Appendix 1: Nottinghamshire Healthy Families Programme: Long-Term Delivery report to Adult Social Care and Public Health Select Committee 9th September 2024

Options Appraisal for the future commissioning of the 0-19 Healthy Families Programme in Nottinghamshire

July 2024

Contents

1.0. Introduction

1.1 The Healthy Child Programme (HCP) is the national, evidence-based prevention and early intervention public health framework for children and families [1]. It aims to bring together health, education and other main partners to deliver an effective programme which includes screening, immunisation, health and development reviews, health improvement, wellbeing and parenting [1,2]. The programme is led by public health nursing services for children and young people aged 0 to 19 years. The 0 to 5 element is led by health visiting services and the 5 to 19 element is led by school nursing services.

1.2 The Health and Social Care Act 2012 sets out a local authority's statutory responsibility for commissioning public health services for children and young people aged 0 to 19 years [2]. Nottinghamshire County Council commission the Nottinghamshire Healthy Families Programme (HFP) in line with the Governments HCP.

1.3 The Nottinghamshire HFP is a public health nursing service that supports families to provide their children with the best start in life through a range of nursing and health interventions. It is delivered by multi-disciplinary Healthy Family Teams working in close partnership with the children's health, care and early help system to promote early intervention by identifying and delivering targeted support to families in need. It is a universal service for all Nottinghamshire's children and young people aged 0 to 19 (or 24 where there are special educational needs and disabilities), and their parents and carers. The HFP currently includes the delivery of:

- Health visiting and school nursing
- Mandated health and development reviews for 0 to 5's
- The national child measurement programme (NCMP)
- An early intervention offer for parents with additional vulnerabilities
- The family nurse partnership

1.4. Aim

1.4.1. The overall aim is that Nottinghamshire County Council (NCC) delivers the HFP in a way that best supports parents and carers to give children the best start in life, keeping children healthy and safe and enabling them to reach their full potential. The aim is that the service is provided in a way that achieves the best outcomes for our children and families.

1.4.2. This options appraisal aims to support the Council in making an informed decision regarding the options for future service delivery and procurement of the Nottinghamshire HFP. This appraisal does not consider options around 'what' is delivered (i.e. the service model), but only addresses 'how' it is delivered and procured. This options appraisal seeks to consider the relative desirability, viability and feasibility of the different options for delivery arrangements [(3)].

2.0. Background

2.1 The current Nottinghamshire HFP contract commenced in April 2017. It integrated several areas of service delivery which had previously been separate contracts: health visiting service, school nursing service, Family Nurse Partnership Programme, National Childhood Measurement Programme and infant feeding support services. The current contract was procured by competitive tender; Nottinghamshire Healthcare NHS Foundation Trust (NHFT) were successful in being awarded the contract and provide the HFP as a single integrated service. Following two contract extensions, the contract is now due to end on 30th September 2025.

2.2. A decision is therefore needed around the future service delivery of the Nottinghamshire HFP from 1st October 2025 onwards. The purpose of this options appraisal is to provide information about the options to inform and support a future decision on 'how' the Nottinghamshire HFP is delivered and procured.

2.3. Commissioning Context

2.3.1. The current national and local direction of travel is towards greater integration of healthcare services to ensure high quality care and long-term stability for local populations.

2.3.2. It is important that commissioning and procurement aligns with objectives in NCC's procurement strategy [(4)], and the vision and principles of strategic commissioning [(5)]. There is a vision within NCC that our strategic commissioning is data and evidence-led, collaborative and supports the achievement of strategic aims by securing high quality, cost-effective outcomes [(5)].

2.3.3. The options considered in this appraisal will inform decision on 'how' the Nottinghamshire HFP is delivered. That consideration includes 'make or buy'; reviewing whether NCC can deliver the service in-house (or elements of it) i.e. 'make', or whether they will be looking to the external market i.e. 'buy'.

2.3.4. Since the service was previously tendered in 2016 there have been changes to the rules about procurement of health care services in England. There is a new set of regulations; Provider Selection Regime (PSR) 2023 (6). Previous commissioning followed the Public Contract Regulations (PCR) 2015[1].

2.3.5. The Provider Selection Regime allows three processes for the award of contracts for health care services (7).

- Competitive process (further information given in option 1 below).
- Direct award processes A, B and C. These involve awarding contracts to providers in circumstances below, when there is no good reason to seek to change from the existing provider or where only a particular group of providers is to be assessed. None of these are available so are not considered further:

  A: The existing provider is the only provider that can deliver the health care services– *not the applicable case for the Nottinghamshire HFP, so not available.*

  B: Patients have a choice of providers, and the number of providers is not restricted by the relevant authority – *not the case for the Nottinghamshire HFP, so not available.*

  C: The existing provider is satisfying its existing contract, will likely satisfy the new contract to a sufficient standard, and the proposed contracting arrangements are not changing considerably – *not the case for the Nottinghamshire HFP, so not available*.
- Most suitable provider process (further information given in option 2 below). This involves awarding a contract to a provider without running a competitive process, because the relevant authority can identify the most suitable provider. This robust process may be used when – among other criteria – the Council decides that taking into account all likely providers and all relevant information available at the time, it is likely to be able to identify the most suitable provider without running a competitive tender process.

2.3.6 It would breech PSR regulations, making the Council non-compliant, if the current contract were to be extended again beyond 30th September 2025. This is because an urgent process was used to extend the current contract due to circumstances that were not foreseeable by or attributable to NCC, but this mechanism cannot be used again as the 12-month extension allows sufficient time for a new procurement process to be undertaken.

[1] Note that the 'co-operation agreement' approach previously detailed in reports to Cabinet is not available under the PSR.

3.0. Evidence

What is delivered.

3.1. From the outset, the intention was that the HCP should be based on evidence-led approaches to preconception care, promoting child development, improving children and young people's health outcomes, and ensuring families at risk are identified at the earliest opportunity [1]. It was first introduced in 2009 based on the best available evidence summarised in 'Healthy for All Children' and supplemented with guidance from NICE [8]. Since then, the evidence base has grown. In 2015, Public Health England published a rapid review to update evidence for the 0-5 elements of the HCP [9]. This study found that evidence continues to support the programme recommendations and, in many cases, improvement in one early outcome can yield future benefits in many different areas of a child's life.

3.2. In 2018, the Early Intervention Foundation published an evidence update on 'what works to enhance the effectiveness of the healthy child programme' [8]. This found that the HCP remains a good delivery mechanism for many interventions, although this study does not make recommendations as to how the service is best delivered. It is recognised that good systems are required to identify need and refer families onto additional support when needed.

3.3. For children aged 0-5, there are well-defined Public Health Outcomes Framework indicators which allow the monitoring and comparison of health outcomes amongst this age group; these indicators provide strong evidence on the positive impact of health visitors on the health outcomes of children and their families [10]. For children and young people aged 5-19, there is only clear evidence from the NCMP which is required to be collated nationally; there is a lack of consistency in other evidence about service delivery and monitoring of outcomes for this age group [11].

3.4. For example, there is not central government oversight into school nurses, making it difficult to know how many school nurses are in place in which areas, or where services have been increased or decreased. It is known that the number of school nurses has been falling steadily, and there is a patchwork of services across the country, with some areas now receiving no school nurse support [11]. The Local Government Association (LGA) recognises the role of school nurses in identifying children's needs and in reducing health inequalities through a holistic approach [12]. The LGA has called for an increase in the public health grant to enable councils to commission a school nurse for every secondary school and cluster of primary school, as well as a workforce plan to address shortages. However, there is very limited evidence around the impact of cutting school nurses on public health [11].

How the service is delivered.

3.5. Much of the evidence base for the HCP is around ‘what’ is delivered rather than ‘how it is delivered. There is a lack of evidence around what the best mode of delivery for the service is and any impact on health outcomes. Qualitative evidence on experiences of local authorities gathered through the process of developing this appraisal has been included as part of the SWOT analysis for each option.

3.6. The Institute for Government published a report on government outsourcing which recommended that more detailed studies are needed into insourcing, in particular with regards to assessing potential savings [13]. The report found no examples of rigorous comparative studies that compared the cost and quality or services before and after insourcing, nor any that robustly assessed whether projected savings had been realised. Several people interviewed for the report were sceptical that claimed savings could be sustained over time, arguing many estimates did not fully account for rising long-term costs due to pensions and insurance. This lack of comparative evidence is likely related to services changing scope and nature when brought in-house, which was identified as a challenge for evaluation by local authorities consulted in the process of developing this appraisal. Similarly, the Institute of Government has advised that better evidence is needed with regards to outsourcing services [14]. The evidence available cannot itself answer the question as to ‘how’ the Nottinghamshire HFP would best be delivered.

4.0 Methodology

4.1. This options appraisal has been led by a Speciality Registrar in Public Health and a Public Health and Commissioning Manager within the Place directorate at NCC. Neither had worked on the 0-19 Healthy Families Programme prior to starting this appraisal in May 2024, and therefore led this work to provide an increased degree of objectivity to the appraisal. The team which manages the current HFP contract were not directly involved in the development of this report to further increase objectivity.

4.2. A previous options appraisal was developed by the Public Health team at NCC as an appendix of the report taken to Cabinet in June 2023. This explored how the Nottinghamshire HFP may be provided in the future. Following the announcement of the CQC rapid review of the current HFP provider, a decision was made by Cabinet in March 2024 that further work was needed to make an informed decision regarding the options for future service delivery of the HFP. This paper aims to explore options in more detail and update options from the previous options appraisal based on PSR 2023.

4.3. Government and Local Government Association guidance on writing options appraisals was reviewed, as well as options appraisals conducted internally on other topics and externally by other authorities on the same (or similar) topic(s) [3,15]. These

documents helped to develop the template used for this appraisal, which was initially adapted from a similar options appraisal conducted in another local authority and evolved as key considerations emerged through further reading and conversations with internal and external colleagues. Published and grey literature on the current evidence for the HCP was also reviewed to highlight key evidence on the topic, although an in-depth literature or systematic review was not conducted.

4.4. Evidence has been obtained about methods of delivery of the HCP across the country by contacting local neighbours, researching delivery methods online, and contacting other local authorities through word of mouth. This helped inform a list of potential options for the delivery of Nottinghamshire's HFP. Ten other local authorities were consulted during May to June 2024. These included local neighbouring authorities as well as colleagues in other regions who are using a variety of delivery methods for their Healthy Child Programmes. Five of the authorities consulted were in the Midlands and six of the authorities consulted were counties. Information regarding this can be shared upon request.

4.5. Internal NCC departments were consulted to discuss elements around the practicality and feasibility of each option for our authority. This included colleagues in procurement, HR, legal, estates, finance and children's services. This information, along with that gained from other local authorities, informed the 'key features' and 'SWOT analysis' sections of each option.

4.6. A vast number of potential options were initially identified, and these formed a longlist of options. The longlist was condensed to a finalised shortlist of options, which was decided pragmatically based on those that are legally viable, have been successfully achieved elsewhere, and would potentially be possible for NCC.

4.7. It is necessary to have a clear set of criteria against which to measure each option. The criteria used to assess the shortlist of options against are detailed at the start of section 5. These were developed having taken into account government guidance (see paragraph 4.3), other authorities' options appraisals, conversations with internal and external colleagues about key aspects of the HFP and from the outcomes of the Joint Scrutiny Review of the recommissioned HFP (January 2024)[2]. Having established the criteria to be used, the options would then be scored.

4.8. The scoring was done by the independent two report authors, as well as a separate and impartial colleague within Public Health and a colleague from the Children and Families directorate, using the information provided in sections A to C for each option. Options were scored on a scale of 0 to 3 (see section 5). The scoring categories were adapted from those used to score tender bids. Each of the four scorers independently scored each option against the criteria. The mean of the four scores was used

[2] The criteria were agreed and signed off by the DPH, procurement colleagues and members of the HFP project team, each of whom would not be scoring the options against the criteria.

to give an average score for each option against each criterion. Where scores were more than one ranking apart (e.g. 1 and 3) there was mediation to achieve consensus. The scores helped to inform recommendations but are subjective and should be used in conjunction with the other information provided in the report.

4.9. Some assumptions were made as part of this report. It was assumed that the service model itself will remain the same. This is because this options appraisal was reviewing the options of service delivery (i.e. **how** the service is delivered), rather than options for the model of the service (i.e. **what** is delivered). Additionally, it was assumed that the agreed funding for the service from the Public Health Grant will remain the same.

4.10. There are some limitations in the approach taken to developing this paper. Many of the features, strengths, weaknesses, opportunities and threats identified for each option were taken from insights provided by local authority areas. As every Council and population is different, not all findings from those consulted will necessarily be applicable to NCC (however, options were scored as applicable to NCC). There were challenges in the timescales of developing this paper. Internal colleagues were consulted, however there were challenges in estimating the financial impact of each option. Furthermore, the scoring of the options against the criteria is subjective and not an exact science. This was somewhat mitigated against for having independent and impartial scorers, but the scores for each option should be used alongside the broader content within the paper and not in isolation.

5.0. Options considered

This section sets out the evidence obtained using the methodology described above, and comments on that evidence.

There are many different options as to how the Nottinghamshire HFP could be delivered.

The shortlist of options detailed in this paper is as follows:

- Option 1A: Going out to procure via competitive tender - tender a single, integrated service for 0-19's.
- Option 1B: Going out to procure via competitive tender - tender the service as separate lots.
- Option 2: Award the contract via the Provider Selection Regime most suitable provider process.
- Option 3: Provide the 0-19 Healthy Families Programme from within the Council – whole service.
- Option 4A: Split the service, providing elements in-house with others not provided in-house - 0-5 not in-house, 5-19 provided in-house.

- Option 4B: Split the service, providing elements in-house with others not provided in-house - 0-11 not in-house, 11-19 provided in house.

Listed below are the options included in the longlist but which were not included in the shortlist to be explored further, along with the reason as to why they were not included in the shortlist.

Option	**Reason not included in shortlist**
Do not provide the 0-19 Healthy Families Programme	This is not an option, as the Authority has a statutory responsibility to ensure that the Department of Health and Social Care's Healthy Child Programme is provided to the local resident population and therefore this option is not considered further.
'Call off' from a framework contract	This would require the Council to 'call off' services from a neighbouring authority or national framework to supply the services required for the 0-19 Healthy Families Programme. This is not a viable option for this service. There are no such frameworks in place for this type of service due to the requirements around service delivery, resource, and integration with Health systems and therefore this option is not considered further.
Direct award of the contract	Explained in section 2.8.5
Award the contract to the incumbent provider utilising a specific co-operation exemption	This is not an option as it does not fall within PSR 2023 regulations which came into force 01/01/2024.
Split the service, with the 0-5 service provided in-house and the 5-19 service not provided in-house	This was not considered within this paper, given that the 0-5 services contain more of the clinical elements of the service and therefore potentially the most complexity for bringing in house (e.g. with regards to clinical governance and CQC registration). Therefore, whilst this might be possible, it was deemed less desirable, viable and feasible than option 4A. It was there not explored further.
Split the service, with the 0-11 service provided in-house and the 11-19 service not provided in-house	This was not considered within this paper, given that the 0-11 services contain more of the clinical elements of the service and therefore potentially the most complexity for bringing in house (e.g. with regards to clinical governance and CQC registration). Therefore, whilst this might be possible, it was deemed less desirable, viable and feasible than option 4B. It was there not explored further.
Split the service into more than two 'lots'	Whilst this is possible, this has not been explored within this paper given that it would lead to increased fragmentation of an established integrated service.

	Additionally, this approach would be more time and resource intensive than options 1B, 4A and 4B explored. We did not come across other local authorities that have taken this approach, likely for the reasons listed. These factors made this option less desirable, viable and feasible than options explored in this paper.
A contractual joint venture approach	This was not considered within this paper given that it is primarily an approach used for commercial services and is not an approach routinely used for healthcare services. Ordinarily joint ventures are between two private organisations or through a public private partnership where a joint venture is 'an arrangement between two or more parties who pool their resources and collaborate in carrying on a business activity with a shared vision and a view to mutual profit'. As a defined healthcare provision with a set budget there is little to no opportunity for profit growth. A joint venture would increase risk to the authority and would add costs in setting up a joint venture over and above the service provision itself.

Additionally, there are multiple different ways in which the HFP could be split, providing some element(s) in-house and some not. Given the ages of school transitions (and transitions of services utilised within the HFP), and following discussions with other local authorities, options 4A and 4B appear to be the most popular and perhaps most practical options. Therefore, these are the two options explored in more depth under option 4 (splitting the service, providing elements in-house with others not provided in-house) and other options as to how the service could be split have not been considered within this paper.

The shortlist of options are presented in the same format, as follows:

Section A: Brief description of the option

Section B: Key features

Section C: SWOT analysis to outline the strengths, weaknesses, opportunities, and threats of the options.

Each option is then considered against a set of key criteria to aid comparison, outlined in Table 1 below.

Theme	Criteria	Description	Section which detail is included in
Desirability *(extent to which the option aligns with NCC preferences)*	Improved outcomes for service users	The ability of the HFP to deliver the best possible outcomes for children and families in Nottinghamshire through **continual service improvement**. The chosen delivery method (or transition to it) **will not impact the service delivery** in a way that negatively affects outcomes.	Service delivery and SWOT
	Integration with NCC services (i.e. with Nottinghamshire Early Help Offer)	The ability of the HFP to be **fully integrated with the NCC Early Help Offer**, Children and Families services (including **Family Hubs**), the **Schools Health Hub** (within the Council's Tackling Emerging Threats to Children Team) and the **Youth Service**.	Service delivery and SWOT
	Integration with local NHS services	The ability of the HFP to have **established, embedded two-way referral pathways** to local NHS organisations to support coordinated and effective service delivery.	Service delivery and SWOT
	Flexibility to respond to change	The ability for the service to respond in a **timely and effective** way to changing **need**, emerging **challenges** and new **opportunities**.	Service delivery and SWOT
Viability *(ability of the option to work successfully)*	Short financial impact (0-2 years)	The ability of the service to **remain within the agreed financial envelope** from the Public Health Grant.	Financial impact and SWOT
	Medium/long term financial impact (2+ years)	The ability of the service to remain within the agreed financial envelope from the Public Health Grant with the possibility of **increasing efficiencies** (aligned with the NCC MTFS) whilst maximising outcomes.	Financial impact and SWOT
	Workforce recruitment and retention	The ability of the HFP to **retain** the current workforce and **recruit** future workforce.	Workforce and HR considerations and SWOT
	Reputational risk	The mechanism of service delivery that provides **minimal risk** to the **public perception** and **reputation** of NCC and the HFP.	Additional considerations and SWOT
Feasibility *(extent to which the option can be accomplished successfully)*	Implementation timescales	The ability to implement the service delivery mechanism **by 1st October 2025**.	Implementation timescales, Workforce and HR, and SWOT
	Safeguarding procedures	The ability of the service to deliver **effective safeguarding activity** and work as part of a wider, **multidisciplinary, multi-agency network** to help promote the welfare and safety of children and young people.	Safeguarding procedures and SWOT

	Clinical governance and CQC arrangements	The ability to have **safe, effective, and robust clinical governance** mechanisms and structures in place.	Clinical governance arrangements and SWOT
	Additional implementation considerations: estates, IT	The ability to implement the service, utilising **appropriate estates** and **safe, robust clinical record management systems** in a way that is **timely and cost-effective**.	Additional considerations and SWOT

Table 1: Criteria that each option will be scored against

Each option will be scored against each criterion on a scale of 0-3, detailed below:

- 0 = Unsatisfactory. This option will fail to address the criteria description.
- 1 = Some concerns. There would be significant challenges to this option meeting the criteria description.
- 2 = Acceptable. This option should meet the criteria description, but there might be some challenges.
- 3 = Good. This option should address the criteria description with little/no challenges.

See sections 4.7 and 4.8 for the methodology of how the options were scored against the criteria. The overview of the criteria and associated score for each option is detailed in section 5.5.

5.1. Option 1: Going out to procure via competitive tender

5.1.1. Option 1A: Going out to procure via competitive tender for a single, integrated 0-19 service (single provider)

Section A: Summary

Description
This option describes a competitive tender process that invites bidders to tender for the delivery of the full Nottinghamshire Healthy Families Programme, with bids evaluated against a set of fixed criteria. All services within the HFP would be delivered by one provider under a single contract.

The structure of the Healthy Families Programme would not change as the whole service is currently delivered by one provider. Early market engagement to gather market intelligence would be conducted to engage with potential providers as per best practice.

NCC would have the flexibility to run a bespoke procurement process in that the Council can engage in dialogue with potential provider or a shortlist of potential providers, providing opportunity for both NCC and potential providers to work together to influence the specification and develop the most appropriate solution. NCC can specify which areas for dialogue e.g. service delivery proposals or assumptions and factors that may affect the financial model, though any areas of the procurement may be discussed. This would allow potential providers the opportunity to have dialogue in the areas that will have the greatest proportionate impact on their final proposals. It is generally run as a staged approach, for example the initial dialogue session could look at the overall offer, and later meetings cover areas in more detail. The time period of the dialogue may be open ended and may run over a considerable time frame, or NCC can time limit when the dialogue needs to end by. However, the dialogue should reach a point of identifying a solution(s) which would meet our needs and then we would invite providers to submit final tenders based on the solution arrived at and no further discussion is allowed.

Alternatively, NCC could negotiate with all potential providers, with a view to improving on their initial offers that are submitted at the start of the procurement process, however if any of the initial bids meet NCCs needs then the contract can be awarded without any further negotiation.

The process could also include the development of consortia arrangements (where two or more suppliers come together to bid for the contract) and sub-contracting structures for elements of the service. Additionally, a dialogue process could be used to consider exploring new models of shared service ownership, governance or partnership if required.

The provider that is successful in the process would be awarded a contract for a defined time period, for example a maximum of 5 years (being an initial 3years with the option to extend for 2 years). It would also contain standard contract provisions including a detailed specification of the work to be done, contract management and performance delivery mechanisms.

Section B: Key Features

Service delivery

Through the contract, the provider will be held accountable for performance. This will help to ensure the successful delivery of programme outcomes. During the period of contract extension with the incumbent provider, enhanced levels of performance monitoring has been conducted to support service development, including comprehensive key performance indicators. These performance monitoring measures could be carried forward for the new contract with any provider. Performance management of the contract will be overseen by Public Health.

The outcomes of the Joint Scrutiny Review of the recommissioned HFP (published 25th January 2024) articulated plans to ensure the HFP would work in partnership with a wide range of children's and family services and would be a core component in the delivery of the Council's Early Help Offer. Whilst the outcomes and recommendations of this review were made in reference to the current provider, the learnings from this would be applicable to a new provider. This work could continue to ensure there is partnership working in a joined up, coordinated manner with both NCC and local NHS organisations.

There could be limited scope for making changes to the service once the contract is in place, although this will depend on the contract itself and length of contract put in place.

Once the contract is in place, there could be scope for making changes to the service if there was clarity in the specification that it was intended that the service should change over time, and there was a clear mechanism for how the changes would be discussed and made. The requirement for cooperation and service development can be built into the competitively procured contract.

Financial impact

Funding of the programme would continue to be included as part of the Public Health Grant which is a ring-fenced budget to be used for public health functions. The budget associated with the new contract has been agreed as part of the Public Health Grant, with a contract value of £15,473,968 per annum. It is expected that this will remain consistent for the life of the contract. Other than organisational capacity, it is not expected that there would be increased short-term costs to facilitate this option.

NCC and the current provider follow open-book accounting principles. This arrangement could be agreed as part of the tender requirement with any new potential provider to give timely visibility of spend.

Implementation timescales

The aim is that the chosen option is delivered by 1st October 2025. The procurement timescale should be achievable given the preparatory work that has been undertaken to develop the service model and specification. However, there would be time pressure to ensure the tender process and mobilisation of a new contract could be completed within the 12-month contract extension period.

Workforce and HR

There are no direct HR implications for the Council arising out of this option as this relates to the provision of an externally commissioned service. The effect of the award of the contract would, if there was a change in provider from the incumbent provider, be that the current staff engaged in the service would transfer to the new provider under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE); or if NHFT were to be successful, staff would remain within the Trust.

Uncertainty around the future of the contract could cause instability in the workforce with anxiety about TUPE processes. This could affect retention of current staff, and recruitment of future staff during the tendering period.

Clinical governance and CQC arrangements

Clinical governance arrangements (i.e. systematic approaches to maintaining and improving the quality of patient care) would be included as part of the tender requirement.

The nursing activities in the HFP involve the provision of health and social care. As such, this is a 'regulated' activity under Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which means that the legal entity carrying out the regulated activity must be registered with the Care Quality Commission (CQC). This would need to be included as part of the tender requirement.

Safeguarding procedures

Safeguarding procedures will be included as part of the tender requirement. The currently established pathways in place between the current provider, children's social care and the Multi-Agency Safeguarding Hub (MASH) will need to be established and prioritised by any new provider to support delivery of effective safeguarding activity.

Additional considerations (including reputational risk, estates, IT)

IT and patient record system requirements would be included as part of the tender requirement.

The provision of suitable estates/facilities would be included as part of the tender requirement.

The length of the contract would need to be agreed. A shorter contract length with options for extension could reduce any potential reputation risk to the local authority, should there be any concerns with the chosen provider. However, this can cause uncertainty and instability amongst the workforce, which may lead to attrition. A longer contract length could help to mitigate this but would potentially increase risk to the local authority.

For this option, it is important to consider the very limited options in the competitive market. During the previous tender process in 2016/17, only one bid was received.. Pre-market engagement would be required to research the market and consider which external providers there are that could deliver the service – this would lengthen timescales. If it is evidenced that there is no market, then a competitive tender process would not be the most appropriate route to take given the other options under PSR.

Procurement features

The contract would be awarded to a single provider.

Legal features

The contract placed would be a Nottinghamshire County Council Public Health Contract as designed for these purposes.

Section C: SWOT Analysis

Strengths	Weaknesses
• Whilst this would follow a new PSR process, the principles of a competitive tender process are familiar for the commissioner and any provider. • Clinical governance processes can be included as part of the tender requirement.	• There is a risk that only the incumbent provider will bid for the contract: A robust competitive tender process was carried out in 2015 which included a focus on delivering a high-quality service in partnership with other services for children, young people and families. Despite carrying out extensive market development

• Appropriate registration and quality assurance processes would be the responsibility of the selected provider. *This has been seen as a strength by other local authorities that have used this approach*. • Having a single integrated (0-19) service can maximise opportunities for joined up working, multi-disciplinary approaches and reduce gaps between services across childhood. *This has been seen by other local authorities that have used this approach*. • This approach is likely to have low reputational risk given that it reflects a new formally established commissioning approach. • Referral pathways with local NHS services could be included as part of the scoring process to ensure coordinated and effective service delivery.	activity including early publication of a prior invitation notice and a series of bidder events only one bid was received, from the incumbent provider. There could be a high risk of there being no other local providers. • A competitive tender process is time and resource intensive. This approach would require significant capacity in the short-term from both Public Health and procurement colleagues.
Opportunities	**Threats**
• This option will allow any potential new provider to bid for the contract. • Provides an opportunity to design a tender process that focuses on delivering a best-value, high-quality service in conjunction with other services for children, young people, and families, and ensures there is definitive evidence of the winning bidders ability to deliver this. • Opportunities and ideas for integration within the Nottinghamshire Early Help offer will be specified as a requirement for part of the scoring process and the contract specification requirements to ensure there are robust partnership working arrangements. • The competitive nature of the approach can encourage innovation and creativity from bidding providers in order to win the contract. *This has been seen by other local authorities that have used this approach*.	• Competitive tender changes the focus of activity, restricting the extent and pace of any collaboration with the current provider during a tender process. • Workforce attrition at a time of national shortage: Uncertainty around the future of the contract is likely to cause instability in the workforce with anxiety about TUPE processes. Historically there has been increased turnover where services are competitively tendered; attrition in Quarter 4 of 2016-17 was higher than at any time during 2021-22. It is important to note that there are national shortages of qualified health visitors and school nurses, and retention is therefore a key consideration for the Council. • The current level of integration between the Healthy Families Programme and other NHS services for children, young people, and families, currently delivered by Nottinghamshire Healthcare NHS Foundation Trust, would be a challenge for a non-NHS provider. For example, streamlined referral pathways and information sharing agreements would need to be established.

	• Whilst it is possible to complete the competitive process in the 12-month period before the current contract ends (September 2025), this will be a challenge. *Other local authorities who have used this approach recently described that it took 12-18 months to complete the tender process for an integrated service*. • A new provider may use another IT/clinical record system. There might be challenges around identifying ways to share/migrate information from current systems. • If the contract is awarded to a new provider, there is risk that the cost of appropriate estates will increase. This could result in reduced funding within the budget envelope for service delivery. • If a tender process was not successful, NCC would have very limited time in which to explore alternatives for service delivery. This would increase risk to delivery and efficiency of the service, as well as transformation work. *This has been experienced by other local authorities that have used this approach and subsequently needed to bring the service in-house.*

5.1.2. Option 1B: Going out to procure via competitive tender, tendering the service as separate lots (multiple providers)

Section A: Summary

Description
This option describes dividing the currently integrated Nottinghamshire Healthy Families Programme into component parts or 'lots'. There are many different ways in which the service could be split into separate lots. Each lot would then have a competitive tender process that invites bidders to tender for the delivery of that lot. This would likely result in multiple providers delivering the Healthy Families Programme. To create separate lots, the programme could be divided by services (e.g. health visiting, school nursing services etc), or by age groupings of children and young people.

Prior to the current integrated contract commencing in 2017, the services had separate contracts for different service areas.

That approach has not been further explored in this options appraisal because this would remove the value of integration and would also require significant additional Council capacity to procure and manage multiple contracts.

This options appraisal does not consider dividing the service by age groupings. There are multiple ways that the programme could be divided. However, given clear divides by school ages and associated services, this appraisal pragmatically considers two ways that the service could be split into separate lots:

1. Services within the Healthy Families Programme for 0-5 years are delivered by one provider, whilst services for children and young people aged 5-19 years could be delivered by another provider.
2. Services within the Healthy Families Programme for 0-11 years are delivered by one provider, whilst services for children and young people aged 11-19 years could be delivered by another provider.

Note, there is a possibility that the same provider could be successful in the tender process to deliver each of the separate lots.

Section B: Key Features

Service delivery
Although this option involves dividing the service provision into two contracts, the intention is that the resulting delivery of the service would not change although work would be required to ensure integration of the separate lots. As with option 1A, through the contracts the provider(s) will be held accountable for performance. This will help to ensure the successful delivery of programme outcomes. During the period of contract extension with the incumbent provider, enhanced levels of performance monitoring has been conducted to support service development, including comprehensive key performance indicators. These performance monitoring measures could be carried forward for the new contracts. Performance management of the contract will be overseen by Public Health.

The outcomes of the Joint Scrutiny Review of the recommissioned HFP (published 25th January 2024) articulated plans to ensure the HFP would work in partnership with a wide range of children's and family services and would be a core component in the delivery of the Council's Early Help Offer. The outcomes and recommendations of this review were made in reference to the current provider delivering one integrated service. Whilst work could be done to encourage partnership working between providers, NCC and local NHS organisation, this will be more of a challenge with the service split into separate lots.

As with option 1A, once the contracts are in place there could be scope for making changes to the service if there was clarity in the specification that it was intended that the service should change over time, and there was a clear mechanism for how the changes would be discussed and made. The requirement for cooperation and service development can be built into the competitively procured contracts.

Financial impact

Funding of the programme would continue to be included as part of the Public Health Grant which is a ring-fenced budget to be used for public health functions. As with option 1A, the budget associated with the new contract(s) has been agreed as part of the Public Health Grant, with a total value of £15,473,968 per annum. It is expected that this will remain consistent for the life of the contract. Other than organisational capacity, it is not expected that there would be increased short-term costs to facilitate this option.

Further scoping work would be needed to appropriately apportion costs to the 'lots' decided upon. Costs for services for the 0-5 years age group (of which mandatory checks by health visitors makes up the vast proportion) are significantly higher than costs of services for older children and young people. As the present service is delivered as a single integrated service, it is difficult to straightforwardly attribute exact costs to different age groups. Therefore, work would be needed to agree the proportion of the total allocation that should be allocated to each lot.

Implementation timescales

Initial work would be needed to split the current service model into lots which will add to timescales.

The procurement and mobilisation timescales should be achievable, however, there would be time pressure to ensure this process could be completed within the 12-month contract extension period.

Workforce and HR
There are no direct HR implications for the Council arising out of this option as this relates to the provision of an externally commissioned service. The effect of the award of the contracts would, if there was a change in provider from the incumbent provider, be that the current staff engaged in the service would transfer to the new provider under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE); or if NHFT were to be successful, staff would remain within the Trust. Uncertainty around the future of the contract(s) could cause instability in the workforce with anxiety about TUPE processes. This could affect retention of current staff, and recruitment of future staff during the tendering period.
Clinical governance and CQC arrangements
Clinical governance arrangements (i.e. systematic approaches to maintaining and improving the quality of patient care) would be included as part of the tender requirement for each contract. The nursing activities in the HFP involve the provision of health and social care. As such, this is a ‘regulated’ activity under Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which means that the legal entity carrying out the regulated activity must be registered with the Care Quality Commission (CQC). This would need to be included as part of the tender requirements.
Safeguarding procedures
Safeguarding procedures will be included as part of the tender requirements. Additional work might be required to integrate procedures between the providers. The currently established pathways in place between the current provider, children’s social care and the Multi-Agency Safeguarding Hub (MASH) will need to be established and prioritised by new providers to support delivery of effective safeguarding activity. As the majority of safeguarding activity is within the 5-19 service, separation of the service may create a significant lack of capacity in a priority area.
Additional considerations (including reputational risk, estates, IT)

IT and patient record system costs would be included as part of the tender requirement. However, different systems might be used by different providers. The provision of suitable estates/facilities would be included as part of the tender requirements. However, stipulation of premises requirements may limit market interest. Pre-market engagement would be required to research the market and consider which external providers there are that could deliver the services – this would lengthen timescales. If it is evidenced that there is no market, then a competitive tender process would not be the most appropriate route to take given the other options under PSR. Alternately, both contracts could be won by the same provider despite dividing the service into separate lots. The length of the contracts would need to be agreed. A shorter contract length with options for extension could reduce any potential reputation risk to the local authority, should there be any concerns with the chosen provider. However, this can cause uncertainty and instability amongst the workforce, which may lead to attrition. A longer contract length could help to mitigate this but would potentially increase risk to the local authority.
Procurement features
The contract for each lot would be awarded to a provider. This could result in more than one provider for the service, as a different provider may be permitted for each lot.
Legal features
The contracts placed would be a Nottinghamshire County Council Public Health Contract as designed for these purposes.

Section C: SWOT Analysis

Strengths	Weaknesses
• This option might be more attractive to potential bidders with expertise in one or other element of service delivery. This could lead to more choice in provider options than if	• Introduces the potential for multiple providers delivering different elements of the 0 to 19 Healthy Child Programme, which may result in:

the service were to be tendered as a single integrated service. • Whilst this would follow a new PSR process, the principles of a competitive tender process are familiar for the commissioner and any provider. • Clinical governance processes can be included as part of the tender requirement. • This approach is likely to have low reputational risk given that it reflects a new formally established commissioning approach. • Appropriate registration and quality assurance processes would be the responsibility of the selected provider(s). • Referral pathways with local NHS services could be included as part of the scoring process to ensure coordinated and effective service delivery.	○ increased management and overhead costs, adversely impacting the cost-effectiveness of the service, ○ poorer service user experience and outcomes as a result of the involvement of multiple practitioners. • The approach is likely to be more time and resource intensive during the procurement process than option 1A for both Public Health and procurement colleagues as it involves the development of more than one contract, and subsequent scoring of multiple bids. • This approach is likely to be more time and resources intensive to contract manage during the contract period than option 1A. Public health colleagues will need to manage more than one contract, and potentially develop working relationships with more than one provider.
Opportunities	**Threats**
• This option would allow any potential new providers to bid for the contract and could encourage SME's to bid. • Opportunities and ideas for integration within the Nottinghamshire Early Help offer will be specified as a requirement for part of the scoring process and the contract specification requirements to ensure there are robust partnership working arrangements. • The competitive nature of the approach can encourage innovation and creativity from bidding providers in order to win the contract. • Specialised approaches dedicated to specific age groups might improve the quality of the offer to families.	• Competitive tender changes the focus of activity, restricting the extent and pace of any collaboration with the current provider during a tender process. • Workforce attrition at a time of national shortage: Uncertainty around the future of the contract is likely to cause instability in the workforce with anxiety about TUPE processes. Historically we have seen significantly increased turnover where services are competitively tendered, attrition in Quarter 4 of 2016-17 was higher than at any time during 2021-22. It is important to note here that there are national shortages of qualified health visitors and school nurses, and retention is therefore a key consideration for the Council. • If the contract is awarded to new providers, there is risk that the cost of appropriate estates will increase. This could result in reduced funding within the budget envelope for service delivery.

	• The current level of integration between the Healthy Families Programme and other NHS services for children, young people, and families, currently delivered by Nottinghamshire Healthcare NHS Foundation Trust, would be a challenge for non-NHS providers. For example, streamlined referral pathways and information sharing agreements would need to be established. • The option would result in the fragmentation of an established integrated service which may have an adverse impact on integration and collaboration across health and care services, including early help and children's transitions. • If this approach resulted in multiple providers, this would lead to fragmentation in the delivery of services and in record keeping, which could lead to gaps and generate risk to safeguarding work. • Different providers may use different IT/clinical record system. There might be challenges around identifying ways to share/migrate information from current systems to new systems, and between the new systems used by separate providers. • Whilst it is possible to complete the competitive process in the 12-month period before the current contract ends (September 2025), this will be a challenge. • If a tender process was not successful, NCC would have very limited time in which to explore alternatives for service delivery. This would increase risk to delivery and efficiency of the service, as well as transformation work.

5.2. Option 2: Award the contract via the Provider Selection Regime most suitable provider process

Section A: Summary

Description
The most suitable provider process involves awarding a contract to providers without running a competitive process, because the relevant authority can identify the most suitable provider[(7)]. This process may be used when all of the following apply: • The relevant authority is not required to follow direct award process A or B. • The relevant authority cannot or does not wish to follow direct award process C. • The relevant authority is of the view, taking into account likely providers and all relevant information available to the relevant authority at the time, that it is likely to be able to identify the most suitable provider (without running a competitive tender process). That is, the most suitable provider selection process allows authorities to make an assessment on which provider is most suitable to deliver the proposed contracting arrangements based on consideration of the key criteria and the basic selection criteria [(7)]. Relevant authorities are advised to follow this approach only when they are confident that they can, acting reasonably, clearly identify all likely providers capable of providing the health care services and passing any key criterion or sub-criterion which has been designated as pass/fail. When following the most suitable provider process, the Council: • Would be advised to consider undertaking a pre-market engagement exercise to help identify all suitable providers and develop the service specification. • Must decide on the relative importance of each of the key criteria ('quality and innovation', 'value', 'integration, collaboration and service sustainability', improving access, reducing health inequalities and facilitating choice', and 'social value') for the service in question. It is advised that for higher contract values, greater focus is given to value for money and the quality and efficiency of the services provided, unless this means the service does not best meet the needs of the population it is serving. • Must assess any potential providers identified, considering the key criteria and applying the basic selection criteria in a fair way across them (i.e. on the same basis), and choose the most suitable provider(s) to which make an award.

- Must publish notices before beginning the process, about the intention to award the contract to the chosen provider, and about the award of the contract once it has been entered into.

The Council must be able to demonstrate that they have understood the alternative providers and reached a reasonable decision when selecting a provider – but this does not need to be via a formal competitive exercise. They must keep robust records of these considerations and follow the relevant transparency requirements.

If at any point in the most suitable provider process the relevant authority has insufficient information to make an assessment under the most suitable provider process, for example, because it did not receive sufficient information to help its decision-making, it is advised to use the competitive process (detailed in option 1). If the Council fails to identify the most suitable provider (or a group of providers), then it must follow the approach for the competitive process to select a provider.

The length of the contract awarded by the process would need to be considered. For example 3+2+2; the contract could be awarded for 3 years, with the opportunity to extend for a further 2 years.

Section B: Key Features

Service delivery
Through the contract, the provider will be held accountable for performance. This will help to ensure the successful delivery of programme outcomes. During the period of contract extension with the incumbent provider, enhanced levels of performance monitoring has been conducted to support service development, including comprehensive key performance indicators. These performance monitoring measures could be carried forward for the new contract with any provider identified as most suitable. Performance management of the contract will be overseen by Public Health. The outcomes of the Joint Scrutiny Review of the recommissioned HFP (published 25th January 2024) articulated plans to ensure the HFP would work in partnership with a wide range of children's and family services and would be a core component in the delivery of the Council's Early Help Offer. Whilst the outcomes and recommendations of this review were made in reference to the current provider, the learnings from this would be applicable to a new provider. This work could continue to ensure there is partnership working in a joined up, coordinated manner with both NCC and local NHS organisations.

There could be limited scope for making changes to the service once the contract is in place, although this will depend on the contract itself and length of contract put in place.

Once the contract is in place, there could be scope for making changes to the service if there was clarity in the specification that it was intended that the service should change over time, and there was a clear mechanism for how the changes would be discussed and made. The requirement for cooperation and service development can be built into the competitively procured contract.

Financial impact

Funding of the programme would continue to be included as part of the Public Health Grant which is a ring-fenced budget to be used for public health functions. The budget associated with the new contract has been agreed as part of the Public Health Grant, with a contract value of £15,473,968 per annum. It is expected that this will remain consistent for the life of the contract. Other than organisational capacity, it is not expected that there would be increased short-term costs to facilitate this option, and the capacity needed for this option is expected to be less than for all other options.

NCC and the current provider follow open-book accounting principles. This arrangement could be agreed as part of the tender requirement with any provider that is identified as most suitable, to give timely visibility of spend.

Implementation timescales

Due to PSR regulations commencing in January 2024, the most suitable provider process has not yet been completed within the Council and therefore it is difficult to estimate timescales. However, it is anticipated that the timescales needed for this process should be shorter than those needed for a competitive process and therefore this should be achievable within required timescales.

Workforce and HR

There are no direct HR implications for the Council arising out of this option as this relates to the provision of an externally commissioned service. The effect of the award of the contract would, if there was a change in provider from the incumbent

provider, be that the current staff engaged in the service would transfer to the new provider under Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE); or if NHFT were to be identified as most suitable, staff would remain within the Trust. Uncertainty around the future of the contract could cause instability in the workforce with anxiety about TUPE processes. This could affect retention of current staff, and recruitment of future staff during the process.

Clinical governance and CQC arrangements

Clinical governance arrangements (i.e. systematic approaches to maintaining and improving the quality of patient care) would be included as part of the requirements in the contract.

The nursing activities in the HFP involve the provision of health and social care. As such, this is a 'regulated' activity under Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which means that the legal entity carrying out the regulated activity must be registered with the Care Quality Commission (CQC). This would need to be included as part of the requirements in the contract.

Safeguarding procedures

Safeguarding procedures will be included as part of the requirements in the contract. The currently established pathways in place between the current provider, children's social care and the Multi-Agency Safeguarding Hub (MASH) will need to be established and prioritised if a new provider is identified as most suitable, to support delivery of effective safeguarding activity.

Additional considerations (including reputational risk, estates, IT)

IT and patient record system requirements would be included as part of the requirements in the contract.

The provision of suitable estates/facilities would be included as part of the requirements in the contract.

The length of the contract would need to be agreed. A shorter contract length with options for extension could reduce any potential reputational risk to the local authority, should there be any concerns with the chosen provider. However, this can cause uncertainty and instability amongst the workforce, which may lead to attrition. A longer contract length could help to mitigate this but would potentially increase risk to the local authority.

Pre-market engagement would be required to identify all suitable providers prior to assessment being made as to which is most suitable.
Procurement features
This approach would allow NCC to award the contract to a single provider without having to run a competitive process.
Legal features
The Council must follow the statutory guidance for following this process, including the relevant information keeping requirements detailed in Regulation 24 and the requirements for the transparency notices. The contract placed would be a standard Nottinghamshire County Council Public Health Contract as designed for these purposes.

Section C: SWOT Analysis

Strengths	Weaknesses
• Integration within the Nottinghamshire Early Help offer will be specified as a requirement in the contract to ensure there are robust partnership working arrangements. • Clinical governance processes can be included as part of the tender requirement. • Appropriate registration and quality assurance processes would be the responsibility of the selected provider. • Having a single integrated (0-19) service can maximise opportunities for joined up working, multi-disciplinary approaches and reduce gaps between services across childhood. • Referral pathways with local NHS services could be included as part of the scoring process to ensure coordinated and effective service delivery.	• Does not enable potential new providers to bid for the contract. If NCC requires further information from potential providers to make an assessment of which is most suitable, this can be requested. • PSR regulations were new in January 2024 so this will be a new process for everyone involved. • The lack of competitive process could limit creativity and innovation, or lead to complacency from the provider if a lengthy contract is secured.

Opportunities	Threats
• Enables a collaborative relationship between provider and commissioner throughout the procurement process by removing the 'competitive nature' of tender and facilitates open and honest dialogue without traditional restrictions. *Other authorities that have used a similar approach have indicated this method increases partnership and trust.* • NCC can decide the weighting of the pre-determined key criteria which any potential providers are assessed against. This could help to ensure that the provider which is chosen as most suitable delivers the best-value, high-quality service in conjunction with other services for children, young people, and families. Integration with the Nottinghamshire Early Help offer through ensuring there are robust partnership working arrangements can also be highly weighted.	• Workforce attrition at a time of national shortage: Uncertainty around the future of the contract is likely to cause instability in the workforce with anxiety about TUPE processes. It is important to note that there are national shortages of qualified health visitors and school nurses, and retention is therefore a key consideration for the Council. • The current level of integration between the Healthy Families Programme and other NHS services for children, young people, and families, currently delivered by Nottinghamshire Healthcare NHS Foundation Trust, would be a challenge for a non-NHS provider. For example, streamlined referral pathways and information sharing agreements would need to be established. • A new provider may use another IT/clinical record system. There might be challenges around identifying ways to share/migrate information from current systems. • If the contract is awarded to a new provider, there is risk that the cost of appropriate estates will increase. This could result in reduced funding within the budget envelope for service delivery. • If NCC are not successful in identifying the most suitable provider through this process, there would be limited time to either complete a competitive tender process or bring the service in-house. This would increase risk to delivery and efficiency of the service, as well as transformation work.

5.3. Option 3: Provide the whole 0-19 Healthy Families Programme from within the Council

Section A: Summary

Description
This option describes transferring the 0-19 Healthy Families Programme 'in house', to be provided directly by Nottinghamshire County Council. This refers to the 'make' option within the Council's 'make-or-buy' decision. The evidence set out in the 'Key Features' and the SWOT table below outline the features that arise were the service to be provided internally, rather than outsourced to an external supplier. This option would not require a procurement exercise. Instead, there would need to be more work carried out into the detail of feasibility and deliverability because the information below provides initial oversight but does not contain a level of detail which would give sufficient information to allow a robustly informed decision to be made. The timing and costing risks associated with that further work are set out below. The process would include setting up a multidisciplinary project management team including HR, Legal, Governance, Asset Management and IT, and which would require external consultancy support with experience in in-sourcing, particularly due to the clinical nature of the service. That would oversee the further detailed feasibility work and, if a decision was taken to in-source, would oversee the transition of the service from the incumbent provider into direct local authority control.

Section B: Key Features

Service delivery
As this paper is focusing on the options of 'how' the HFP is delivered rather than 'what' is delivered, it is assumed that for this option the service would be transferred in-house as is (i.e. as per the existing service model). Even if the model of the service does not change (i.e. the service delivered once transitioned in-house is like for like with the service currently delivered), consultation will likely be needed were it to be transitioned in-house.

Redesign of the programme would be possible, but any redesign of the service required to maximise benefits from the transition, would require consultation and this needs to be factored into timescales. Once the service is migrated in-house, the Council will have increased flexibility to change or transform the service (recognising statutory elements of the service will not be amendable to change) as they will not be committed to a specific contract length as would be the case were the service delivered by an external provider. This flexibility could be seen particularly for 5-19 services, where the NCMP is only the mandated element. There would be potential for the Council to redesign elements of the service, which has been done in some of the other areas which have brought the service in-house.

A directorate in the Council within which the 0-19 HFP would be housed, would need to be identified and agreed. Consideration would be needed as to how the service will be managed and how the KPIs and outcomes will be monitored, including governance, accountability and relational factors between departments.

The integration of the service into the local authority will require an on-going commitment to organisational development, recruitment, and consultation to support staff through the transition. Preparatory work to support workforce integration and the associated cultural shift will be required, and this also needs to be factored into transition timescales.

Consideration is needed as to how the service will continue to run effectively and efficiently during the period of transition, so that the quality of the service is not reduced and there is no threat to population outcomes. Capacity for service development and improvement will inevitably be reduced during this period, and mitigating actions will need to be included as part of the transition plan.

Financial impact

The budget associated with the new contract has been agreed as part of the Public Health Grant, with a contract value of £15,473,968 per annum. Funding of the programme would continue to be included as part of the Public Health Grant which is a ring-fenced budget to be used for public health functions.

Approximately 90% of service costs are allocated to staffing. If the previously agreed model is replicated within the local authority, staff will need to be transferred over via TUPE and the authority will assume all responsibility for Agenda for Change pay uplifts, pension contributions and any potential future redundancy costs.

Within the current contract spend, it is difficult to apportion or quantify costs relating to elements such as estates and IT. These will be additional costs for the Council to consider (see 'additional considerations').

As well as ongoing service costs, the transition of such a service will require resourcing and capacity from the local authority. Whilst it is difficult to estimate the total cost of the transition work, it is estimated that this could be upwards of £1 million. For example, external specialist consultancy costs are estimated as up to £900 per day, there would be significant costs associated with the resource required to TUPE across such a large number of staff, and CQC registration would also have an associated cost. A decision would be needed as to where the funding for the transition will come from. If it is expected that this cost will come out of the budget envelope for the service itself, significant transformation would be required to release the funds needed and this may impact service delivery. If the service model were to change as a result of this, consultation would be required which would add to the timescales and could lead to the Council breeching PSR regulations.

Whilst in the short term, there will be increased costs associated with the transition, there might be opportunities for cost-saving in the medium-to-long term. However, as the detailed scoping work with consultancy support has not yet been completed, it is not known whether these cost-savings would be anticipated for NCC or how they might be met.

Implementation timescales

A contract extension is in place until 30th September 2025. In-sourcing the service could take more than one year, resulting in the local authority breeching PSR regulations and potentially not meeting its obligation to provide a Healthy Family Programme to residents and reducing public health outcomes for residents. In practice, this would mean that option 2 might need to be used in the short/medium term whilst in-sourcing is carried out. However, this could negatively impact the stability of the service and could exacerbate or worsen potential workforce implications detailed below.

A significant amount of resource and capacity would be required to bring in house within the timeframe, although this was achieved by one authority consulted.

Workforce and HR

Consultation with other local authorities that have brought the service in-house indicates that HR is an area with significant challenges and costs.

There are currently over 300 Trust staff members working on the Healthy Families Programme. TUPE of these staff from the incumbent provider is highly likely and given that this could risk staff members leaving rather than moving to the Council, a substantial piece of recruitment might also be needed. If staff are transferred across to NCC via the TUPE process, the Council would be responsible for maintaining access to, and providing employer contributions to the NHS pension scheme for a large number of employees.

NHS Agenda for Change pay bandings do not directly correlate with Council pay bandings. Staff transferred over via the TUPE process will be required to remain on their current terms, conditions and pay. Job evaluation will be required to ensure roles fit within local authority bandings and are broadly in line with local providers to support recruitment and retention of staff. There could be pay comparability issues with local authority staff.

The integration of the service into the local authority will require an on-going commitment to organisational development, recruitment, and consultation to support staff through the transition. Preparatory work to support workforce integration and the associated cultural shift will be required, and this also needs to be factored into transition timescales.

NCC as provider would be required to support professional registration and revalidation of all nursing staff working as part of the HFP. NCC will also have to ensure access regular and appropriate clinical supervision for staff. At most senior levels, this may be available through mutual agreements with clinical partners, but these agreements will need to be negotiated.

The perceived loss of the NHS identity of the service could affect the reputation of the service amongst staff, which could affect recruitment and retention.
There is potential for loss of workforce as a result of the transition, which may impact delivery of the service and could negatively impact public health outcomes for families.

Clinical governance and CQC arrangements

NCC will be required to take full responsibility for complying with obligations of the Health and Social Care Act 2008 including clinical governance arrangements (i.e. systematic approaches to maintaining and improving the quality of patient care). The Council would have the ensure an appropriate clinical governance framework is in place, including safeguarding and quality assurance. Given that the incumbent provider is also the provider of many other clinical health services locally, the systems and processes currently in place around clinical governance for the service are unlikely to ‘lift and shift’ over to within the Council. Therefore, systems and processes will have to be established within Council structures to meet requirements with appropriate

personnel in post to meet these responsibilities. Whilst these processes are established, negotiation with the incumbent provider might be needed to retain current processes during the transition period.

NCC would also have to register with the CQC and ensure there is a registered manager(s) with capacity and capability to manage the regulated activity.

Safeguarding procedures

Pathways between the Healthy Families Programme, children's social care, local NHS providers and the Multi-Agency Safeguarding Hub will need to be established and prioritised to support the delivery of effective safeguarding activity in compliance with the Nottinghamshire Safeguarding Children Board standards and procedures and the Pathway to Provision (which sets out guidance for practitioners in identifying a child, young person and/or family's level of need, and referral pathways to the most appropriate service to provide support).

Additional considerations (including reputational risk, estates, IT)

Children's services within NCC currently use Mosaic as their case management system. This is not a clinical record system and therefore an additional system would need to be purchased and implemented within NCC, such as SystmOne (used by the incumbent provider and in other local authorities who have in-housed the service). The procurement of a new system and any transfer of clinical information from one platform to another will need to be factored into timescales, and managed in a way that it would not impact service delivery.

Decisions would need to be made as to which community locations the service will be provided in, and where staff members would have appropriate office space. Securing an appropriate estate that facilitates clinical service delivery is required for the effective the provision of the service. If the service were in-housed, there would be four broad options:

- Use existing estates owned by NCC that are currently vacant.
- Share existing estates owned by NCC with other services e.g. children's centres.
- Establish lease agreement(s) with partner organisations (such as local NHS estates), at a substantial cost given the scale of the service.
- NCC could acquire new properties for delivery of the service (least preferred option as most costly).

As the HFP is a clinical service, any premises would need to meet regulatory standards. Existing estates would need to be assessed to ensure they meet requirements, and appropriate modifications would be needed if these standards are not met but

NCC wishes to use existing premises. Other considerations, such as appropriate infrastructure to support IT/clinical record systems will also need to be assessed and factored into estates decisions. Appropriate provision of executive functions such as HR and finance would need to be made within the Council. If the service model remains the same, and therefore there is no direct change to the service for the user, it is difficult to know whether there would be any reputational risk and whether the transition would affect public perception of the service.
Procurement features
There are no direct procurement features with this transfer of the HFP in-house as this does not require going out to the external market. However, once the service is acquired by the Council, there might be future procurement work required for service delivery. This could include the procurement of clinical equipment and clinical record systems. This work will also have to be factored into timescales.
Legal features
Legal advice would need to be sought to ensure the transition complies with all legal requirements; input from an external legal provider would be needed which would contribute to the high transition costs referred to above.

Section C: SWOT Analysis

Strengths	Weaknesses
• May result in cost efficiencies in relation to costs not related to service delivery in the medium-to-long term (although additional work is needed to accurately estimate this).	• Would not be in line with the national and local direction of travel towards greater integration and collaboration of healthcare services as summarised under 'commissioning context' in the introductory section above. The approach would not align with the approach taken by ICB partners regarding other health services for children and young people aged 0 to 19, and their families.

• This option allows closer tailoring of the programme to local need. *Other local authorities that have used this approach to this have recognised this as a strength.* • Decisions regarding the programme could be taken more quicky as these will only need to go through internal governance processes, allowing more timely response to changes required. This could allow quicker responses to changes in demand, technological advances or feedback from residents and service users. • The Local Authority will have full control of the service, including greater control in determining any change required to the programme. • In-housing the service could improve information sharing between the HFP and social care, as there would be fewer information governance restrictions if both are provided by the same organisation.	• The Council would incur the additional cost of developing a clinical management infrastructure to support the service, including the identification of a lead professional health visitor/school nurse who will be responsible for implementing and leading the Standards for employers of public health teams in England. Governance processes would also need to be established. *This has been identified as a key challenge by other local authority areas.* • There would be TUPE implications requiring the transfer of the current workforce to the Council's employment on NHS Agenda for Change terms and conditions. (NHS Agenda for Change terms and conditions are not in line with the Council's terms and conditions potentially resulting in an inequity across similar pre-existing Council roles). *This has been identified as one of the biggest challenges and costs to bringing the service in house by other local authority areas. Some have identified this to be a key reason that bringing the service in house has not overall been cost saving, and some areas are still experiencing challenges around pay, terms and conditions over 5 years after bringing the service in-house.* • Whilst the Council already has a direction order in place to facilitate the continuation of the NHS pension for a small number of existing staff, the Authority would be responsible for maintaining access to, and providing employer contributions to the NHS pension scheme for a much larger workforce. • Other financial considerations include: ensuring access to continuing professional development and mandatory clinical training in line with legal requirements, and the costs of relevant indemnity insurance to cover the services provided. • Could place strain on internal Council relationships if the service provision was overseen by one directorate (i.e. Children and Families), but contract managed by Public Health. However, not having performance management mechanisms in place could

	threaten delivery of high-quality outcomes. *This is a challenge that has been identified by other local authority areas.* • This approach does not facilitate the continuation of a robust collaborative relationship between provider and commissioner for the remainder of the current contract period. This limits opportunity to focus on transformation and integration with the Council's Early Help offer.
Opportunities	**Threats**
• Provides an opportunity to fully integrate the Healthy Families Programme with the Council's Children's Centre Service/Family Hubs and the wider Early Help offer. *This has been a key factor as to why some other local authorities have brought the service in house.* • Could allow more opportunity and flexibility to diversify the workforce and expand skill-mix. *This was identified as an opportunity for this approach by another local authority.*	• Could result in the fragmentation of several aspects of the Healthy Families Programme that are integrated, jointly delivered, or have shared posts with other health services for children and families provided by NHFT. In some cases, additional investment and service development may mitigate the adverse impact at least in part. • Could create new and additional integration challenges and potential cost in regard to the referral pathways to and from other NHS services external to NHFT, such as community paediatrics, primary care, and neonatal and maternity services at the three acute hospital Trusts. • Could erode the coherence and consistency of the approach to safeguarding children across all care pathways that NHFT deliver for children and young people aged 0 to 19. *Safeguarding process challenges have been experienced by other local authority areas that have brought the service in house.* • Could create new and additional integration challenges and potential cost regarding securing access to a complete electronic patient record which currently (i) ensures that safeguarding information is available in 'real time' to clinicians working with families, regardless of which specific health service they are working within, and (ii) is compatible with clinical patient records used by other 0-19 health services including community, acute and primary care NHS services. *Implementation of a patient record system has been identified as a challenge to*

	bringing the service in house by other local authorities, who explained the implementation was both complex and costly.
	• Acquiring the organisational capability and capacity to support the employment of NMC registered clinicians would require significant investment and implementation. NMC registered clinicians are required for the delivery of the mandated elements of the service:
	  • All health visiting and school nursing services must be registered with the Care Quality Commission. This is a legal requirement as defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. *Other areas have explained this is a lengthy process, taking up to 6 months.*
	  • Requirement to ensure that that the workforce meet their legal requirements for professional registration and revalidation with the Nursing and Midwifery Council, (revalidation is a public protection measure and legal requirement for nurses, midwives, and health visitors to practice in the UK). *Some other local authorities that have brought the service in house already had these processes in place, whereas these would need to be established at NCC.*
	  • Provision of clinical supervision, continual professional development and access to training and preceptorship
	  • Ensuring service delivery is underpinned by research and evidence (including NICE guidelines)
	  • The maintenance of 'safe staffing' levels.
	• Past experience demonstrates that uncertainty around the future of the service/employer causes instability in the workforce with anxiety around TUPE and loss of professional identity as NHS nurses. This could result in workforce attrition at a time of national shortages of qualified health visitors and school nurses. Retention is therefore a key consideration for the Council. *Some other authorities that have in-housed the service have experienced loss of staff.*

	• The perceived loss of NHS identity could affect ongoing recruitment and retention efforts across this workforce. *This has been identified as a challenge by local authorities which have brought the service in-house.* This could also affect public perception and the reputation of the service. • Securing an appropriate estate that facilitates clinical service delivery is required for the effective the provision of the service. This could come at significant cost to NCC. *Providing suitable accommodation in community locations has been identified as a challenge by other local authorities that have brought the service in house*.

5.4. Option 4: Split the service, providing elements in-house with others not provided in-house.

As stated at the start of section 5, there are multiple different ways in which the HFP could be split, providing some element(s) in-house and some not. Given the ages of school transitions (and transitions of services utilised within the HFP), and following discussions with other local authorities, options 4A and 4B appear to be the most popular and perhaps most practical options. Therefore, these are the two options explored in more depth under option 4 and other options as to how the service could be split have not been considered within this paper.

5.4.1. Option 4A: Split the service, with the 0-5 service not provided in-house and the 5-19 service provided in-house.

Section A: Summary

Description
This option explores the division of the Healthy Family Programme into two services, to be delivered by two mechanisms. 1. The 0-5 element would be delivered by an external provider. This consists of the health visiting service, provision of 5 mandated reviews, an early intervention offer, and the Family Nurse Partnership, which could be sourced through one of two options already explored in this paper. This would require a decision to be made between:

A: a competitive procurement led by the Public Health Division at Nottinghamshire County Council for this distinct lot.

Or

B: awarding the contract via the Provider Selection Regime most suitable provider process.

Detailed descriptions of these options and considerations are provided above in Options 1 and 2.

2. The 5-19 element of the Healthy Families Programme would be transferred 'in house', including the delivery of school nursing services and the national child measurement programme (NCMP). These elements would be provided directly by Nottinghamshire County Council. Detail of this is provided in Option 3, but for the 5-19 service this would be on a smaller scale (although the same feasibility work detailed in the option 3 description would be needed).

This option assumes that the service would be delivered in line with the existing agreed model including the provision of registered public health nurses. Any material transformation and changes to the model would require a period of consultation that would affect timescales and resources.

Dissolution of the current approach, which integrates health visiting and school nursing provision and has been in place since 2017 will require additional work to separate and align the new service. Additionally, as with option 3, the process of moving the 5-19 element in-house would require external consultancy support with experience in in-sourcing (to a lesser extent than option 3).

Section B: Key Features

Service delivery
As explained above, the 0-5 services will be delivered by an external provider. This will either be through a competitive tender process (detailed in option 1A) or through the most suitable provider process (detailed in option 2). The 5-19 services will be provided in-house by NCC (detailed in option 3). As outlined in Option 3, the transference of any element of the Healthy Families Programme will require a decision to be taken on which directorate will house the service and

best facilitate integration and contract management. It is assumed that this would likely be Children's and Families, with Public Health continuing to provide contract management.

The division of the service would need to be explored and new ways of working identified between the two providers to avoid duplication of provision and understand more fully the impact on family experience and public health outcomes. This activity would need to begin pre transition and be managed throughout the life of the contract.

The integration of the 5-19 service into the local authority will require an on-going commitment to organisational development, recruitment, and consultation to support staff through the transition. Preparatory work to support workforce integration and the associated cultural shift will be required, and this also needs to be factored into transition timescales.

Consideration is needed as to how the service will continue to run effectively and efficiently during the period of transition, so that the quality of the service is not reduced and there is no threat to population outcomes. In the short to medium term the capacity for service development and improvement will inevitably be reduced during the transition period, and mitigating actions will need to be included as part of the transition plan.

Once the service is migrated in-house, the Council will have longer term increased flexibility to change or transform the 5-19 service (recognising statutory elements of the service will not be amendable to change) as they will not be committed to a specific contract length as would be the case were the service delivered by an external provider. As the NCMP is the only mandated element of the 5-19 service, there would be flexibility for the Council to redesign or reconfigure elements of the service.

Financial impact

The budget associated with the new contract has been agreed as part of the Public Health Grant, with a contract value of £15,473,968 per annum. Funding of the programme would continue to be included as part of the Public Health Grant which is a ring-fenced budget to be used for public health functions.

Further scoping work would be needed to appropriately apportion costs to the 0-5 and 5-19 elements respectively. Costs for services for the 0-5 years age group (of which mandatory checks by health visitors makes up the vast proportion) are significantly higher than costs of services for older children and young people. As the present service is delivered as a single integrated service, it is difficult to straightforwardly attribute exact costs to different age groups.

For the 5-19 element transitioned in-house, the Council would assume responsibility for all pay uplifts, pension contributions and any potential future redundancy costs of new staff members or staff members transferred across via TUPE.

As well as ongoing service costs, the transition of such a service will require resourcing and capacity from the local authority. Whilst it is difficult to estimate the total cost of the transition work, it is estimated that this would cost less than the transference of the full 0-19 service but may reduce economies of scale.

Additional capacity and resources will be required to support delivery on two strands of activity concurrently to achieve the timescale.

Some functions (such as HR, CQC requirements, IT systems) may be duplicated across both services (both in-house and via the external provider), potentially increasing costs.

Whilst in the short term, there will be increased costs associated with the transition of an element of the service in-house, there might be opportunities for cost-saving in the medium-to-long term. However, as the detailed scoping work with consultancy support has not yet been completed, it is not known whether these cost-savings would be anticipated for NCC or how they might be met.

Implementation timescales

For the 0-5 service, please see options 1 and 2 for the details around the competitive tender process or most suitable provider process.

For the 5-19 service, please see option 3 for details around bringing the service in-house.

There would be time pressure to ensure the processes could be completed within the 12-month contract extension period which would potentially need to be increased by the need to complete both strands of activity concurrently unless additional resource was identified.

The additional work generated by the division of the service could negatively impact the timeframe. If the 5-19 service was redesigned as part of the transition it would require an additional consultation period.

The 5-19 service is smaller than the 0-5 element, but it has been noted that 12 months may not be sufficient time to bring a service in house considering the preparatory work, TUPE process and transition activity.

Workforce challenges listed below may impact ability to launch inhouse service on time.

If this option were to be pursued, this might mean that in practice, as with option 3, option 2 might need to be used for the 5-19 element in the short/medium term whilst in-sourcing is carried out. However, this could negatively impact the stability of the service and could exacerbate or worsen potential workforce implications detailed below.

Workforce and HR

This option has a number of variations and decisions taken will impact HR considerations.

For the 0-5 provision, the workforce and HR considerations will be as above for options 1 or 2 (depending on the chosen approach).

For the 5-19 provision, TUPE of staff from the incumbent provider might be required, or recruitment would be needed. If staff are transferred across to NCC via the TUPE process, the Council would be responsible for maintaining access to, and providing employer contributions to the NHS pension scheme for a number of employees.

NHS Agenda for Change pay bandings do not directly correlated with Council pay bandings. Job evaluation will therefore be required to ensure roles fit within local authority bandings and are broadly in line with local providers to support recruitment and retention of staff.

For the 5-19 service, the loss of NHS identity could impact the recruitment and retention of staff. Separation of the service could also increase workforce anxiety. School nursing recruitment and retention challenges may have a greater impact without the mitigating support of Health Visiting colleagues.

There is potential for loss of workforce as a result of the transition, which may impact delivery of the service and could negatively impact public health outcomes for families.

Clinical governance and CQC arrangements
NCC will have full responsibility for meeting the obligations of the Health and Social Care act, as it applies to 5-19 provision. The Council would have the ensure an appropriate clinical governance framework is in place, including safeguarding and quality assurance. Systems and processes will have to be established within Council structures to meet requirements with appropriate personnel in post to meet these responsibilities. NCC would have to register with the CQC and ensure there is a registered manager(s) with capacity and capability to manage any regulated activity in the 5-19 service. Both the Council and the external provider would need to ensure clinical governance mechanisms are in place, and establish processes for how these link and work in partnership. Both providers could also require CQC registration, which could reduce funding available for provision of the programme itself.
Safeguarding procedures
There is a shortage of Public Health Specialist Nurses within the School nursing function nationally and locally. As the majority of safeguarding activity is within the 5-19 service, separation of the 0-5 service from the 5-19 may create a significant lack of capacity in a priority area. Pathways between the Healthy Families Programme 0-5, Healthy Families Programme 5-19, children's social care, local NHS organisations and the Multi-Agency Safeguarding Hub will need to be established and prioritised to support the delivery of effective safeguarding activity in compliance with the Nottinghamshire Safeguarding Children Board standards and procedures and the Pathway to Provision (which sets out guidance for practitioners in identifying a child, young person and/or family's level of need, and referral pathways to the most appropriate service to provide support). Information sharing agreements, process and procedures between the two organisations would be required at an operational level to ensure records can be shared where required.
Additional considerations (including reputational risk, estates, IT)
For 0-5 services, please see options 1 or 2 for additional detail. For 5-19 services, please see option 3.

Whilst delivery of the existing agreed model has been assumed, in-housing the 5-19 service will increase future agility, transformation and service redesign in line with national appetite for a revision of school age provision.

The burden on estates and core NCC functions would be less than required for option 3 as there is a smaller number of staff that deliver the 5-19 service.

Separation of activity may contribute to a perceived reduction in the value of school-based provision with reduced capacity and resources. This may be a risk to reputation if coupled with increasing mental health challenges for children and young people in the county.

Division of the service could reduce capacity and economies of scale. It could also lead to tensions between providers when partnership working will be of increasing importance, potentially reducing capacity for transformation and ongoing improvement in both areas.

Compatibility of any clinical record management system procured for the in-house 5-19 service with the external providers system for the 0-5 service, will need to be considered.

Procurement features

Two procurement options are available for the 0-5 elements as outlined in options 1 and 2.

There are no direct procurement features with this transfer of the 5-19 HFP in-house as this does not require going out to the external market.

Legal features

Legal advice would need to be sought for the in-sourced elements to ensure the transition complies with all legal requirements; input from an external legal provider would be needed which would contribute to the high transition costs referred to above.

Section C: SWOT Analysis

Strengths	Weaknesses

• Provides future opportunity and flexibility to transform the service, allowing the programme to be tailored to local need.
• For the 5-19 service, this option may result in cost efficiencies in relation to costs not related to service delivery in the medium-to-long term (although additional work is needed to accurately estimate this).
• Decisions regarding the 5-19 service could be taken more quicky as these will only need to go through internal governance processes, allowing more timely response to changes required. This could allow quicker responses to changes in demand, technological advances or feedback from residents and service users.
• In-housing the 5-19 service could improve information sharing between the HFP, youth services and social care for this age group, as there would be fewer information governance restrictions if services are provided by the same organisation.
	Please see all weaknesses identified under option 3 – they all apply here as well.
	• With an external provider and NCC delivering different elements of the 0 to 19 Healthy Child Programme, there may be:
	  ○ increased management and overhead costs, adversely impacting the cost-effectiveness of the service,
	  ○ poorer service user experience and outcomes as a result of the involvement of multiple practitioners.
	• The approach is likely to be time and resource intensive for both NCC and procurement colleagues as it involves either option 1 or 2 for the 0-5 service, and resource and capacity to move the 5-19 service in-house.
	• This approach is likely to be time and resource intensive to contract manage. This will likely result in public health colleagues needing to contract manage the 0-5 service with the external provider and establish mechanisms for monitoring outcomes of the internal 5-19 service. Effort will be needed to ensure oversight is maintained and KPIs met.

Opportunities	**Threats**
• Provides an opportunity to integrate the 5-19 Healthy Families Programme with the Council's Children's Centre Service/Family Hubs and the wider Early Help offer. • Could allow more opportunity and flexibility to diversify the workforce and expand skill-mix in the 5-19 service.	*Please see all threats identified under option 3 – they all apply here as well.* • There could be challenges in coherence and consistency in the approach to safeguarding, particularly in the age transition window (i.e. around age 5 when services transition from being externally provided to provided in-house). *Safeguarding process challenges have been experienced by other local authority areas that have brought the service in house.* • Could create new and additional integration challenges and potential cost regarding securing access to a complete electronic patient record particularly in the age transition window

	(i.e. around age 5 when services transition from being externally provided to provided in house). *Implementation of a patient record system has been identified as a challenge to bringing the service in house by other local authorities, who explained the implementation was both complex and costly.* • There could be challenges to achieve the current level of integration between the HFP and other NHS services. • The option is likely to result in the fragmentation of an established integrated service which may have an adverse impact on integration and collaboration across health and care services, including early help and children's transitions. • Having multiple providers could lead to fragmentation in the delivery of services and in record keeping, which could lead to gaps and generate risk to safeguarding work. • Different providers may use different IT/clinical record system. There might be challenges around identifying ways to share/migrate information from current systems to new systems, and between the new systems used by separate providers. • Timescales to complete option 1 or 2 for the 0-5 service, and bringing the 5-19 service in house, would be a challenge to complete in the 12-month period before the current contract ends.

5.4.2. Option 4B: Split the service, with the 0-11 service not provided in-house and the 11-19 service provided in-house.

Section A: Summary

Description
This option explores the division of the Healthy Family Programme into two services, to be delivered by two mechanisms.

1. The 0-11 element would be delivered by an external provider. This consists of the health visiting service, provision of 5 mandated reviews, an early intervention offer, the Family Nurse Partnership and National Child Measurement Programme which could be sourced through one of two options already explored in this paper. This would require a decision to be made between:

    A: a competitive procurement led by the Public Health Division at Nottinghamshire County Council for this distinct lot.

    Or

    B: awarding the contract via the Provider Selection Regime most suitable provider process.

    Detailed descriptions of these options and considerations are provided above in Options 1 and 2.

2. The 11-19 element of the Healthy Families Programme would be transferred 'in house', which is primarily the delivery of secondary school nursing services. This would be provided directly by Nottinghamshire County Council. This option would not require a procurement exercise. Instead, a multidisciplinary project management team including HR, Legal, Governance, Asset Management and IT would be required to oversee the transition of the service from the incumbent provider into direct local authority control. Detail of this is provided in Option 3, but for the 11-19 service this would be on a smaller scale.

This option assumes that the service would be delivered in line with the existing agreed model including the provision of registered public health nurses. Any material transformation and changes to the model would require a period of consultation that would affect timescales and resources.

Dissolution of the current approach, which integrates health visiting and school nursing provision and has been in place since 2017 will require additional work to separate and align the new service. Additionally, as with option 3, the process of moving the 11-19 element in-house would require external consultancy support with experience in in-sourcing (although to a lesser extent than option 3 and 4A).

Section B: Key Features

Service delivery
As explained above, the 0-11 services will be delivered by an external provider. This will either be through a competitive tender process (detailed in option 1) or through the most suitable provider process (detailed in option 2). The 11-19 services will be provided in-house by NCC (detailed in option 3). As outlined in Option 3, the transference of any element of the Healthy Families Programme will require a decision to be taken on which directorate will house the service and best facilitate integration and contract management The division of the service would need to be explored and new ways of working identified between the two providers to avoid duplication of provision and understand more fully the impact on family experience and public health outcomes. It is anticipated that this would be of most significance where there are safeguarding concerns and additional vulnerabilities. This activity would need to begin pre transition and be managed throughout the life of the contract. The integration of the 11-19 service into the local authority will require an ongoing commitment to organisational development, recruitment, and consultation to support staff through the transition. Preparatory work to support workforce integration and the associated cultural shift will be required, and this also needs to be factored into transition timescales. Consideration is needed as to how the service will continue to run effectively and efficiently during the period of transition, so that the quality of the service is not reduced and there is no threat to population outcomes. In the short to medium term the capacity for service development and improvement will inevitably be reduced during the transition period, and mitigating actions will need to be included as part of the transition plan. With high impact areas and no mandated contacts, this age group is most suitable for transformation. Once the service is migrated in-house, the Council will have increased flexibility to change or transform the 11-19 service as they will not be committed to a specific contract length as would be the case were the service delivered by an external provider.
Financial impact

The budget associated with the new contract has been agreed as part of the Public Health Grant, with a contract value of £15,473,968 per annum. Funding of the programme would continue to be included as part of the Public Health Grant which is a ring-fenced budget to be used for public health functions.

Further scoping work would be needed to appropriately apportion costs to the 0-11 and 11-19 elements respectively. Costs for services for the younger years are significantly higher than costs of services for older children and young people. As the present service is delivered as a single integrated service, it is difficult to straightforwardly attribute exact costs to different age groups.

For the 11-19 element transitioned in-house, the Council would assume responsibility for all pay uplifts, pension contributions and any potential future redundancy costs of new staff members or staff members transferred across via TUPE.

As well as ongoing service costs, the transition of such a service will require resourcing and capacity from the local authority. Whilst it is difficult to estimate the total cost of the transition work, it is estimated that this would cost less than the transference of the full 0-19 service but may reduce economies of scale.

Additional capacity and resources will be required to support delivery on two strands of activity concurrently to achieve the timescale. Any future transformation work once the 11-19 service is moved in-house will also require resourcing.

Some functions (such as HR, CQC requirements, IT systems) may be duplicated across both services (both in-house and via the external provider), potentially increasing costs.

Whilst in the short term, there will be increased costs associated with the transition of an element of the service in-house, there might be opportunities for cost-saving in the medium-to-long term. However, as the detailed scoping work with consultancy support has not yet been completed, it is not known whether these cost-savings would be anticipated for NCC or how they might be met.

Implementation timescales

For the 0-11 service, please see options 1 and 2 for the details around the competitive tender process or most suitable provider process.

For the 11-19 service, please see option 3 for details around bringing the service in-house.

There would be time pressure to ensure the processes could be completed within the 12-month contract extension period which would be increased by the need to complete both strands of activity concurrently.

The additional work generated by the division of the service could negatively impact the timeframe. If the 11-19 service was redesigned as part of the transition it would require an additional consultation period. Benefits of any potential redesign post-transition may not be felt until the medium to long term.

The 11-19 service is smaller than the 0-11 element, but it has been noted that 12 months may not be sufficient time to bring a service in house considering the preparatory work, TUPE process and transition activity. However, given the smaller number of staff involved, timescales for transition required for this option will be less than for option 3 and option 4A.

Workforce challenges listed below may impact ability to launch inhouse service on time, however this may be mitigated by lack of mandated contacts during this period.

If this option were to be pursued, this might mean that in practice, as with option 3 and 4A, option 2 might need to be used for the 11-19 element in the short/medium term whilst in-sourcing is carried out. However, this could negatively impact the stability of the service and could exacerbate or worsen potential workforce implications detailed below.

Workforce and HR

This option has a number of variations and decisions taken will impact HR considerations.

For the 0-11 provision, the workforce and HR considerations will be as above for options 1 or 2 (depending on the chosen approach).

For the 11-19 provision, TUPE of staff from the incumbent provider might be required, or recruitment would be needed. If staff are transferred across to NCC via the TUPE process, the Council would be responsible for maintaining access to, and providing employer contributions to the NHS pension scheme for a number of employees.

NHS Agenda for Change pay bandings do not directly correlate with Council pay bandings. Job evaluation will therefore be required to ensure roles fit within local authority bandings and are broadly in line with local providers to support recruitment and retention of staff.

For the 11-19 service, the loss of NHS identity could impact the recruitment and retention of staff. Separation of the service could also increase workforce anxiety. School nursing recruitment and retention challenges may have a greater impact without the mitigating support of Health Visiting colleagues. However, there is potential for redesign and transformation work when the service is moved in-house, which could increase skill-mix and reduce some workforce pressures.

There is potential for loss of workforce as a result of the transition, which may impact delivery of the service and could negatively impact public health outcomes for families.

Clinical governance and CQC arrangements

NCC will have full responsibility for meeting the obligations of the Health and Social Care act, as it applies to 11-19 provision. The Council would have to ensure an appropriate clinical governance framework is in place, including safeguarding and quality assurance. Systems and processes will have to be established within Council structures to meet requirements with appropriate personnel in post to meet these responsibilities.

NCC would have to register with the CQC and ensure there is a registered manager(s) with capacity and capability to manage any regulated activity in the 11-19 service.

Both the Council and the external provider would need to ensure clinical governance mechanisms are in place, and establish processes for how these link and work in partnership. Both providers could also require CQC registration, which could reduce funding available for provision of the programme itself.

Safeguarding procedures

There is a shortage of Public Health Specialist Nurses within the School nursing function nationally and locally. As the majority of safeguarding activity is within the 5-19 service, separation of the service may create a significant lack of capacity in a priority area for a 11-19 service.

Pathways between the Healthy Families Programme 0-11, Healthy Families Programme 11-19, children's social care, local NHS organisations and the Multi-Agency Safeguarding Hub will need to be established and prioritised to support the delivery of effective safeguarding activity in compliance with the Nottinghamshire Safeguarding Children Board standards and procedures and the Pathway to Provision (which sets out guidance for practitioners in identifying a child, young person and/or family's level of need, and referral pathways to the most appropriate service to provide support).

Information sharing agreements, process and procedures between the two organisations would be required at an operational level to ensure records can be shared where required.

Additional considerations (including reputational risk, estates, IT)

For 0-11 services, please see options 1 or 2 for additional detail. For 11-19 services, please see option 3.

Whilst delivery of the existing agreed model has been assumed, in-housing the 11-19 service will increase future agility, transformation and service redesign in line with national appetite for a revision of school age provision. Integration and alignment of a 11-19 service with existing Children's and Young People provision within the local authority may provide additional opportunities to add value.

The burden on estates and core NCC functions would be less than required for option 3 or 4A as there is a smaller number of staff that deliver the 11-19 service.

Separation of activity may contribute to a perceived reduction in the value of school-based provision with reduced capacity and resources. This may be a risk to reputation if coupled with increasing mental health challenges for children and young people in the county.

Division of the service could reduce capacity and economies of scale. It could also lead to tensions between providers when partnership working will be of increasing importance, potentially reducing capacity for transformation and ongoing improvement in both areas.

Compatibility of any clinical record management system procured for the in-house 11-19 service with the external providers system for the 0-11 service, will need to be considered. However, as provision of the 11-19 service is less clinical that other

elements of the HFP, MOSAIC (currently used within NCC) may suffice as a record management system for the in-housed service.
Procurement features
Two procurement options are available for the 0-11 elements as outlined in options 1 and 2. There are no direct procurement features with this transfer of the 11-19 HFP in-house as this does not require going out to the external market.
Legal features
Legal advice would need to be sought for the in-sourced elements to ensure the transition complies with all legal requirements; input from an external legal provider would be needed which would contribute to the high transition costs referred to above.

Section C: SWOT Analysis

Strengths	Weaknesses

• Provides future opportunity and flexibility to transform the service, allowing the programme to be tailored to local need. If a decision was made to discontinue the provision of school nurses in the 11-19 age group, this could remove the need for the Council to support the employment of NMC registered clinicians, including CQC registration and clinical supervision. *Other local authorities that have used this approach have removed the clinical element of their 11-19 offer.* However, if this were to be done as part of the transition, this would require redesigning the service model and consultation would be required.	*Please see all weaknesses identified under option 3 – they all apply here as well.*
	• With an external provider and NCC delivering different elements of the 0 to 19 Healthy Child Programme, there may be:
	  ○ increased management and overhead costs, adversely impacting the cost-effectiveness of the service,
	  ○ poorer service user experience and outcomes as a result of the involvement of multiple practitioners.
	• The approach is likely to be time and resource intensive for both NCC and procurement colleagues as it involves either option 1 or 2 for the 0-11 service, and resource and capacity to move the 11-19 service in-house.

• As above, depending on the service offer implemented for the 11-19 service, TUPE might not apply. This could be cost saving. • For the 11-19 service, this option may result in cost efficiencies in relation to costs not related to service delivery in the medium-to-long term (although additional work is needed to accurately estimate this). • Decisions regarding the 11-19 service could be taken more quickly as these will only need to go through internal governance processes, allowing more timely response to changes required. This could allow quicker responses to changes in demand, technological advances or feedback from residents and service users. • In-housing the 11-19 service could improve information sharing between the HFP, youth services and social care for this age group, as there would be fewer information governance restrictions if services are provided by the same organisation.	• This approach is likely to be time and resource intensive to contract manage. This will likely result in public health colleagues needing to contract manage the 0-11 service with the external provider and establish mechanisms for monitoring outcomes of the internal 11-19 service. Effort will be needed to ensure oversight is maintained and KPIs met.
Opportunities	**Threats**
• Provides an opportunity to integrate the 11-19 Healthy Families Programme with the Council's Children's Centre Service/Family Hubs and the wider Early Help offer. • Could allow more opportunity and flexibility to diversify the workforce and expand skill-mix in the 11-19 service.	*Please see all threats identified under option 3 – they all apply here as well.* • There could be challenges in coherence and consistency in the approach to safeguarding, particularly in the age transition window (i.e. around age 11 when services transition from being externally provided to provided in-house). *Safeguarding process challenges have been experienced by other local authority areas that have brought the service in house.* • Could create new and additional integration challenges and potential cost regarding securing access to a complete electronic patient record particularly in the age transition window (i.e. around age 11 when services transition from being externally provided to provided in house). *Implementation of a patient record system has been identified as a challenge to*

	bringing the service in house by other local authorities, who explained the implementation was both complex and costly. • There could be challenges to achieve the current level of integration between the HFP and other NHS services. • The option is likely to result in the fragmentation of an established integrated service which may have an adverse impact on integration and collaboration across health and care services, including early help and children's transitions. • Having multiple providers could lead to fragmentation in the delivery of services and in record keeping, which could lead to gaps and generate risk to safeguarding work. • Different providers may use different IT/clinical record system. There might be challenges around identifying ways to share/migrate information from current systems to new systems, and between the new systems used by separate providers. • Timescales to complete option 1 or 2 for the 0-11 service, and bringing the 11-19 service in house, would be a challenge to complete in the 12-month period before the current contract ends.

5.5. Overview of options against criteria.

The methods used to score each option can be found in sections 4.7 and 4.8, and the description of each criterion can be found at the start of section 5.0.

Each option was be scored against each criterion on a scale of 0-3, detailed below:

- 0 = Unsatisfactory. This option will fail to address the criteria description.
- 1 = Some concerns. There would be significant challenges to this option meeting the criteria description.
- 2 = Acceptable. This option should meet the criteria description, but there might be some challenges.

- 3 = Good. This option should address the criteria description with little/no challenges.

The table below illustrates the average score for each option.

Theme	Criteria	Option					
		1A: Competitive tender of single integrated service	**1B:** Competitive tender (separate lots)	**2:** PSR Most Suitable Provider approach	**3:** Whole service in-house	**4A:** Split service with 0-5 external provider and 5-19 in-house	**4B:** Split service with 0-11 external provider and 11-19 in-house
		SCORE					
Desirability *(extent to which the option aligns with NCC preferences)*	Improved outcomes for service users	2	1	2	1.5	1.75	2
	Integration with NCC services (i.e. with Nottinghamshire Early Help Offer)	1.5	1	1.5	3	2	2
	Integration with local NHS services	1.5	1.5	1.5	1	1.75	1.75
	Flexibility to respond to change	1.75	1.5	2	2.25	2	2
Desirability total score /12		**6.75**	**5**	**7**	**7.75**	**7.5**	**7.75**
Viability *(ability of the option to work successfully)*	Short financial impact (0-2 years)	2.5	2.5	2.5	1.5	2	2
	Medium/long term financial impact (2+ years)	2	1.5	2	2.5	2	2
	Workforce recruitment and retention	1.75	1.75	1.75	1.25	1.75	2
	Reputational risk	2	1.75	2	1.25	2	2
Viability total score /12		**8.25**	**7.5**	**8.25**	**6.5**	**7.75**	**8**
	Implementation timescales	2	1	2	0.75	1.5	1.5

Feasibility *(extent to which the option can be accomplished successfully)*	Safeguarding procedures	2	1	2	2	1.75	1.75
	Clinical governance and CQC arrangements	2.5	2.5	2.5	2	2	2
	Additional implementation considerations: estates, IT	2.5	2	2.5	1.5	2	2
Feasibility total score /12		**9**	**6.5**	**9**	**6.25**	**7.25**	**7.25**
Total /36		**24**	**19**	**24.25**	**20.5**	**22.5**	**23**

6.0. Conclusions and recommendations

The decision on the future commissioning of the Nottinghamshire HFP is not straightforward or clear cut, and it must be acknowledged all options come with strengths, weaknesses, opportunities, and threats, detailed in the report above. The table above, which assesses each option against a range of criteria, has been developed as a tool to aid comparison of options and support decision-making.

The options can be reviewed against the three themes of desirability, viability and feasibility. The extent to which each option appeals to NCC overall will depend on the relative importance or weight given to each of these different factors.

For **desirability** (i.e. the extent to which the option aligns with NCC preferences for the HFP), options 3 and 4B score the highest. The criteria within this are; improved outcomes for service users, integration with NCC services, integration with local NHS services, and flexibility to respond to change.

For **viability** (i.e. the ability of the option to work successfully) which includes, short- and medium-term financial impact, workforce recruitment and retention and reputational risk, options 1A and 2 score the highest.

For **feasibility** (i.e. the extent to which the option can be accomplished successfully) and includes implementation timescales, safeguarding procedures, clinical governance and CQC arrangements, and considerations around estates and IT, options 1A and 2 scores the highest.

Overall, options 1A (competitive tender process) and 2 (most suitable provider process) are the highest scoring options based on the criteria. On balance, whilst option 2 scores 0.25 higher, option 1A emerges as the preferred option when considering all factors.

This process will invite bidders to tender for the delivery of the full Nottinghamshire Healthy Families Programme, with bids evaluated against a fixed set of criteria. This has been recommended because:

- It will allow full assurance that NCC has assessed the whole market in a recognised and transparent process through inviting bidders to tender for the service delivery.
- It will allow requirements to be included in the contract specification such as integration with NHS and Council (e.g. Early Help) services, consortia arrangements, and the ability of the service to adapt/respond to changing need, emerging challenges or new opportunities.
- Option 2 is a new process that has not yet been undertaken by the Council so we cannot be certain around timescales to complete the procurement process. Furthermore, if it is not possible to identify a provider deemed as 'most suitable', option 1A would then have to be completed in addition.
- Options which would involve bringing the service (or elements of it) in-house (3, 4A and 4B) would be very challenging to achieve in the timescales required and are likely to present increased risks to workforce recruitment and retention.
- Options which involve splitting the service (1B, 4A and 4B) would present additional challenges for integration and safeguarding.

7.0. References

(1) GOV.UK. Healthy Child Programme Schedule of Interventions. Office for Health Improvement and Disparities. 2023. Available from: https://www.gov.uk/government/publications/healthy-child-programme-schedule-of-interventions

(2) GOV.UK. Healthy Child Programme 0 to 19: health visitor and school nurse commissioning. Public Health England. 2016. Available from: https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

(3) GOV.UK. Stage 5: Options Appraisal. 2017. Available from: https://www.gov.uk/government/publications/libraries-alternative-delivery-models-toolkit/stage-5-options-appraisal

(4) Nottinghamshire County Council. Procurement Strategy 2019-2023. Available from: https://home.nottscc.gov.uk/media/2322415/procurement-strategy-2019-2023-final.pdf

(5) Nottinghamshire County Council. Strategic Commissioning. Available from: https://home.nottscc.gov.uk/managing/finance-pay/strategic-

commissioning?_gl=1*l79tzy*_ga*NzAxNzEzMzkzLjE3MTg5NTI2NjA.*_ga_2W78ZJC2TJ*MTcxODk2MTYzNC4zLjEuMTcxODk2MTcwNS4wLjAuMA..
(6) The Health Care Services (Provider Selection Regime) Regulations 2023. Available from: https://www.legislation.gov.uk/uksi/2023/1348/contents/made
(7) NHS England. The Provider Selection Regime: draft statutory guidance. Available from: https://www.england.nhs.uk/long-read/the-provider-selection-regime-statutory-guidance/
(8) Early Intervention Foundation. What works to enhance the effectiveness of the Healthy Child Programme: An evidence update. 2018. Available from: https://www.eif.org.uk/report/what-works-to-enhance-the-effectiveness-of-the-healthy-child-programme-an-evidence-update
(9) Public Health England. Rapid Review to Update Evidence for the Healthy Child Programme 0-5. 2015. Available from: https://assets.publishing.service.gov.uk/media/5a7f1d92e5274a2e87db3e34/150520_RapidReviewHealthyChildProg_UPDATE_poisons_summary.pdf
(10) Royal College of Nursing. Health visitors and school nurses: a summary of recent evidence and trends in the UK workforce.
(11) The Queen's Nursing Institute. A School Nurse in Every School: Report from a Round Table discussion held on 15 December 2023. Available from: https://qni.org.uk/wp-content/uploads/2024/03/Round-Table-Report-A-School-Nurse-in-every-School-December-2023.pdf
(12) Local Government Association. School nursing: Looking after the health and wellbeing of school children. 2022. Available from: https://www.local.gov.uk/publications/school-nursing-looking-after-health-and-wellbeing-school-children#:~:text=The%20LGA%20has%20long%20called,workforce%20plan%20to%20address%20shortages.
(13) Institute for Government. Government Outsourcing. When and how to bring public services back into government hands. 2020. Available from: https://www.instituteforgovernment.org.uk/sites/default/files/publications/government-outsourcing-public-services-government-hands.pdf
(14) Institute for Government. Government Outsourcing. What has worked and what needs reform? 2019. Available from: https://www.instituteforgovernment.org.uk/sites/default/files/publications/government-outsourcing-reform-WEB.pdf
(15) Local Partnerships. Options Appraisal workbook. 2012. Available from: https://www.local.gov.uk/sites/default/files/documents/pas-options-appraisal-wor-7f5.pdf
(16) Care Quality Commission. Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust. March 2024. Available from: https://www.cqc.org.uk/publications/nottinghamshire-healthcare-nhsft-special-review/background