brady Barbara Brady Penny Spring	Tristan Poole Anne Pridgeon Tracey Burton / Cheryl George
9 January 2014	Performance and Finance Report for July – Sept 2013	Cathy Quinn	Sally Handley
6 March 2014	Performance and Finance Report for Oct - Dec 2013	Cathy Quinn	Sally Handley
8 May 2014	Performance and Finance Report for Jan-Mar 2014	Cathy Quinn	Sally Handley
3 July 2014			

Proposed Future Items (& suggested date)

- Follow up reports on service developments – sexual health, health checks, tobacco, etc
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