Nottinghamshire County Council

Public Health Committee

Thursday, 01 December 2016 at 14:00

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

AGENDA

1	Minutes of the last Meeting held on 29 Sept 2016	5 - 8
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Domestic Violence and Abuse Services – Presentation by Nottinghamshire Women's Aid and Women's Aid Integrated Services	
5	Changes to the Structure of the Children's Integrated Commissioning Hub	9 - 12
6	Implications of the Nottinghamshire Sustainability and Transformation Plans for Public Health	13 - 20
7	Director of Public Health's Annual Report 2015/16	21 - 50
8	Public Health Service Plan 2016/17 - Progress Report	51 - 58
9	Public Health Services Performance and Quality Report for Contracts Funded with Ring-Fenced Public Health Grant, Quarter 2 2016/17	59 - 72
10	NHS Health Checks IT Service Procurement Update	73 - 76

11 Work Programme 77 - 80

12 Exclusion of the Public

The Committee will be invited to resolve:-

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

Note

If this is agreed, the public will have to leave the meeting during consideration of the following items.

13 Exempt appendix to item 10: NHS Health Checks IT Service Procurement Update

- Information relating to the financial or business affairs of any particular person (including the authority holding that information);

Notes

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

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

Customer Services Centre 0300 500 80 80

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

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

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

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

Nottinghamshire County Council

minutes

Meeting	PUBLIC HEALTH COMMITTEE
Date	29 September 2016 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

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

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

OFFICERS IN ATTENDANCE

Kerrie Adams, Public Health
Kate Allan, Public Health
Pete Barker, Democratic Services
Nathalie Birkett, Public Health
Barbara Brady, Interim Director of Public Health
Kay Massingham, Public Health

APOLOGIES FOR ABSENCE

No apologies for absence were received.

MINUTES

The minutes of the meeting held on 14 July 2016 were confirmed and signed by the Chair.

PRESENTATION BY SOLUTIONS4HEALTH ON TOBACCO CONTROL SERVICES

Alistair Nixon from Solutions4Health gave a presentation to Committee on the work of the organisation.

RESOLVED 2016/022

That Committee note the contents of the presentation.

IMPLEMENTATION OF A SCHOOLS HEALTH HUB

RESOLVED 2016/023

1) That the progress made in developing and implementing plans for the Schools Health Hub within Nottinghamshire be noted.

2) That the interdependencies and joint working between the Schools Health Hub and other support to schools services, particularly the Tackling Emerging Threats to Children Project, be noted.

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

RESOLVED 2016/024

That the award of the contract for the Integrated Healthy Child and Public Health Nursing Programme for 0 – 19 year olds to the winning tenderer, as set out in the exempt appendix, be approved.

NHS HEALTH CHECK PROCUREMENT UPDATE

The Chair informed Members that this report would now be brought to a future meeting of the Committee.

ESTABLISHMENT OF A HEALTH AND HOUSING COORDINATOR

RESOLVED 2016/025

That the establishment of a post of Public Health and Commissioning Manager (Health and Housing) at Hay Band D and on a fixed term contract for two years from the date of appointment, subject to the approval of external funding to meet the costs of the post, be approved.

UPDATE ON PUBLIC HEALTH BUDGETS 2016/17

RESOLVED 2016/026

1) That the position regarding the Public Health grant and budget up to March 2018 be noted

2) That the list of changes to realignment in 2016/17, as set out in paragraphs 8 and 9 of the report, be approved.

3) That following the decision by the Health and Wellbeing Board on alternative funding for HPAS, the use of the released Public Health funds to expand the activities identified in paragraph 13 of the report, be approved.

PUBLIC HEALTH SERVICES PERFORMANCE AND QUALITY REPORT FOR CONTRACTS FUNDED WITH RING-FENCED HEALTH GRANT, QUARTER 1, 2016/17

RESOLVED 2016/027

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

.WORK PROGRAMME

RESOLVED 2016/028

That the committee's work programme be noted.

EXCLUSION OF THE PUBLIC

RESOLVED: 2016/029

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

EXEMPT INFORMATION ITEM

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

RESOLVED: 2016/030

That the information set out in the exempt appendix be noted.

The meeting closed at 3.46 pm.

CHAIR

Nottinghamshire County Council

Report to the Public Health Committee

1 December 2016

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

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

Purpose of the Report

1. This report provides information on changes to the structure of the Integrated Children's Commissioning Hub and seeks approval from the Public Health Committee to establish the posts of Public Health and Commissioning Manager, and Public Health Support Officer.

Background

2. The Children's Integrated Commissioning Hub (ICH) provides a single point of coordination for commissioning relating to children's health and wellbeing. Set up in September 2013, and based within the Division of Public Health, the ICH works on behalf of five Nottinghamshire clinical commissioning groups (CCGs) and Nottinghamshire County Council, including Children's and Public Health services. This arrangement excludes Bassetlaw CCG.

3. Commissioning activity delivered by the ICH on behalf of the Nottinghamshire CCGs is funded through an annual contribution of £230,000 towards the costs of the Hub. The ICH leads on the commissioning of statutory and priority services for the CCGs, including the Integrated Community Children and Young People's Healthcare Services (ICCYPH), Community Paediatrics, Special Educational Needs and Disabilities (SEND) health services, health services for looked after children, maternity services and Child and Adolescent Mental Health Services.

Information and Advice

4. Following a re-structure within the public health division, the following posts in the ICH have been vacated by officers who have been successfully appointed to permanent positions in the division:

    - 1.0 FTE Band D Strategic Performance and Needs Assessment Manager (permanent);
    - 2 FTE Band D ICCYPH Programme Managers (fixed term).

5. The Consultant in Public Health responsible for the ICH and the ICH Senior Public Health and Commissioning Manager met with the Chief Operating Officers of the CCGs on 26th September 2016. At this meeting it was confirmed that the CCGs were highly satisfied with the work of the ICH, and Chief Officers confirmed their continued intention to fund current ICH arrangements for a further three year period. The CCGs' priorities for the ICH were also restated, to include ongoing implementation of the ICCYPH, SEND, Better Births and Future in Mind arrangements, and a review of community paediatric services.

6. To deliver on the priorities set out by the CCGs, it is now necessary to appoint new officers to the ICH with appropriate experience and skill sets, in particular with regards to commissioning of health services. As such, it is proposed that the posts recently vacated are deleted from the Public Health department establishment, and replaced by the following new posts:

   - 1.0 FTE Band D Public Health and Commissioning Manager (permanent);
   - 1.0 FTE Band B Public Health Support Officer (permanent).

7. Following a period of significant change in personnel within the ICH, appointing on a permanent basis will provide stability and assurance to the CCGs, and support the recruitment retention of high calibre officers. The proposed posts are fully funded by the CCGs, and given the three year term of the funding, appointing on a permanent basis will not incur any additional cost risk associated with employment rights, either through external advert or internal secondment.

8. A failure to appoint appropriately skilled officers in a timely manner would incur a risk to the Council that the CCGs withdraw their funding, which supports a range of posts within the Public Health Division, and the benefits of an integrated commissioning structure could be lost. These risks would be mitigated through proceeding to appointment.

Other Options Considered

9. Consideration was given to appointing to the posts within the existing establishment. However, as the priorities for the CCG funders relate to commissioning activity, and with a reduced requirement for programme management skills in the future, creating new posts more closely aligned with the demands of the post is considered a more appropriate approach.

Reason for Recommendation

10. The Council's Constitution require all posts on the establishment to be approved by the appropriate Committee.

Statutory and Policy Implications

11. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution, the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability

and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

12. A job description for the post of Public Health and Commissioning Manager has been evaluated as Band D. The costs associated with establishing this post at the top of the scale will be £41,551 per annum (plus on costs).

13. A job description for the post of Public Health Support Officer has been evaluated as Band B. The costs associated with establishing this post at the top of the scale will be £34,196 per annum (plus on costs).

14. There is no additional Council resource required to meet the costs of the post as the posts would be fully funded through the CCG investment in the ICH.

Human Resources Implications (SJ 14.11.2016)

15. The Human Resources implications are outlined within the body of this report.

RECOMMENDATION

1) Public Health Committee is asked to approve the establishment of a permanent post of Public Health and Commissioning Manager at Hay Band D, and a permanent post of Public Health Support Officer at Hay Band B.

Barbara Brady
Director of Public Health

For any enquiries about this report please contact:
Nicole Chavaudra
Senior Public Health and Commissioning Manager
Tel: 0115 9773843
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Constitutional Comments (CEH 10.11.16)

16. The recommendation falls within the delegation to the Public Health Committee under its terms of reference.

Financial Comments (DG 8.11.16)

17. The financial implications are contained within paragraphs 12 to 14 of the report.

Background Papers and Published Documents

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

Electoral Divisions and Members Affected

- All

Nottinghamshire County Council

Report to Public Health Committee

1 December 2016

Agenda Item: 6

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

IMPLICATIONS OF THE NOTTINGHAMSHIRE SUSTAINABILITY AND TRANSFORMATION PLANS FOR PUBLIC HEALTH

Purpose of the Report

1. Inform members of the Public Health Committee of the implications of the Sustainability and Transformation Plans (STP) on the PH team and PH commissioned services.

Background

2. Over the last few months, every health care system in England (44 in total) has developed a 5 year Sustainability and Transformation Plan (STP). Each plan shows how local services will work together to improve the quality of care, their population's health and wellbeing as well as the local finances of the care system (NHS and LA). These plans are intended to accelerate the implementation of the NHS Five Year Forward View (FYFV) and improve outcomes between 2016 and 2021. One of the key components in the FYFV is the focus on prevention. The following is an extract from the FYFV. *The first argument we make in this five year forward view is that the future health of millions of children, the sustainability of the NHS and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health.*

Information and Advice

Progress so far

3. There are two STPs for the Nottinghamshire area. Their coverage has been determined by NHS England (NHSE). Bassetlaw is part of the South Yorkshire STP footprint, whilst the remainder of the county along with the City forms the Nottinghamshire STP. Given the aspirations of the FYFV, 'prevention' is a priority within both STPs.

4. The focus of the 'Primary' prevention aspect (preventing the onset of disease) of the STP is on tackling those activities that will address the underlying risk factors associated with ill health, e.g. smoking, alcohol, diet and nutrition, physical activity, weight management and mental wellbeing. NICE (National Institute of Health and Care excellence) has published guidance on four of these areas. This guidance and associated tools (which estimate the return on investment) have been applied to the Nottinghamshire population and show that by 2020 if the current commissioned activity continues (blue line on figures 1 & 2) the prevention activities described above are expected to contribute £19.8 million of benefits to the health care system and a further £2.8 million to the social care system. Please see Appendix 1.

5. Whilst PH have led the primary prevention aspects of the STP, the team have also been supporting other sections of the plan in our role as providers of specialist PH advice to CCGs.

Implications going forward

6. The opportunity that both STPs present are of securing a 'fully engaged' care system from a prevention perspective. Whilst the evidence base for prevention is strong, so far it has not been possible to secure the organisational and/or clinical support to ensure that primary prevention is fully embedded into the care system. A key component of a fully engaged system is the systematic delivery of Making Every Contact Count (MECC). MECC uses existing interactions between clinicians and patients/general public to identify opportunities for adoption of healthy lifestyles and their promotion. If successful the systematic roll out of MECC will result in patients/public deciding to change their behaviour and adopt healthier lifestyles. Some of these individuals will need support to help with that change process, so whilst PH currently commissions certain levels of capacity in each our behavioural change services (e.g. stop smoking), it is too early to say if this will be enough to meet potential demand increases. However, this is an area that will be monitored closely.

7. The majority of the work described in this paper is complementary to our HWB Strategy and builds on work already underway. However, it does not capture all the primary prevention work undertaken by Public Health. Due to the 5 year time frame of the STP both plans have not detailed the longer term work e.g. with children, which is still needed in order to secure longer term health benefits.

Fig 1: The financial effect of prevention scenarios on **healthcare** costs

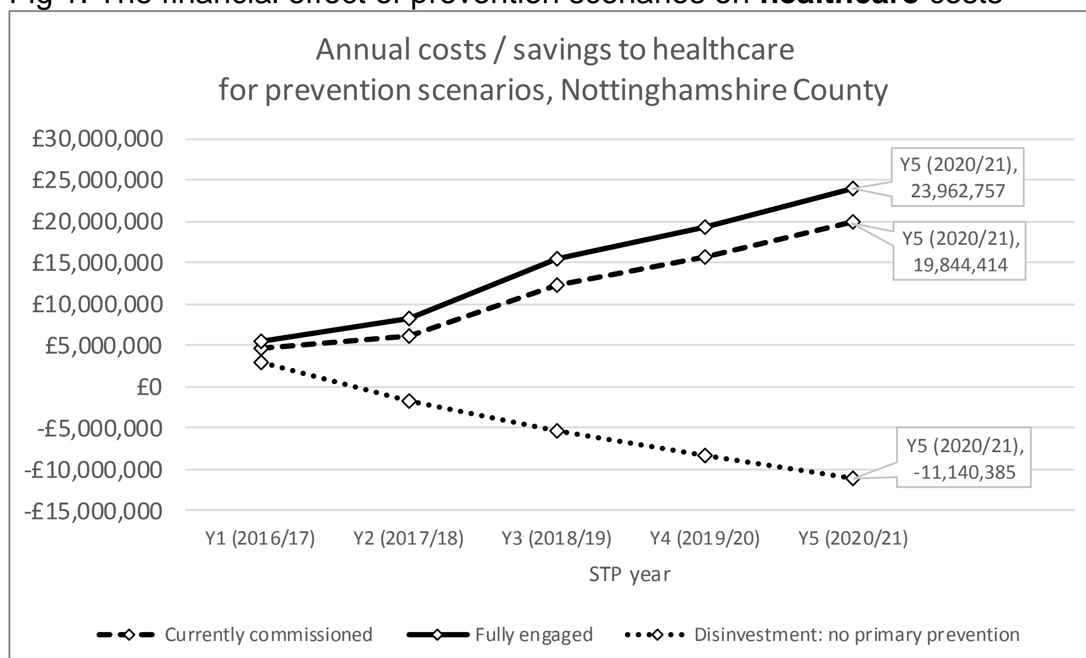
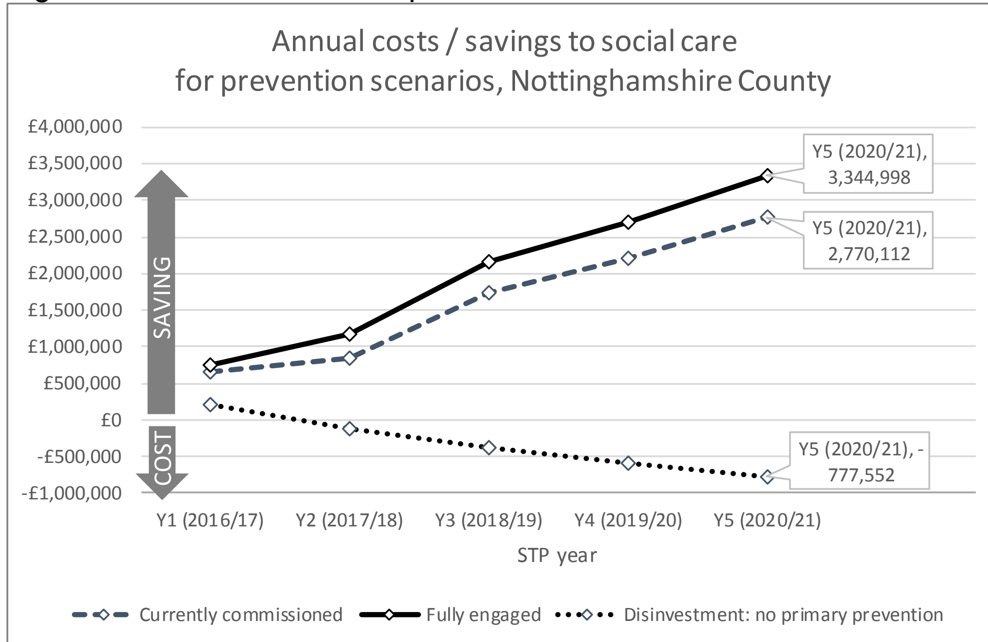


Fig 2: The financial effect of prevention scenarios on **social care** costs



8. Several of the indicators from the Public Health Outcomes framework relate to the primary prevention priorities in the STPs. The Nottinghamshire STP has included in its performance framework targets for these areas. As Nottinghamshire County relates to both STPs, work is currently underway to establish targets for the whole of the County that would in turn contribute to both STPs. Targets and trajectories for the following are now being calculated for

- Slope index of inequality (mortality from causes considered preventable).
- prevalence of smoking in the general population, with separate targets for pregnancy, routine and manual workers
- prevalence of excess weight in children, aged 10-11
- levels of physical inactivity
- alcohol admissions
- Breastfeeding rates
- uptake of NHS health checks
- Low birth weight babies

Summary

9. There has been a focused piece of work which the PH team has supported to enable the development of two robust STP plans that cover the Nottinghamshire Population. These plans were submitted to NHS England on the 21st October and formal feedback is expected shortly. Both STPs primary prevention aspects build on work already underway to support the Nottinghamshire HWB strategy. The PH targets and trajectories once developed will be shared with the PH committee.

Other Options Considered

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

Reason for Recommendation

11. The Public Health Committee is responsible for the PH grant and the PH function

Statutory and Policy Implications

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

Financial Implications

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

Recommendations

Members of the Public Health Committee are asked to:

1) Note the PH team's contribution to the development of the STP
2) Note the assumptions made regarding ongoing PH funding for PH commissioned services including the return on investment

Barbara Brady
Interim Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (CH 01/11/16)

14. The report is for noting purposes only.

Financial Comments (DG 04/11/2016)

15. The financial implications are contained within paragraph 13 of the report.

Background Papers and Published Documents

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

Appendix 1

Sustainability and Transformation Plans (STPs) require local partners to assess how their activities contribute to the reduction of three gaps:

- Health and wellbeing
- Finance and efficiency
- Care and quality.

The requirement to quantify these gaps - and how proposed activity might reduce them – is a new one which STPs are approaching in different ways. This paper relates to the contribution that primary prevention in Nottinghamshire County can make to the health and wellbeing and associated finance gaps across the County.

The value of primary prevention

By definition, prevention involves stopping events happening; this makes it hard to quantify the effects of such work. There are however data sources that can be used to estimate the total amount of disease, ill-health and disability in populations and also how interventions might reduce this burden of disease.

What is the current health and disability gap?

The Global Burden of Disease (GBD) (http://www.healthdata.org/gbd) is a world-wide initiative that aims to quantify the burden of disease and disability for the world population, global regions, individual countries and – increasingly – sub-national populations. The initiative has produced analyses since 1990 and now runs as a consortium of over 1,800 researchers in 120 countries. As well as the total burden of disease and disability, the researchers aim to identify and quantify the links between risk factors and consequent ill-health and mortality. If some risk factors are modifiable – as many are – then the burden of disease can be reduced. The burden is quantified as potential life-years lost, either because of premature death or a reduced quality of life because of long-term illness or disability.

Estimating the burden of disease for the Nottinghamshire population

For the 2013 release of the GBD, Public Health England collaborated with the GBD project to produce data for English regions - including the East Midlands - and by deprivation group within each region. We know the how the STP population compares to the East Midlands (the percentage of STP resident in each deprivation quintile for instance) and can so estimate the burden of disease, with links between risk factors and illness and disability, for the STP population.

Summary of results for Nottinghamshire County

- The Nottinghamshire population has an estimated total disease and disability burden of 294,102 life-years.
- Over half of the burden is caused by just three groups of diseases and conditions: Circulatory disease (26.9% of the total), Cancers (16.9% of the total) and diabetes and other metabolic disorders (12.0% of the total)
- GBD evidence suggests that 49% of the disease burden can be linked to specific risk factors. In the Nottinghamshire population, dietary risks account for 16.0% of attributable life-years, smoking 15.3% and overweight/ obesity 14.4%. Other risk factors amenable to primary prevention include alcohol and drug use (7.8% of the attributable burden), low

levels of physical activity (4.3% of the total), occupational health risks (3.81%) and anthropogenic air-pollution (2.6%).

The results also reveal a complex relationship between risk factors and conditions and diseases. As figure 1 shows, few conditions and diseases are related to only one or two risk factors. Instead exposure to single risk factors has effects on many conditions and diseases; conversely multiple risk factors affect each listed disease and condition. There is no one, single risk factor that should be tackled above all others.

Life-years amenable to change in the STP population

DALYs incorporate years lost to disability (years in poor health or disabled) as well as years of life lost (early deaths)

Risk factors related to conditions

Conditions (<<- higher contribution to total DALYs ... lower contribution to total DALYs ->>)

Risk factors	The impact that changing these risk factors ... will have on DALYs caused by these conditions	Circulatory diseases	Diabetes, reproductive, urinary	Cancers	Chronic chest diseases	Mental and substance use disorders	Unintentional injuries	Musculoskeletal disorders	Cirrhosis	Nutritional deficiencies	*Percentage of all DALYs amenable to intervention*
higher contribution to total DALYs ->>	Dietary risks	✓✓✓	✓✓	✓✓	-	-	-	-	-	-	*15.9*
	Tobacco smoke	✓✓	✓	✓✓✓	✓✓	-	-	-	-	-	*15.6*
	High body-mass index	✓✓✓	✓✓	✓	-	-	-	✓	-	-	*14.2*
	High systolic blood pressure	✓✓✓	✓	-	-	-	-	-	-	-	*11.8*
	Alcohol and drug use	-	-	✓	-	✓✓	✓	-	✓	-	*8.2*
	High fasting plasma glucose	✓✓	✓✓✓	-	-	-	-	-	-	-	*7.4*
	High total cholesterol	✓✓✓	-	-	-	-	-	-	-	-	*5.5*
<<- lower contribution to total DALYs	Low glomerular filtration rate	✓	✓✓	-	-	-	-	-	-	-	*4.9*
	Low physical activity	✓✓	✓	✓	-	-	-	-	-	-	*4.3*
	Occupational risks	-	-	✓	✓	-	✓	✓	-	-	*3.8*
	Air pollution	✓	-	✓	✓	-	-	-	-	-	*2.6*
	Low bone mineral density	-	-	-	-	-	✓✓	-	-	-	*2.2*
	Child and maternal malnutrition	-	-	-	-	-	-	-	-	✓	*1.6*
	Percentage of all DALYs amenable to intervention	*46.2*	*16.3*	*15.8*	*5.1*	*3.7*	*3.3*	*3.0*	*1.5*	*1.5*	

Key

✓✓✓	Largest impact - 5% or more of all DALYs
✓✓	Medium impact - 2 to 5% of all DALYs
✓	Lower impact - up to 2% of all DALYs
-	No contribution

Notes

- This chart incoporates 95% of all disability adjusted life years amenable to intervention
- Estimates for the STP population are derived from data for East Midlands deprivation quintiles, from the WHO Global Burden of Disease initiative

Figure 1 How risk factors relate to conditions and diseases for Nottinghamshire & Nottingham STP population

The health effect of interventions and life-years gained

There is robust, quantifiable evidence for the impact of several primary prevention initiatives in the form of return on investment (ROI) tools developed by NICE and Public Health England. These tools use the best available evidence to assess the cost-effectiveness and benefit in terms of life-years for different interventions at a whole population scale.

The ROI tools for tobacco, overweight and obesity, physical activity and alcohol were used to assess the impact of primary prevention on Nottingham and Nottinghamshire populations. Together these tools include 42% of the life-years amenable to intervention; no estimates were made for other interventions (for example dietary risks) where there was no robust evidence for population health gain. In each case care was taken to assess the health impact only over the 5-year timeframe for the STP: life-time health gains (which for risks such as tobacco can be much larger than short-term gains) were not used.

The tools were all used to quantify the life-years gained or lost for three scenarios:

- The current commissioned level of intervention in Nottinghamshire County
- A 'fully engaged' level of intervention; maximising the reach of interventions with minimal or no further investment
- No primary prevention; in essence the effect on health if there were no public health grant and no commissioned primary prevention activity.

The total life-years gained could then be expressed as a percentage of the total GBD burden of disease and disability.

The financial gap

As described above, the GBD aims to quantify the total burden of disease and disability for given populations: if this burden were zero then there would be no disease or disability and there would be no resources needed for health or social care. The projected total spend for health and social care in 2020 for the Nottinghamshire population is estimated at £1.029 billion, so each life-year can be valued at (£1.029bn/ 249,102 life-years) or £3,500 per life-year.

Results

The results are summarised in figures 2 and 3, which show the projected savings or costs for the three scenarios outlined above for the health and social care economies.

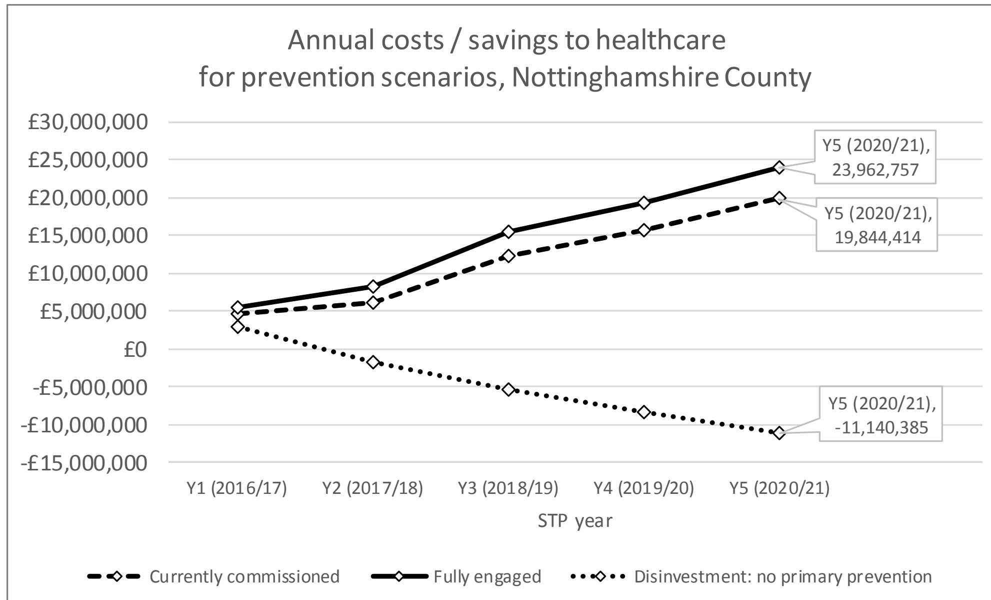

Figure 2 The financial effect of prevention scenarios on healthcare costs

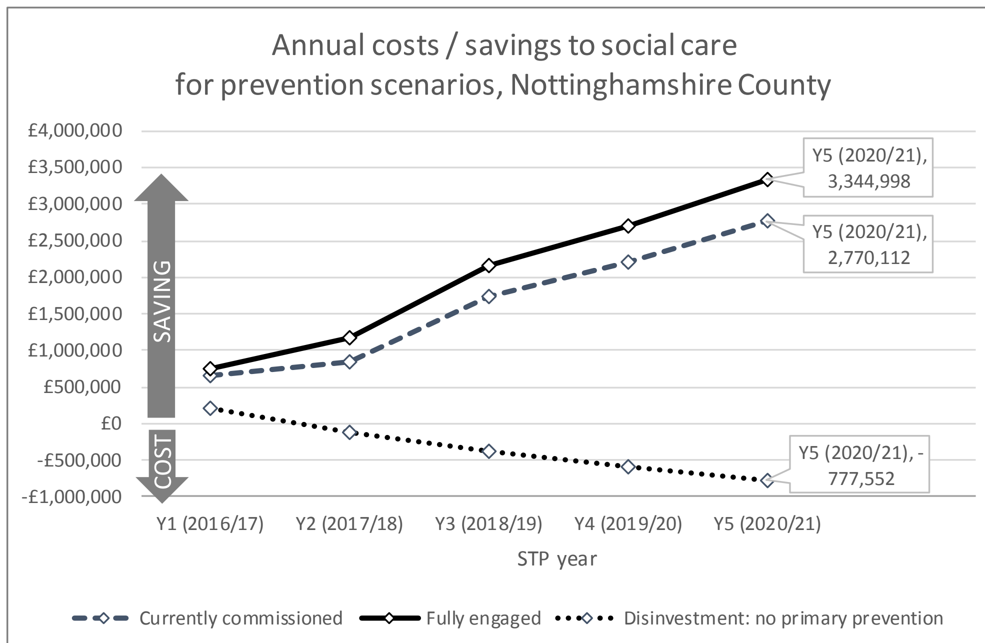

Figure 3 The financial effect of prevention scenarios on social care costs

These results demonstrate that in 2020, across Nottinghamshire, the primary prevention activities described above will contribute up to £35.1m and £4.1m to the healthcare and social care economies respectively.

Conclusions
The use of the Global Burden of Disease data, coupled with robust evidence from ROI tools, has enabled an estimate of the health & wellbeing and financial impact of primary prevention work. These figures are likely to be underestimates: a lack of evidence for interventions on diet, sexual health, mental health and work with 0 to 19 year olds in particular means that the life-year gain for these areas of work are not included in this work. NICE released ROI tools for social and emotional wellbeing (including aspects of mental health) and Children, young people and pregnant women in late October 2016; these will be incorporated into the models as the next phase of work.

David Gilding
Public Health Information and Intelligence

Nottinghamshire County Council

Report to the Public Health Committee

1 December 2016

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015-16

Purpose of the Report

1. To note the contents, and approve the publication, of the Annual Report of the Director of Public Health.

Background

2. The attached report is the independent Annual Report of the Director of Public Health (DPH). It relates to the year April 2015 to March 2016.

3. The DPH Annual Report is a statutory requirement. In general the statutory responsibilities of the DPH are designed to match exactly the corporate public health duties of their local authority. The exception is the Annual Report on the health of the local population - the DPH has a duty to write a report whereas the authority's duty is to publish it (section 73B (5) and (6) of the Health Act 2006 inserted by section 31 of the Health and Social Care Act 2012). The content and structure of the report is something to be decided locally.

Information and Advice

4. The report is designed to be a critical assessment of the health and wellbeing needs of the local population, and to make recommendations for further action.

5. **Chapter 1** sets the scene by describing briefly the differences between life expectancy and healthy life expectancy in Nottinghamshire, and introducing the concept of health inequalities within the County, through a graphical presentation that illustrates how healthy life expectancy decreases from South to North, and from East to West of the County. Also included is the description of the social gradient in health contained in the 2010 Marmot review of health inequalities, which identifies how health expectations are affected by socio-economic factors.

6. **Chapter 2** looks at the importance of place on people's health and wellbeing, focusing on the Marmot recommendations relating to healthy and sustainable places and communities. The report describes how the Council and its partners can contribute to improving health through improving place, covering the topics of active travel, open and green space, food environment, energy efficiency in housing, systems integration, and support for locally developed and evidence-based community regeneration programmes including those to address social isolation.

7. The Chapter ends by recommending action in several areas, as follows:

    a. Promoting active travel by engaging with planners, developers, employers, communities and schools.
    b. Improving access to open and green spaces.
    c. Promoting the adoption of government buying standards on food by partners and service providers
    d. Increasing participation in the Nottinghamshire HOT merit scheme for fast food businesses
    e. Using the planning system to encourage improvements related to physical activity, active travel, green space, proportion of fast food outlets, and the quality of development and house building
    f. Seeking endorsement of local Spatial Planning documents and protocols
    g. Supporting the voluntary and community sector, using social prescribing to reduce social isolation, and making development of community capacity a priority in the next Health and Wellbeing Strategy

8. **Chapter 3** focuses on how health is influenced by individual behaviour, and how this is linked again to the social gradient described in the Marmot report, in terms of obesity, use of alcohol, and smoking, all of which are significant to the development of chronic diseases. The report describes the impact in Nottinghamshire of each of these behaviours and identifies activities being undertaken by the Council and by partners to address them. It ends by recommending that resources to enable the ongoing delivery of related activities should be protected.

9. **Chapter 4** examines some of the ways of inducing behavioural change, using four examples:

    a. Making Every Contact Count - an initiative which seeks to engage staff who have regular contact with the public in giving Public Health messages and signposting to relevant services. Seizing the opportunity presented by Making Every Contact Count will require a range of local stakeholders to build on past work and to take further action. The report recommends a planned programme to train staff in the skills to have meaningful healthy conversations as part of their day to day work.
    b. The NHS Health Check - a mandatory Public Health function which is offered to the population age 40 – 74. The report recommends targeting those on the patient lists that are most likely to be at high risk of cardiovascular disease.
    c. The National Diabetes Prevention Programme, a new lifestyle change and education programme for adults found to have high risk of developing type 2 diabetes.
    d. The Annual health check for people with learning disabilities - offered by GPs to relevant individuals aged 14 or over. The report recommends that GPs systematically invite relevant patients for these annual checks.

10. **Chapter 5** looks at how preventable ill health drives demand for health and care services, using the example of diabetes. The Quality and Outcomes Framework (QOF) system for the performance management and payment of general practitioners (GPs) awards GP practices achievement points for managing some of the most common chronic diseases, e.g. asthma, diabetes; managing major public health concerns, e.g. smoking, obesity; and implementing preventative measures, e.g. regular blood pressure checks. The report considers the projected prevalence of diabetes in the Nottinghamshire population and recommends action to reduce variation in the identification and care of patients.

11. **Chapter 6** concludes the report, signposts readers to other sources of information, and collates all of the report's recommendations.

Other Options Considered

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

Reason for Recommendation

13. Publication of the independent DPH Annual report is a statutory requirement.

Statutory and Policy Implications

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

Financial Implications

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

RECOMMENDATION

Members are asked to:
1) note the contents of the report
2) approve the publication of the report

Barbara Brady
Director of Public Health

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Constitutional Comments (CEH 10/11/16)

16. The recommendation to approve the publication of the report falls within the remit of the Public Health Committee under its terms of reference. The Authority has a duty to publish an annual report on the health of the local population.

Financial Comments (DG 08/11/16)

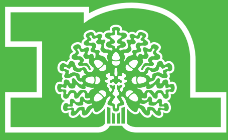
17. The financial implications are contained within paragraph 15 of the report

Background Papers and Published Documents

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

Electoral Divisions and Members Affected

- All



Nottinghamshire County Council

Director of Public Health's

Annual Report

2016

Healthy People, Healthy Communities

Contents

Director of Public Health - **Annual Report 2016**

Contents	1
Acknowledgements	2
Chapter 1: Background	3
Chapter 2: Health starts where we live: the importance of place	6
Chapter 3: How we live now: how behaviour impacts on health	17
Chapter 4: Encouraging change and preventing disease	24
Chapter 5: Dealing with consequences: impacts of preventable disease on the health and care system	32
Chapter 6: Summary of Recommendations	35
References	38

Acknowledgements

To all members of the Nottinghamshire County Council Public Health team, without whom this report would not be possible.

Introduction

The Health and Social Care Act 2012 sets out a requirement for all Directors of Public Health to produce an annual independent report on the health of their local population (the local authority is required to publish it). The report is to raise awareness and understanding of local health issues, highlight areas of specific concern and make recommendations for change.

This is my first report as Director of Public Health. I hope it successfully tells the story of how where we live, combined with how we live, shapes our health and wellbeing. This means how long we live as well as our quality of life and ultimately the impact this has on our health and social care services. We hear a lot about our NHS through the media and whilst some of our health may depend on our health care system, the majority doesn't and we all have a part to play. Almost everything we do has an impact in some way on our health and wellbeing.

One of the reasons that my team and I moved from the NHS into Nottinghamshire County Council in 2013 was to enable us to have a stronger influence on those factors that influence our health and which local government has a responsibility for. So we all need to ensure that health and wellbeing is embedded into all aspects of local government business and that it is a corporate objective for all the Local Authorities working in Nottinghamshire. This report will describe some of the work already underway in Nottinghamshire as well as some of the challenges and opportunities. As the Nottinghamshire Health and Wellbeing strategy will be refreshed in 2017, I will be using this report and the recommendations to influence that new strategy for Nottinghamshire.

Together we need to be confident that we have done all that we can to promote the health of our citizens. We all value our health, but often don't think about it until it's threatened. I have set out recommendations for how local government and all its stakeholders can work together to make further progress on this important agenda.

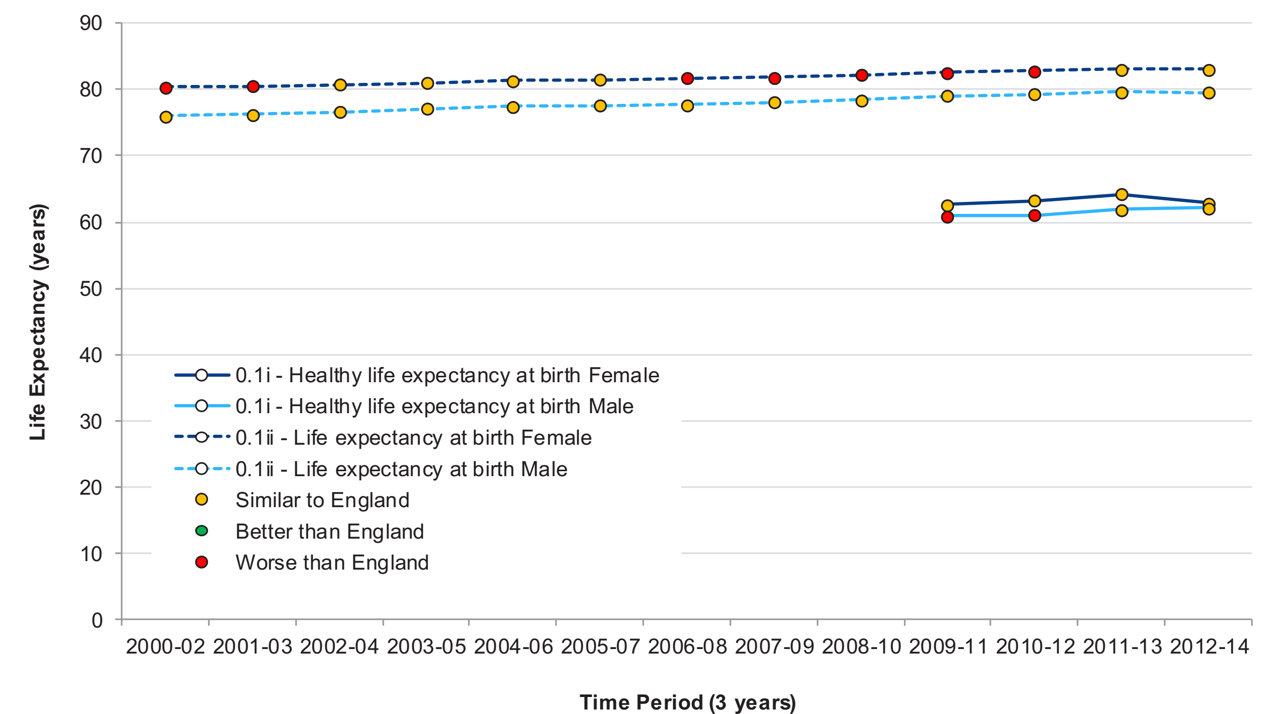
Barbara Brady
Interim Director of Public Health for Nottinghamshire
November 2016

Chapter 1:

Background

Whilst we are living longer, these additional years of life are not always being spent in good health. Figure 1 below shows the difference between life expectancy (how long a person can expect to live) and healthy life expectancy (how long a person can expect to live in "good" health) in Nottinghamshire. Healthy life expectancy begins to be plotted only from 2009, as that is when this data started to be collected. From this graph, you can see that in Nottinghamshire, whilst life expectancy is gradually increasing, healthy life expectancy is gradually improving for women, but has recently declined amongst men. The most recent picture is one comparable with England averages.

Figure 1: Life Expectancy and Healthy Life Expectancy in Nottinghamshire



Definitions

Healthy life expectancy at birth
The average number of years a person would expect to live in good health based on recent mortality rates and levels of self-reported good health.

Note: only measured and reported from 2009 onwards.

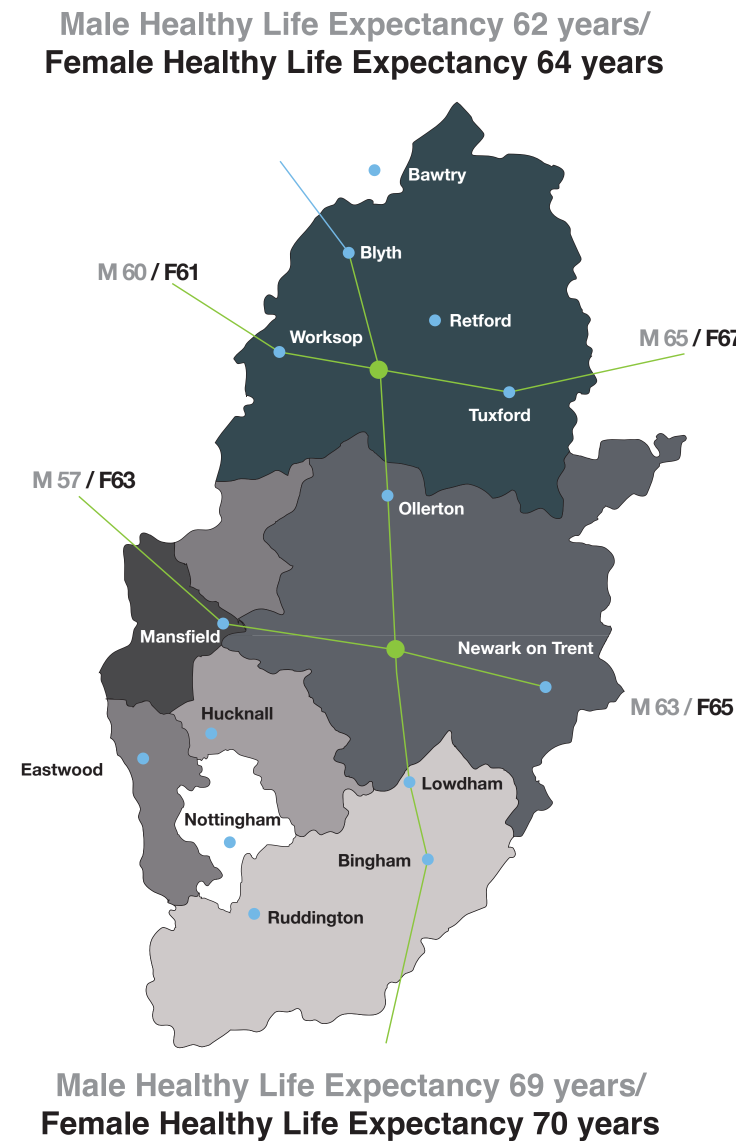
Life expectancy at birth
The average number of years a person would expect to live based on recent mortality rates.

Source: ONS Life Expectancies (via PHE PHOF Fingertips tool) (last accessed November 2016)

The graph at figure 1 shows the picture for Nottinghamshire as a whole, but within the County, some communities have poorer levels of health than others. This eventually impacts on everyone as it places demands on our entire system.

Figure 2 below shows up to a 6 year difference in healthy life expectancy from the North to the South and West to East of Nottinghamshire. For instance, between Mansfield and Newark on Trent, healthy life expectancy drops from 63 to 57 for men and from 65 to 63 for women. In a North-South direction there is a similar discrepancy, from 62 for men and 64 for women in the North of the County to 69 for men and 70 for women in the South. The pattern shown, with different healthy life expectations for different parts of the County, is not unique to Nottinghamshire. I would argue that all our residents should have the opportunity to enjoy the best health and wellbeing they can.

Figure 2: "Road Map" showing differences in healthy life expectancies across Nottinghamshire



The Marmot Report 'Fair Society, Healthy Lives' published in 2010[1] concluded that 'there is a social gradient in health: the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.'

Although we are 6 years on from the publication of that report, it remains as relevant today as when it was published. The Marmot report proposed actions proven to reduce health inequalities. This report concentrates on some of our progress in implementing Marmot's recommendations. This year the focus is on where we live and the choices we make. Reports in future years will cover other aspects of the Marmot report, focussing on those aspects which require action at a local level.

Chapter 2

Health starts where we live: the importance of place

The physical environment, the conditions in which we live and work, affect our health. This includes the built environment, housing, neighbourhoods and transport infrastructure and physical factors such as air and water quality. Where we live is important for our health and wellbeing.

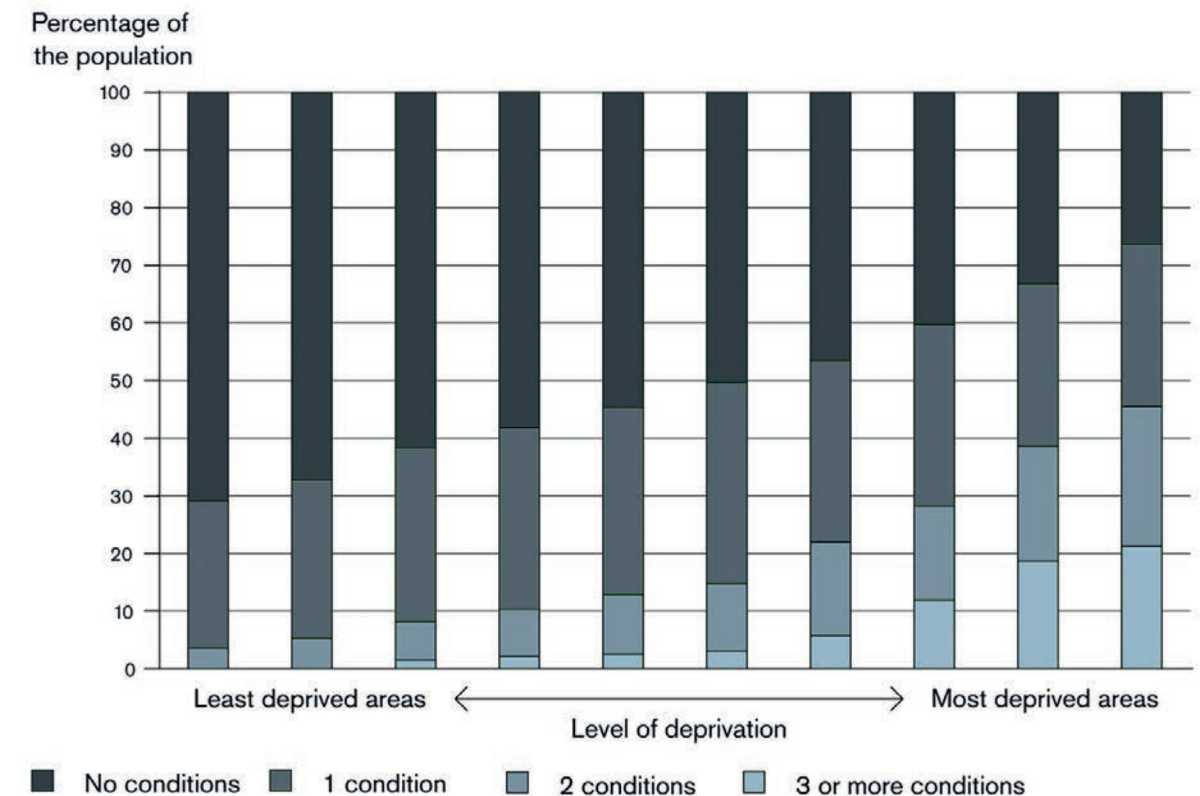
- Our local environment can support our health and help us to make healthy choices. Are there local shops that sell good quality fresh fruit and vegetables? Is it safe to cycle to school and work? Are there local job opportunities that we can get to inexpensively (preferably walking or cycling or by public transport) and in a reasonable amount of time? Is local housing warm, dry and affordable? Is the air clean? Do local restaurants and takeaways provide healthy menu choices?

- Our local environment can also support (or negatively affect) our wellbeing. Is it designed in a way to help people with dementia to move around? Are there safe parks and green spaces in which to exercise, play and relax? Is it an attractive place to live? Does it foster community spirit and encourage people to get to know each other, or does it throw up barriers that make people feel isolated from each other?

- We also have an impact on our environment, from looking after our local surroundings to volunteering, which in turn has an impact on our health and wellbeing. Do we refrain from dropping litter? Are our homes energy efficient? Do we walk instead of driving? Do we consider the environment when we make choices about what we eat? Do we make choices that reduce noise pollution? Do we get involved in our local communities, get to know our neighbours and look out for each other?

The extent to which we live in homes and neighbourhoods that are good for mental and physical health varies considerably. Often those living in deprived areas live with the highest number of unhealthy environmental conditions (see figure 3).

Figure 3: Percentage of the population in England living in areas with the least favourable environment conditions, 2001-6



Source: Marmot Report 'Fair Society, Healthy Lives' 2010[2]

The Marmot Report, Fair Society, Healthy Lives, recommends that local areas:

1. Prioritise policies and interventions that reduce both health inequalities across the social gradient and mitigate climate change, by:
   a. Improving active travel
   b. Improving the availability of good quality open and green spaces
   c. Improving the food environment in local areas
   d. Improving energy efficiency of housing
2. Fully integrate the planning, transport, housing, environmental and health systems to address the social determinants of health in each locality
3. Support locally developed and evidence-based community regeneration programmes that:
   a. Remove barriers to community participation and action
   b. Reduce social isolation

To achieve these goals we must all work together: public agencies, private businesses, voluntary organisations, communities and citizens. Below we look in more detail at how to address the key objectives contained in the Marmot report in order to develop healthy places and communities in Nottinghamshire.

Social Determinants of Health
The conditions in which people are born, grow, live, work and age

Active travel

This involves more journeys happening through active travel (such as walking and cycling) rather than other forms of transport e.g. car. This will help improve the quality of life and physical and mental health of citizens as well as improving the environment by improving air quality and reducing congestion. People who live in walkable neighbourhoods have better social connections compared to areas with heavy car use. They are more likely to know their neighbours, trust other people and be socially engaged, all of which have a positive impact on health[3].

For most people the easiest and most acceptable forms of physical activity are those that can be built into everyday life. The local environment can be an important influence on transport related physical activity (walking and cycling). Areas of greater deprivation are more likely to have transport environments that do not support walking and cycling. Fear of traffic can be a strong disincentive to allowing children to play outside and to go walking and cycling. Children in the 10% most deprived areas in the UK are more than three times more likely to be pedestrian casualties as children in the 10% least deprived[4]. Investing in better walking and cycling routes, reducing car speed to improve road safety and improving public transport all encourage active transport. Ensuring destinations such as workplaces, homes, schools, public facilities and open space are within walking and cycling distance helps to increase their 'walkability' and 'cycle-ability' and consequently to increase physical activity levels. Local areas should be designed so that they are easy and safe to walk around, with destinations such as workplaces, homes, schools, public facilities and open space within walking and cycling distance.

The Strategic Plan for Nottinghamshire[5] and subsequently both the Local Transport Plan[6] and Sustainable School Travel Strategy[7] promote the uptake of walking and cycling, reducing reliance on cars. The 2011 census data shows that 3% of people in Nottinghamshire aged 16-74 years old (excluding those working at home and not in employment) are travelling to work by bicycle. The target included in the Nottinghamshire Cycling Strategy Delivery Plan is to increase this level from 3% to 10% by 2025. Travel plans promote more sustainable travel to work by offering realistic alternatives to car trips. The implementation of these strategies has included the allocation of integrated transport block funding for local transport improvements, including those that specifically provide targeted walking and cycling infrastructure (e.g. footway or cycle route improvements, new crossing facilities) to enable people to access jobs, training and local services on foot or bicycle. These improvements have been complemented by focussed travel behaviour change campaigns such as residential, workplace, jobcentre and school travel planning to promote more sustainable travel to work, training, shops and services, to broaden travel horizons and offer realistic alternatives to car trips.

Recommendation: Continue to invest in safe walking and cycling infrastructure developments linking people to jobs, training and services (including the development and delivery of a joined up, safe and well connected cycle network across the County)

Recommendation: Target travel behaviour change campaigns to inform, encourage and enable people to make more walking and cycling trips more often

Green spaces

The physical environment can have an important influence on choices to be physically active or sedentary. Access to high quality open spaces and opportunities for sport and recreation make an important contribution to the health and wellbeing of communities[8]. It is associated with positive health outcomes and can promote better mental health, decrease stress, reduce isolation, improve social cohesion and ease physical health problems[9]. The provision of natural habitats, trees, parks and walkable green space not only helps to promote physical and mental wellbeing, it improves air and water quality and reduces noise levels. Well designed and maintained good quality green space can also increase levels of social contact and integration[10].

People from lower socioeconomic groups tend to have poorer access to environments that support physical activity such as parks, gardens and safe areas for play; are less likely to visit green space and more likely to live close to busy roads[11].

Addressing this involves the provision and protection of natural habitats, trees, parks and walkable green space. Nottinghamshire County Council and the seven District/Borough Councils together play an important role in promoting parks, open spaces and allotments. They manage and maintain open spaces in the countryside through a network of country parks and cycle routes, including the nationally important Sherwood Forest.

Recommendation: Continue to protect, increase and improve green space particularly in our most deprived communities, and to improve access to open and green space for local residents

Food environment

Our diets are often not as healthy as they should be, too high in fat, sugar and salt and low in fruit and vegetables and so increase the risk of stroke and heart diseases, type 2 diabetes, childhood and adult obesity and certain cancers. Improving the food environment, increasing the availability of good quality food, helps to address this, as do initiatives focused on improving individuals' diets (see chapter 3).

This can be addressed by promoting the provision of healthier food and drink across a range of settings using various tools such as the Government Buying Standards for Food and Catering services (GBSF)[12], the Healthier and More Sustainable Catering guidance, Eatwell Guide and 5 A DAY.

The GBSF are aimed at ensuring food is produced to high levels of sustainability and nutritional standards, with a reduction in products that are high in fat, sugar and salt and promotion of fruit, vegetables and oily fish. Healthier catering needs to be at the heart of the tendering process and commissioners need to ensure that the GBSF and /or dedicated guidelines for early years, schools, hospitals and care homes are included in service specifications for publicly funded services.

The public sector needs to lead by example and healthy catering and vending can make a difference. District /Borough councils run and commission leisure services where there are cafes and vending machines. Nottinghamshire County Council through commissioned social care services has influence over diets of people receiving social care.

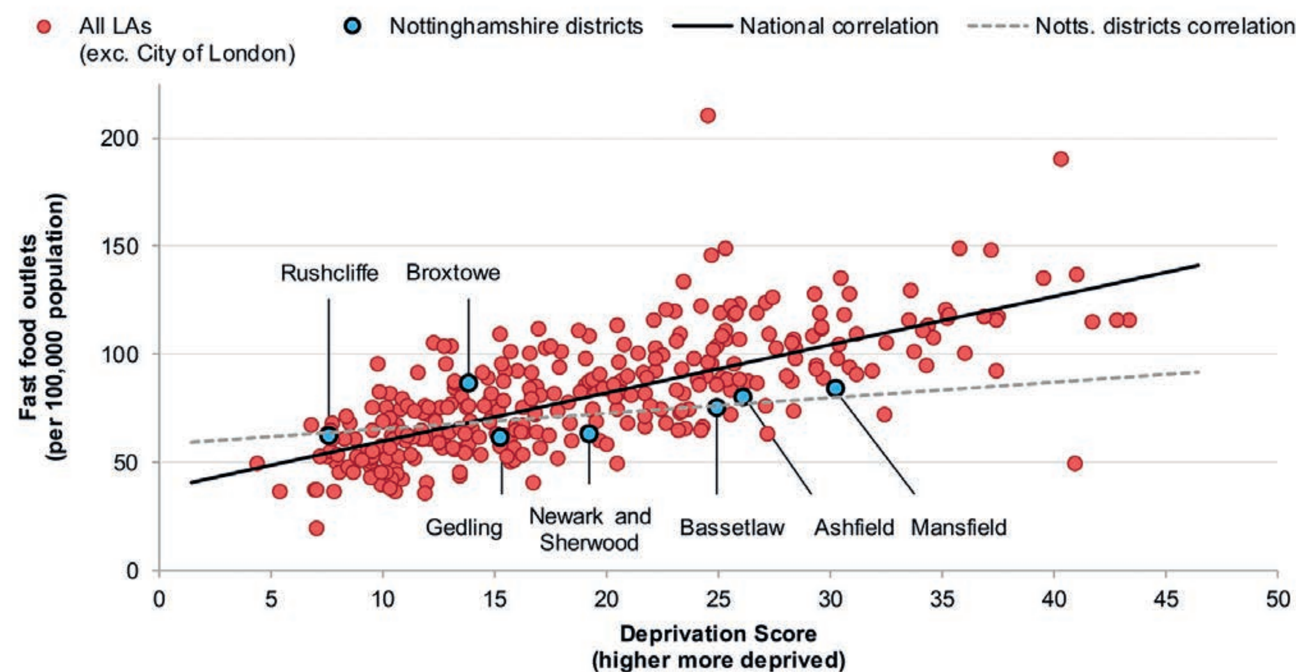
As part of improving health and wellbeing, NHS organisations are being encouraged to provide healthy food for staff, visitors and patients. This involves the banning of price promotions and advertisements of sugary drinks and foods high in fat, sugar and salt and the banning of these foods from checkouts along with ensuring that healthy options are available. This will be expanded to increase the number of sugar free drinks available and reducing portion sizes of snacks, confectionery and pre-packed meals.

Recommendation: All public sector organisations should provide healthy food for staff and visitors in line with what the NHS is doing

The physical environment can have an important influence on access to high calorie food. In deprived areas, healthy food is either not available, unacceptable, inaccessible or unaffordable. Improving the food environment involves addressing accessibility of affordable and nutritious food that is sustainably produced, processed and delivered. Having local shops within walking distance which stock healthy food also provides an environment that allows for active travel opportunities.

There is a positive association between deprivation and density of fast food outlets, with more deprived areas having more fast food outlets per head of population. Figure 4 shows the relationship between the density of fast food outlets and deprivation by local authority with the Nottinghamshire districts highlighted[13]. Locally, 30% of the variation in density of fast food outlets can be accounted for by deprivation.

Figure 4: Relationship between density of fast food outlets and deprivation by local authority with Nottinghamshire County districts highlighted, 2013



Source: Adapted from PHE NOO Fast food outlet density report 2013 URL: http://www.noo.org.uk/visualisation IMD2010 Local Authority Summaries

Action on the food environment is supported by the National Institute of Health and Care Excellence[14] which recommends that the planning system restricts planning permission for takeaways and other food outlets in certain areas. Some local authorities have already started to use the legal and planning system to restrict the density of fast food outlets in local areas[15].

Alongside planning policies, improving the quality of the food environment has the potential to influence food purchasing habits influencing diets[16]. Working with fast food businesses to improve the nutritional quality of the food they sell can improve access to healthier food choices and encourage people to adopt healthier eating habits. The Nottinghamshire Healthier Options Takeaway (HOT) merit scheme delivered by Environmental Health Officers aims to increase the accessibility and awareness of healthier options in hot food takeaways and sandwich shops, targeting those takeaways situated in areas of high deprivation within each district. There are currently nearly 100 businesses across the county that have been awarded the HOT scheme.

Recommendation: Continue to increase the proportion of fast food businesses who take part in the Nottinghamshire HOT merit scheme

Growing food contributes to active lifestyles, healthy diet and tackling food poverty. It provides employment, supports sustainable development and promotes links within and between communities. Food growing in allotments or community gardens promotes inclusion and social interaction. New developments should provide gardens or growing space to enable people to grow food at home which can have a positive impact on physical and mental health. There is increasing evidence of the impact that gardening has on mental health and recovery from mental illness[17].

Energy efficiency in housing

Cold, damp houses have a negative impact on health and wellbeing with older people, children and people with long term illnesses or disabilities at greater risk from poor housing conditions. Another group at risk are elderly people living in big homes which they can't heat. Implementing measures to improve the energy efficiency of homes has the potential to increase the temperature of the home and reduce energy costs, which may have a positive impact on health outcomes[18]. In addition, improving the energy efficiency of the home can reduce carbon emissions and help create a more sustainable environment for the future.

It is important that the most vulnerable residents are able to access support to help reduce fuel poverty, especially older people, families with children under 5 and pregnant women. Nottinghamshire County Council commissions a service for the three boroughs of Gedling, Rushcliffe and Broxtowe. It aims to reduce fuel poverty by referring people to insulation and boiler replacement schemes, helping people switch to a more suitable tariff and providing access to relevant income related benefits. This scheme will from April 2017 be available across the whole County.

Standards can also be important in improving housing quality. Building Research Establishment (BRE) Home Quality Mark (HQM)[19] is a voluntary sustainability standard for new homes which helps house builders to demonstrate the high quality of their homes. At the same time, it also gives householders the confidence that the new homes they are choosing to buy or rent are well designed and built, and cost effective to run. Building for Life 12[20] is a government endorsed industry standard for well-designed houses and neighbourhoods, which uses 12 urban design criteria around integrating into the neighbourhood, creating a place, street and home.

Integrated planning systems

Good planning can have a positive impact on the way we live our lives and can contribute to healthier lifestyles and environments. Local planning authorities should ensure that health and wellbeing, and health infrastructure are considered in local and neighbourhood plans and in planning decision making. Health partners should work effectively with local planning authorities in order to promote healthy communities and support appropriate health infrastructure.

The National Planning Policy Framework (NPPF)[21] (2012) requires planners to work in partnership with public health and other organisations in the promotion of healthy communities and help create healthy living environments. Both the NPPF and The National Planning Practice Guidance (NPPG)[22] (2012) set out a role for planners to consider health and wellbeing through both the plan-making and decision-making processes. An important step in tackling the social determinants of health at a local level is greater integration of health, planning, transport, environmental health and housing departments to improve population health by 'designing in' health and modern health care from the outset to effectively address health and health inequalities.

The 'Spatial Planning for Health and Wellbeing of Nottinghamshire'[23] (2016) document approved by the Nottinghamshire Health and Wellbeing Board, identifies that local planning policies play a vital role in ensuring the health and wellbeing of the population as well as how planning matters impact on the health and wellbeing of Nottinghamshire residents. A health checklist is included to be used when developing local plans and assessing planning applications. This checklist ensures that the potential positive and negative impacts on health and wellbeing of proposals are considered, identifying opportunities for maximising potential health gains and minimising harm and addressing inequalities taking account of the wider determinants of health.

Also underway is the development of a Nottinghamshire 'Planning and Health Engagement Protocol' in which health is fully embedded into planning processes, maximising health and wellbeing and ensuring that health/social care infrastructure requirements are considered to serve the growth requirements of the population of Nottinghamshire. All this work is successfully being undertaken across the two tiers of Local Government in Nottinghamshire as both tiers have planning responsibilities. This additional complexity means that the implementation (the how) of the recommendations below will need to be informed by the local context.

Recommendations: Planning teams should:

- Ensure that planning applications for new developments prioritise the need for both adults and children to be physically active as part of their daily life
- Work with developers to promote active travel and ensure that developments are appropriately designed
- Work with developers to provide new green, safe, accessible and pedestrian-only spaces and to improve the quality of existing green spaces
- Utilise planning powers to restrict the numbers of fast food outlets in line with NICE guidance
- Encourage house builders to use the Building for Life 12 government endorsed industry standard for well-designed houses and neighbourhoods
- Encourage housing developers in Nottinghamshire to sign up to the Building Research Establishment (BRE) Home Quality Mark (HQM) scheme.

Recommendation: Local authorities should:

- Endorse the Spatial Planning for Health and Wellbeing of Nottinghamshire
- Secure support for the Nottinghamshire 'Planning and Health Engagement Protocol'

Community based regeneration

'Communities, both place-based and where people share a common identity or affinity, have a vital contribution to make to health and wellbeing.'[24] The connections that people have with others within communities (often called social capital) can provide vital support and help buffer against life's ups and downs. Our social contacts can help us to find work, provide enjoyment, lend moral and practical support if we're ill or struggling, challenge us, help look after us and enrich our lives. This in turn impacts on our mental and physical health.

Social isolation, on the other hand, can have a negative impact on health and wellbeing. For example – those who have little social contact, are at higher risk of dementia, premature death and suicide.[25] According to one large study, the risk to one's health due to a lack of good social relationships is the same or greater than smoking, obesity or being physically inactive.[26] Poorer health, of course, means greater need for health and care services.

According to the Marmot report, 'social capital is shaped both by the ability of communities to define and organise themselves, and by the extent to which national and local organisations seek to involve and engage with communities.'[27] Social capital can mean different things to different groups, which is why it is crucial to work with communities when seeking to build social capital and to reduce social isolation. Addressing these issues is also important to reduce inequalities, because often more disadvantaged communities have 'high levels of stress, isolation and depression.'[28]

Social isolation and loneliness

There is a difference between social isolation and loneliness. Social isolation generally means not having (enough) contact with other people. Loneliness, on the other hand, is a personal feeling of being lonely. While these two terms are distinct, some of the causes and solutions related to them are similar.

Marmot also recommends supporting community regeneration programmes that remove barriers that stop people from participating in their communities and together taking positive action, such as working at the neighbourhood level and involving local residents in specific projects.

The Marmot report also recommends reducing social isolation. In the 2011 Census in Nottinghamshire, there were around 95,000 one-person households (28% of the total). In 45% of these, around 43,000 households, the occupant was aged 65 and over. While living alone does not necessarily mean that a particular individual is socially isolated (or lonely), it does increase the risk. Other characteristics that may lead to social isolation include having multiple health issues, hearing loss, incontinence, alcohol problems, bereavement, older age, feeling unsafe in one's neighbourhood and being financially constrained.[29]

Strengthening communities and supporting the growth of the voluntary sector are ways to help people become more socially connected. Nottinghamshire has a great wealth of local organisations, self-help groups and community groups, and as funding for local government reduces, these groups will have an even greater role to play in helping communities to be more resilient and self-sufficient. The Council and its partners actively seek to support these groups, including through the Council's Grant Aid scheme, the Community Empowerment and Resilience Programme, and through wider initiatives to strengthen the sector as a whole.

Social Prescribing

Social prescribing programmes are a way for GPs and other health and social care professionals to put people in touch with non-medical sources of support to help with financial, social or practical issues that may be affecting someone's health and wellbeing. These programmes often involve workers who help find and access the support or activities that will meet their needs, for example joining social groups to increase their social networks or getting debt advice.

There are many programmes that help people to become more socially connected, such as the Connect service, which the Council commissions from three voluntary sector organisations in the County, Children's Centres and Bassetlaw's social prescribing scheme, as well as the many clubs, cafes, support groups, befriending projects, community transport schemes, and others provided by voluntary and community organisations that are too numerous to list. These represent a tremendous asset.

The Nottinghamshire Help Yourself website (www.nottshelpyourself.org.uk) is a partnership between health, the voluntary sector and Nottinghamshire County Council to bring information and advice together in one central place, so people can easily find out about services and community groups and join in. The active participation of individuals with their neighbours and in their communities is key to reducing social isolation and making communities healthier and happier places to live.

Recommendation: Continue to support the voluntary and community sector in order to improve health and wellbeing

Recommendation: Enhance social prescribing and related initiatives to help individuals and communities to tackle challenges affecting their health and wellbeing and reduce social isolation

Recommendation: The development of community capacity, empowerment and resilience should be a key component of the next version of the Joint Health and Wellbeing Strategy

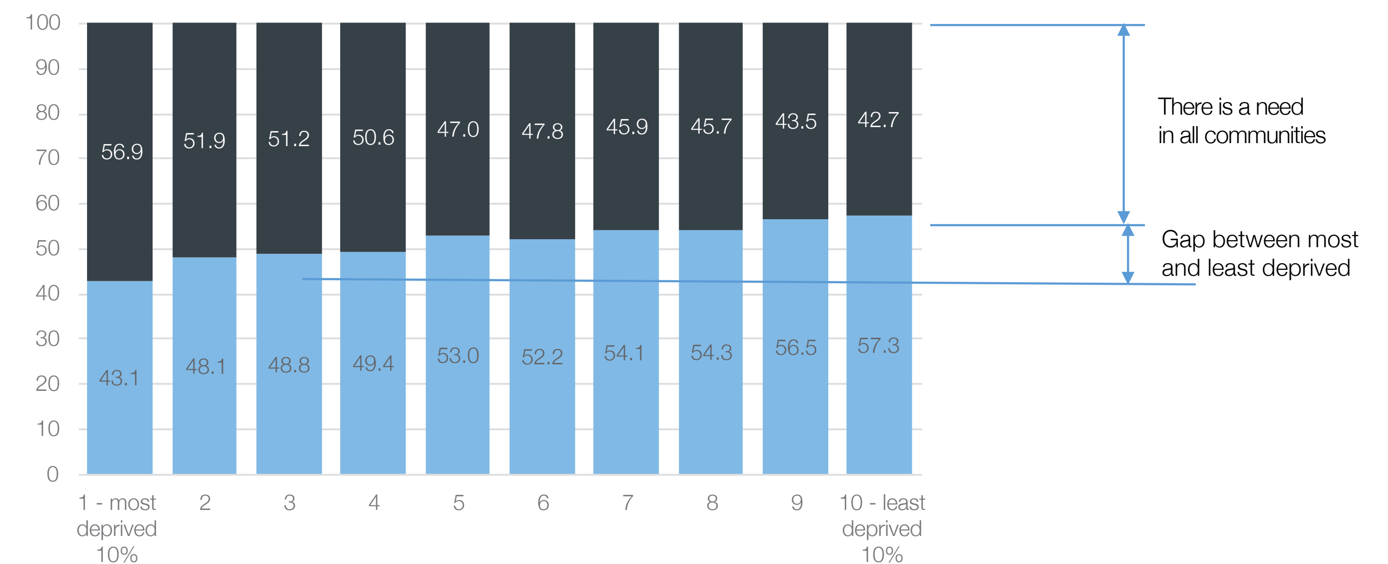
A growing proportion of our citizens are living with one or more long-term diseases (e.g. heart disease or diabetes) that affect both how long a person lives and their quality of life. Many studies show that the risk of developing long term health conditions is affected by behaviours such as smoking, poor diet, using drugs or alcohol, and lack of physical activity.

Making healthy choices at an individual level is influenced by foundations laid in childhood as well as by the some of the environmental factors covered in Chapter 2. Nonetheless, it is possible to modify behaviours to improve health and making healthy decisions needs to be as easy to do as possible.

Diet and Physical Activity

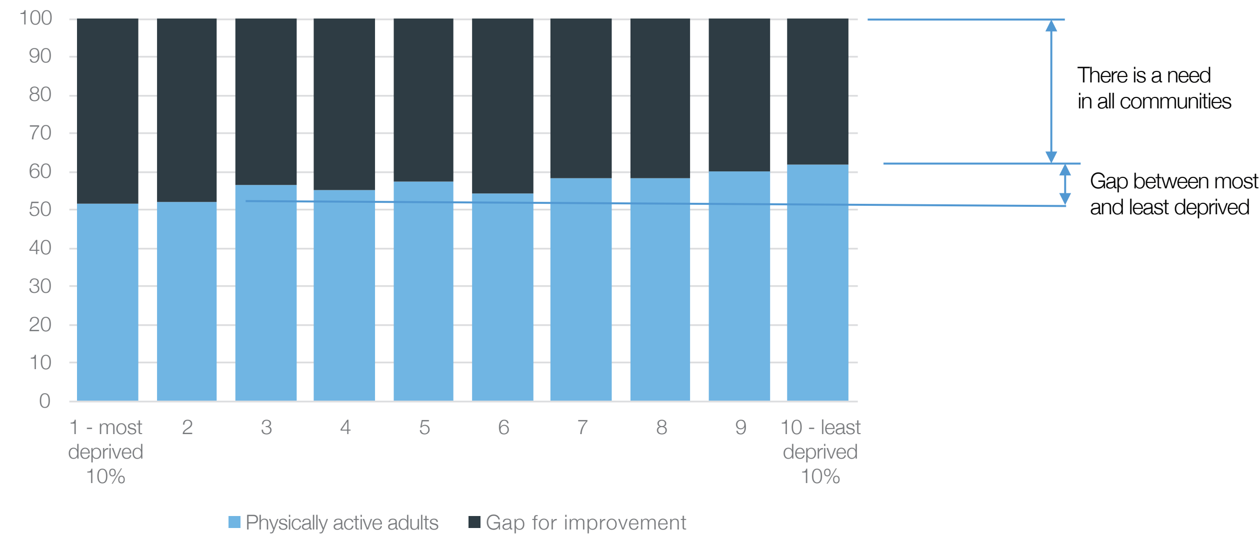
People of lower socioeconomic position tend to eat less healthy diets and be less physically active than people of higher socioeconomic position[30] (figures 5 & 6). These inequalities are likely to contribute to the inequalities in prevalence of obesity, and those diseases associated with it including type 2 diabetes, heart disease, cancer and liver disease. Higher levels of obesity are found among more deprived groups with the association being stronger for women than for men.

Figure 5: Adults meeting the recommended 5 A DAY fruit and vegetable intake in England 2015.



Source: Public Health Outcomes Framework for England deciles of deprivation.

Figure 6: Percentage of adults meeting the recommended 150 minutes per week of physical activity in England, 2015



Source: Public Health Outcomes Framework for England deciles of deprivation.2.13i

Improvements in dietary intake to meet the recently revised Eatwell Guide (figure 7)[31] would have significant benefits to the health of the population and society as a whole. The Eatwell Guide doesn't apply to children under two because they have different nutritional needs. Between the ages of 2-5 children should gradually move to eating the same food as the rest of the family, in the proportions shown in the Eatwell Guide.

Figure 7: The Eatwell Guide

Even small increases in physical activity among those who are the least active can bring health benefits in all stages of life, from helping children and adults maintain a healthy weight to reducing hip fractures in older people. The largest health gains occur in people moving from inactive to moderately inactive and from moderately inactive to moderately active.[32]

In Nottinghamshire, the County Council has commissioned an Obesity Prevention and Weight Management service which delivers initiatives that target high risk population groups, to support children young people and families to eat a healthy diet and be more physically active. Taking a life-course approach this element focuses on:

- Wellbeing at work
- Promoting and implementing community healthy eating and physical activity initiatives engaging with specific community groups through partnership working
- Physical activity and healthy eating initiatives for primary school aged children
- Promoting and supporting initiatives related to national campaigns
- Sustaining behaviour change through maintenance groups linking to local communities
- Promoting physical activity opportunities including walking groups
- Raising awareness through behaviour change training opportunities for front line workers in public, private and community/voluntary sector.

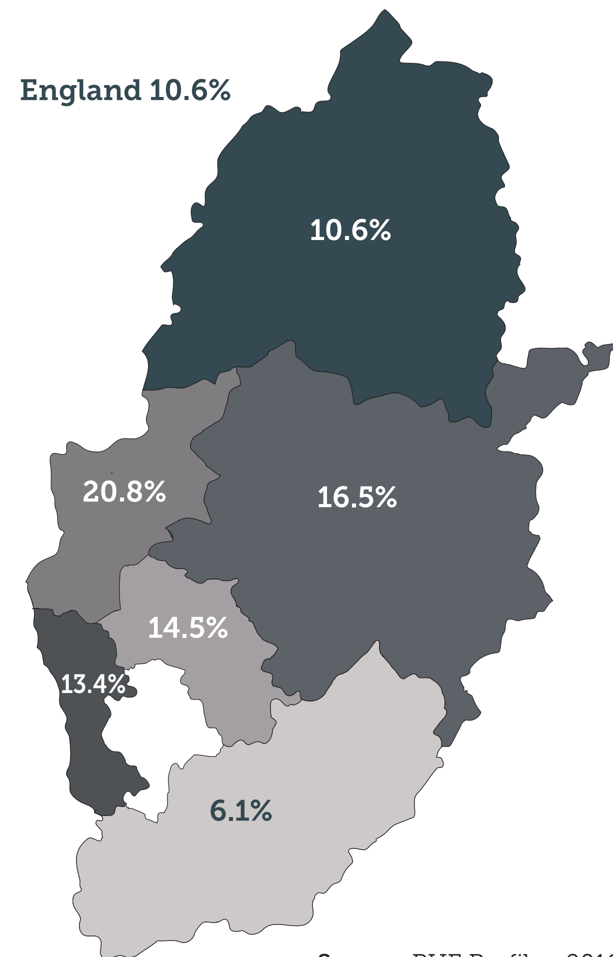
Smoking and Tobacco Control

Smoking is the main cause of preventable illness and premature death. It accounts for 1,300 deaths a year in Nottinghamshire, approximately 17% of all deaths (over the three years 2012-2014 there were 3,879 deaths attributable to tobacco in ages 35 or older[33]) in Nottinghamshire. It is also responsible for a third of all cancers and a seventh of heart disease. So, it's not surprising that smokers have much poorer health outcomes than non-smokers and are more likely to be admitted to hospital.

Smoking has been identified as the single biggest cause of inequality in death rates between rich and poor in the UK. People in poorer social groups who smoke tend to start smoking at an earlier age.[34] For those who take-up the habit before the age of 15 there is higher risk of lung cancer, respiratory and circulatory problems than those who start later, even after the amount smoked is taken into account. It is also true that the earlier someone commences smoking, the more likely they are to be a lifelong smoker.

Smoking prevalence is falling in the county, with the prevalence now at 15.7%. However, that figure rises to 26.2% amongst smokers from routine and manual occupations. Another group concerning us is pregnant women. In Nottinghamshire 14.5% of pregnant women smoke at the time of delivery compared to the national rate of 10.6%.[35] The variation between districts ranges from 6.1% in Rushcliffe to 20.8% in Mansfield, as shown in figure 8 below. Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, low birth-weight and sudden unexpected death in infancy.

Figure 8: Smoking prevalence at the time of delivery by Clinical Commissioning Groups in Nottinghamshire, 2016



Source: PHE Profiles, 2016

In Nottinghamshire, the County Council has commissioned a service which is aimed at preventing people starting to smoke, reducing smoking at time of delivery and addressing wider tobacco control issues such as exposure to second hand smoke. The service prioritises smokers from routine and manual occupations.

The work of this service is complementary to the peer-educator ASSIST programme in secondary schools. The ASSIST programme aims to reduce adolescent smoking prevalence and smoking initiation. It trains Year 8 students to work as 'peer supporters' who in turn will have informal conversations with other Year 8 students about the risks of smoking and using electronic nicotine substitution devices and the benefits of being smoke free. Until fairly recently, tobacco control and health education was concerned with advising young people about the health effects of tobacco use. More recently, however, the emergence of new tobacco and nicotine substitution products means that young people are experimenting with a number of new niche tobacco and nicotine substitution products. These products have risks associated with their use and require educators and public health professionals to rethink approaches to tobacco and nicotine education.

Recent controls on tobacco sales, including the removal of cigarette vending machines, the removal of tobacco displays from all retail premises and the legislation removing branding from cigarette packs, are helping to denormalize tobacco use and will result in fewer young people starting smoking in the future. Our service provider is also working in primary school settings to deliver early interventions in tobacco and nicotine education. The programme delivers a number of key messages to students in assemblies and engages with families to encourage smokefree homes and cars and signpost smokers to local stop smoking services.

The sale of illegal tobacco is not a victimless crime. Tobacco smuggling has strong links to organised criminal gangs and migrant worker exploitation. Often sold to children, illegal tobacco undermines the legal UK controls, creating new generations of children who will become addicted from their teens.

Whilst the smugglers make large amounts of money by avoiding paying taxes, the profits are often used to support other criminal activities. Sales of such products target people in our poorest communities and young people in those areas are especially at risk. There is local evidence that residents and young people in deprived areas in Nottinghamshire are increasingly turning to illegal tobacco sellers to make purchases. Moreover, the sale and distribution of illegal tobacco has emerged as a primary concern to a number of key strategic and local partners because it undermines the health of our most deprived communities. Her Majesty's Revenue and Customs (HMRC) estimates that one in six cigarettes and over half of hand rolled tobacco are now smuggled or fake.[36] In some areas, the sale of illicit cigarettes from pubs, private addresses, car boot sales or local shops is now the norm.

To counter this, Trading Standards along with the Police (funded by NCC) have focused their attention on this particular issue and have found that residents in some areas of our County are far more reliant on illegal tobacco than the HMRC estimates. This work between Public Health, Police and Trading Standards is only one example of what is happening locally. There are other complementary areas of work focused on reducing smoking-related litter and enforcing smoke free law.

The Council is committed to ensuring that tobacco control is part of mainstream public health work to address the harm from smoking. To achieve this, NCC is driving efforts to extend sign-ups to the Nottinghamshire Declaration on Tobacco Control beyond the Health and Wellbeing Board and key local institutions. This is taken forward though a strategic partnership arrangement.

Alcohol

Nationally

9 million adults drink at levels that increase the risk of harm to their health.

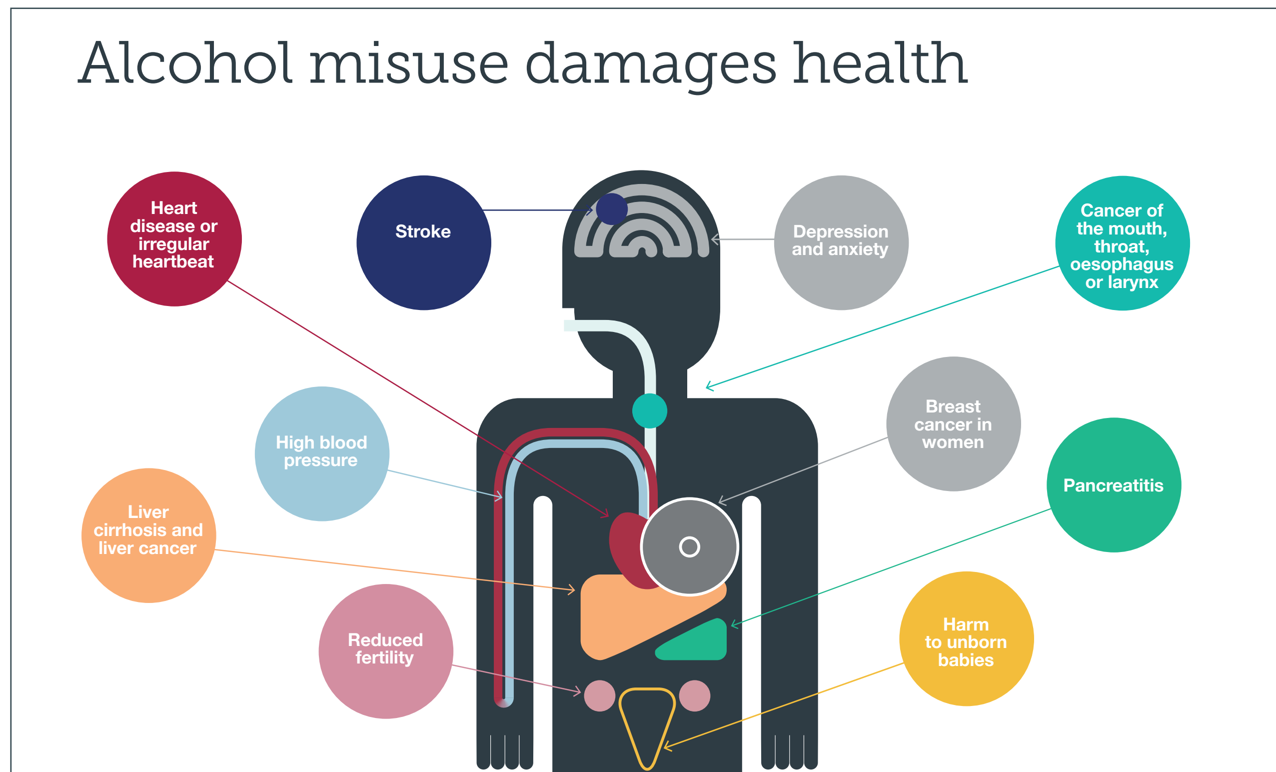
1.6 million show signs of alcohol dependence

Alcohol is the third biggest risk factor for illness and death

Alcohol can damage health and lead to early death. The problems are widespread both in Nottinghamshire and nationally. In Nottinghamshire, it is estimated that there are 131,011 adults who drink at levels that can adversely affect their health, and 21,632 dependent drinkers.

Harm caused by the consumption of alcohol is one of the main contributing factors of premature death and disability. Alcohol consumption contributes to more than 60 diseases and conditions including cardiovascular disease, liver disease and cancer.[37] Alcohol use represents 10% of the burden of disease and death in the UK which places it in the top three lifestyle factors after smoking and obesity.[38]

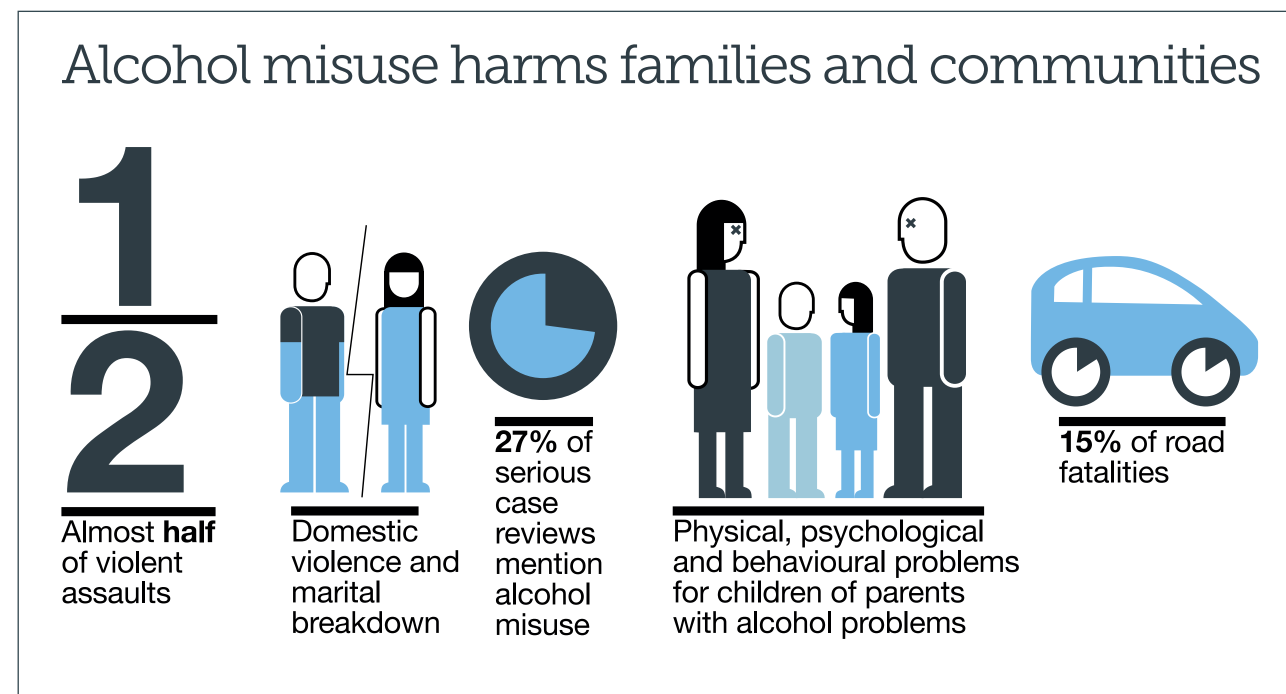
Figure 9: Alcohol misuse damages health



Source: Public Health England, 2013, Alcohol and drugs prevention, treatment and recovery: why invest?

As well as damaging health, alcohol misuse harms families and communities.

Figure 10: Alcohol misuse harms families and communities



Source: Public Health England, 2013, Alcohol and drugs prevention, treatment and recovery: why invest?

In Nottinghamshire, the County Council has commissioned a substance misuse service (both drugs and alcohol), which delivers a behaviour change programme for those who require help with drug and/or alcohol issues. The Police and Crime Commissioner contributes to this contract for those individuals who have substance misuse issues and who are also in the criminal justice system. Services are available in all seven districts of Nottinghamshire. The service has a focus on:

- Supporting individuals to achieve and sustain recovery – recognising that this is not just a process of shedding symptoms but a process of growth and wellbeing; focussing on the potential, not the pathology
- A strengths and assets-based approach – valuing the capacity, skills, knowledge, connections and potential in individuals, families and communities, utilising community assets to support individuals to achieve and sustain their recovery goals
- Improving and increasing access and engagement into the service for those needing support for their substance misuse. In particular, this service reaches into communities to engage with more people year on year 'upstream' before they reach a stage of problematic substance misuse
- Outcomes – of successful completions of substance misuse support, improved mental health and wellbeing, improved housing situations and an increase in engagement with education, training and employment

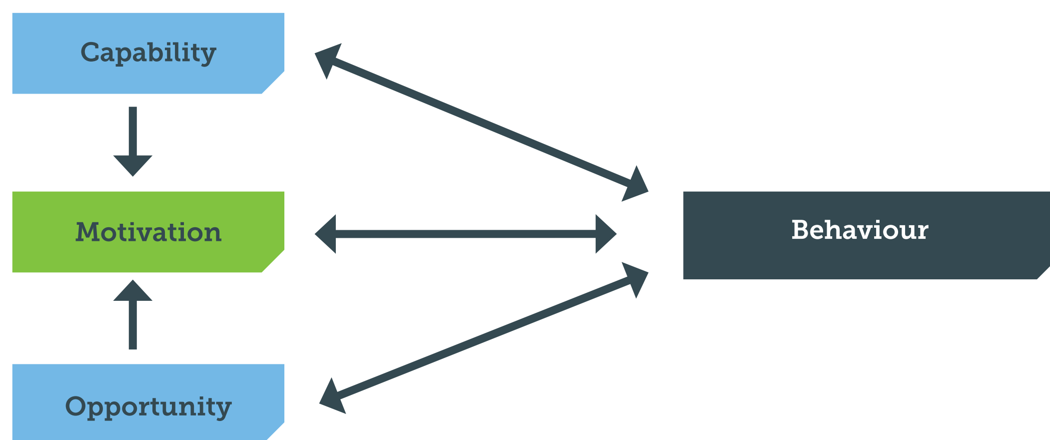
Recommendation: Protect resources which enable the ongoing delivery of activities related to diet and exercise, alcohol and tobacco use

Chapter 4

Encouraging change and preventing disease

'Health Education' has been successful in getting key messages out such as advice about smoking, eating and drinking. More recently there have been national programmes such as 'One You' or 'Change for Life'. In fact it would be difficult today to find someone who hasn't received information about the harm of smoking and drinking alcohol. However, that information doesn't in itself result in changing behaviours, it's more complex than that, as shown in figure 11.

Figure 11: Capability, Opportunity, Motivation - Behaviour[39]



This chapter of the report will highlight 4 areas of work currently underway which are designed to help identify individuals with 'risk factors' and encourage and support them to make change.

- Making Every Contact Count (MECC)
- NHS Health Checks Programme
- National Diabetes Prevention Programme
- Annual Health Checks for People with Learning Disabilities

Making Every Contact Count (MECC)
Work is currently underway to make every contact count (MECC) across the County.

MECC uses the millions of day-to-day contacts that organisations and people have with other people to support them in making positive changes to their health and wellbeing, by offering consistent and concise healthy lifestyle advice and signposting to appropriate local services.

A MECC interaction takes a matter of minutes and is structured to fit into and complement existing professional clinical, care and social engagement. Making every contact count across health and care organisations could potentially have a significant impact on the health of our population.

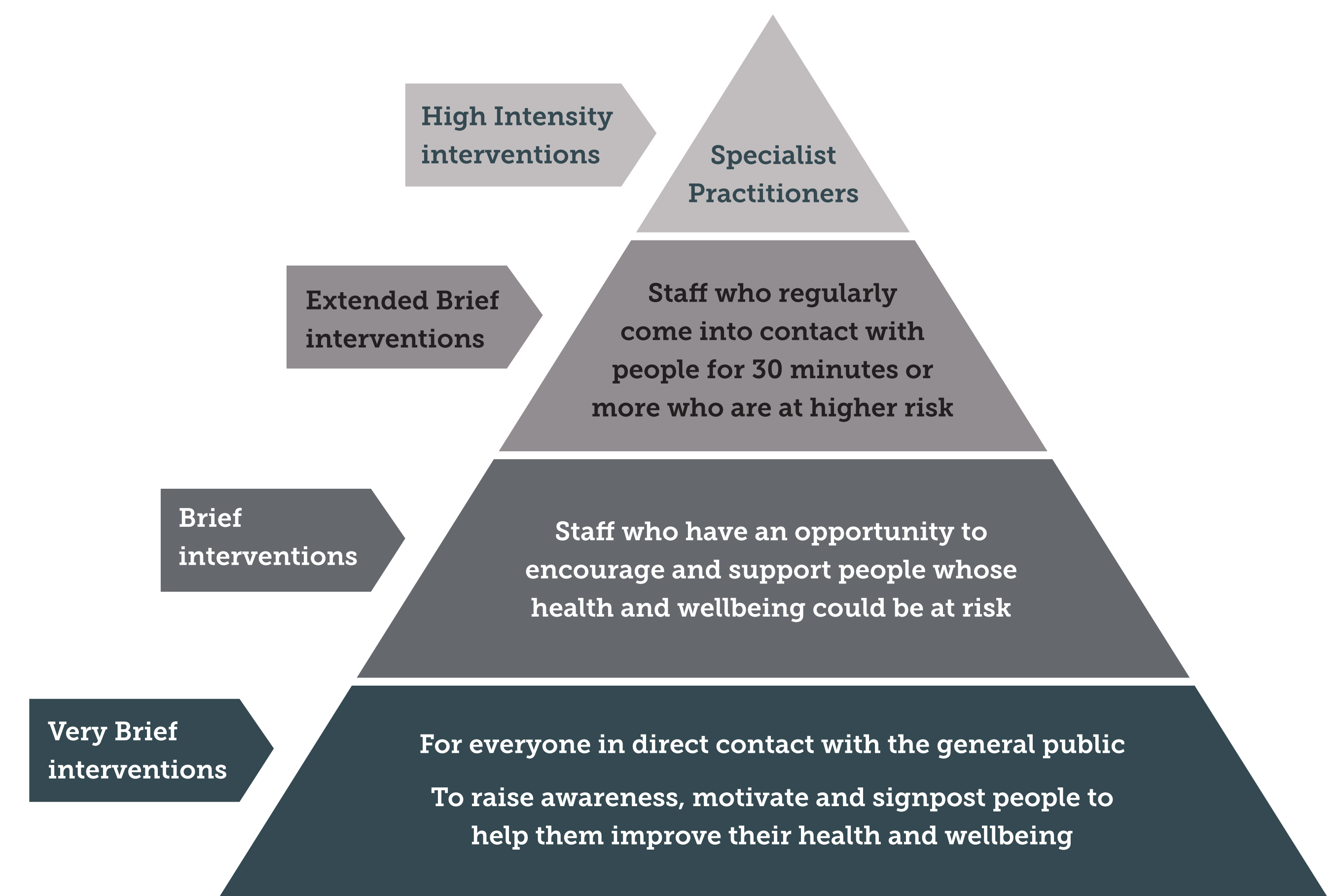
Partner organisations such as local authorities and the voluntary sector can also use the MECC approach, MECC plus, to help people think about wider issues such as debt management, housing and welfare rights advice and directing them to services that can provide support.

To enable this to happen, organisations need to provide their staff with the leadership, environment, training and information they need. For staff MECC means having the competence and confidence to deliver healthy lifestyle messages, to encourage people to change their behaviour, and to direct them to local services that can support them.

For individuals MECC means seeking support and taking action to improve their own lifestyle by eating well, maintaining a healthy weight, drinking alcohol sensibly, exercising regularly, not smoking and looking after their health and wellbeing.

MECC and MECC plus[40] can help to tackle health inequalities by supporting individual behaviour change across a range of behaviours, and addressing wider determinants of health at the individual level.

Figure 12: Making Every Contact Count as a Behaviour Change Intervention[41]



At a population level MECC can also help address equal access to services, by engaging those who may not have otherwise engaged in a 'healthy conversation' or considered accessing specialised local support services, such as for weight management. Across Nottinghamshire, many staff are already "making every contact count" across a wide range of organisations. However, this is not currently done in a systematic, system wide approach.

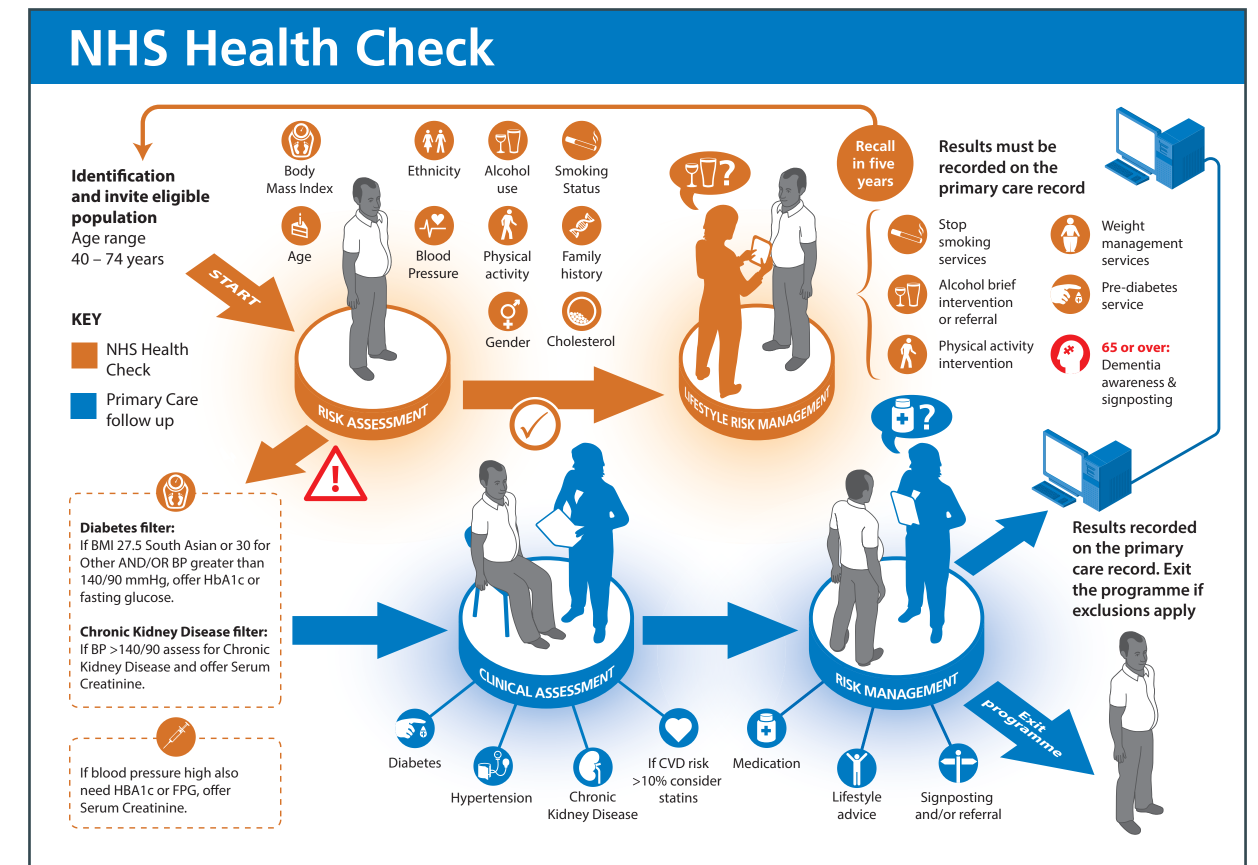
Recommendation: All those organisations represented on the Nottinghamshire HWB Board have an implementation plan that secures the delivery of MECC to include:

- Identification of a Board Level Public Health Champion with responsibility for MECC
- Inclusion of MECC in the mandatory training programme for all appropriate frontline staff
- Working with local Health Education providers to include MECC in local graduate and post-graduate training programmes for relevant staff

NHS Health Check Program

Whereas MECC is focused on using existing professional clinical, care and social engagement, the NHS Health Check is more targeted.   It is a cardiovascular risk assessment programme which aims to delay or prevent the onset of diabetes, heart and kidney disease and stroke for eligible people aged 40-74. It follows a risk assessment approach that results in referrals to existing programmes to support people to address risk factors, such as stopping smoking, losing weight, being more active and drinking within recommended limits.

Figure 13: The NHS Health Check



Cardiovascular disease is the most important cause of early death in Nottinghamshire and can cause a wide range of ill health conditions, including chronic kidney disease, stroke and dementia. Evidence from the UK and internationally shows that risk assessment and management programmes can help to prevent and reduce impact of cardiovascular diseases.[42]

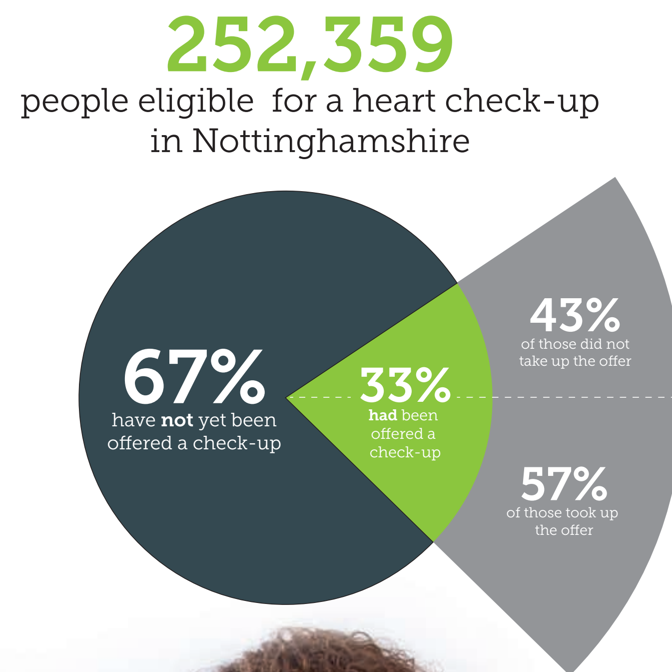
The County Council has a duty to ensure that NHS Health Checks are offered to all eligible 40-74 year olds once every five years, to ensure that the risk assessments meet the required standard and to seek continuous improvement in the uptake of the NHS Health Checks. You are eligible if you haven't had a stroke, don't already have heart disease, diabetes or kidney disease.

The programme started in Nottinghamshire in 2009, delivered by GPs, and initially commissioned by NHS Nottinghamshire County Primary Care Trust and supported by the provision of lifestyle services e.g. stop smoking. Take-up of the check was slow from 2009 to 2013 and was variable around the County due to variation and uncertainty in practice management and implementation. In 2013 the Local Authority became responsible for the programme, and in 2014 following local market research, adopted the brand name NHS Heart Check-Up.

Figure 14: NHS Heart Check Up

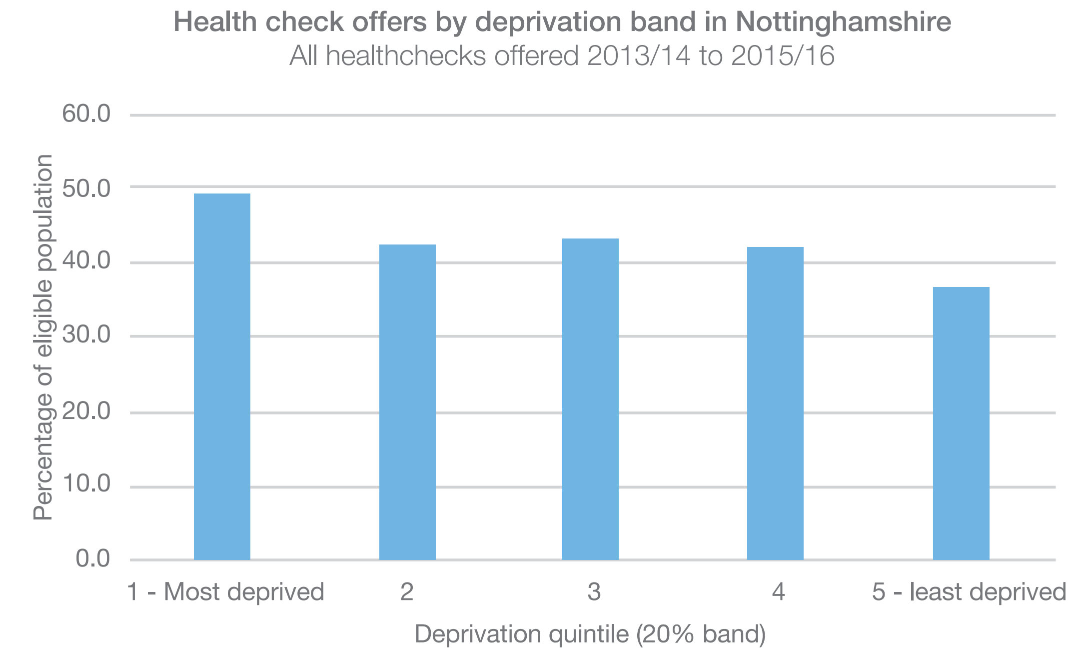
The eligible Nottinghamshire population currently stands at 252,359 people. By March 2016, 33% of the current eligible population had been offered a check. Of those only 57%, took up the offer. Local data suggest that take up in Nottinghamshire is greater in women and older ages.

Figure 15: Health checks offered and taken up in the population



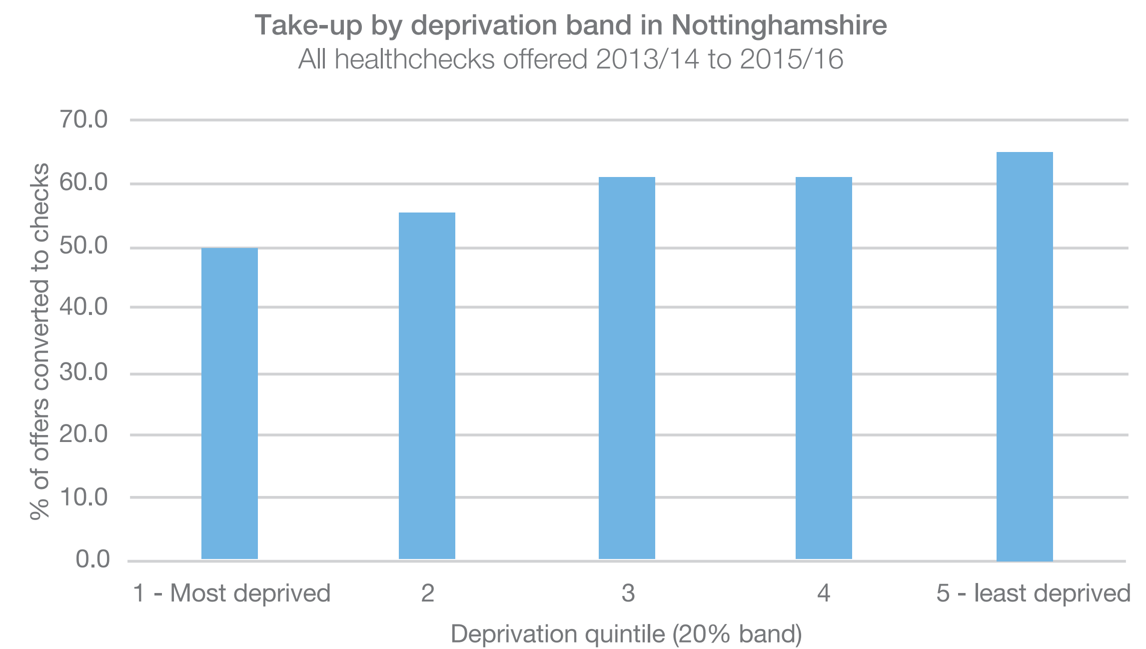
Figures 16 and 17 below show that most deprived are more likely to be offered a health check but the least deprived are more likely to take up the offer.

Figure 16: Health checks offered – by deprivation band



The cardiovascular risk is higher in more deprived populations in the County. The profile of offers across the deprivation scale reflects this need.

Figure 17: Health checks take up – by deprivation band



However the profile of 'conversion' is very different: the more deprived people are, the less likely they are to attend for a health check after an invitation.

National Diabetes Prevention Programme

Mansfield and Ashfield, Newark & Sherwood, Nottingham North & East, Rushcliffe and Nottingham West CCGs, started to implement the new National Diabetes Prevention Programme (NDPP) in 2016. (Bassetlaw CCG is applying to be in the next wave, starting in 2017.)

This lifestyle change and education programme is for adults found to have a high risk of developing type 2 diabetes in the near future (known as pre-diabetes or non-diabetic hyperglycaemia). They will be offered advice and support to reduce and manage their risk, with the aim of preventing or delaying the onset of type 2 diabetes. GP practices in Nottinghamshire started to identify patients who could benefit from the programme in August 2016. At the moment the programme is expecting that 40% of those who could benefit from the program will actually take it up

Annual Health Checks for People with Learning Disabilities

People aged 14 and over who have been assessed as having moderate, severe or profound learning disabilities, or people with a mild learning disability who have other complex health needs, are entitled to a free annual health check with their GP. Regular health checks for people with learning disabilities often uncover treatable health conditions.

During the health check, the GP or practice nurse will carry out the following for the person with learning disability;

- a general physical examination, including checking their weight, heart rate, blood pressure and taking blood and urine samples
- assessing the patient's behaviour, including asking questions about their lifestyle, and mental health
- a check for epilepsy
- a check on any prescribed medicines the patient is currently taking
- a check on whether any chronic illnesses, such as asthma or diabetes, are being well managed
- a review of any arrangements with other health professionals, such as physiotherapists or speech therapists.

The scheme differs from the NHS Health Check Programme as it includes assessment of specific risks that most affect the health and wellbeing of people with learning disabilities e.g. thyroid function tests.

A report on learning disabilities health checks conducted in other areas suggests that less than half of people with learning disabilities are having the appropriate checks done, and that some elements of the check are not being done as well as others. In Nottinghamshire in 2011, 48% of those eligible for a health check actually received one. It is not clear from the data if this is because eligible individuals weren't offered the check or those chose not to take it up. Either way this is another missed opportunity to help prevent health problems, or identify them early.

Recommendation: GP practices target those on their patient lists eligible for the appropriate health check that are most likely to be at high risk (5 yearly NHS Health Check for those aged 40-74)

Recommendation: GP practices systematically and consistently invite relevant individuals from their patient lists for annual Learning Disability health checks

Chapter 5

Dealing with consequences: Impacts of preventable disease on the health and care system

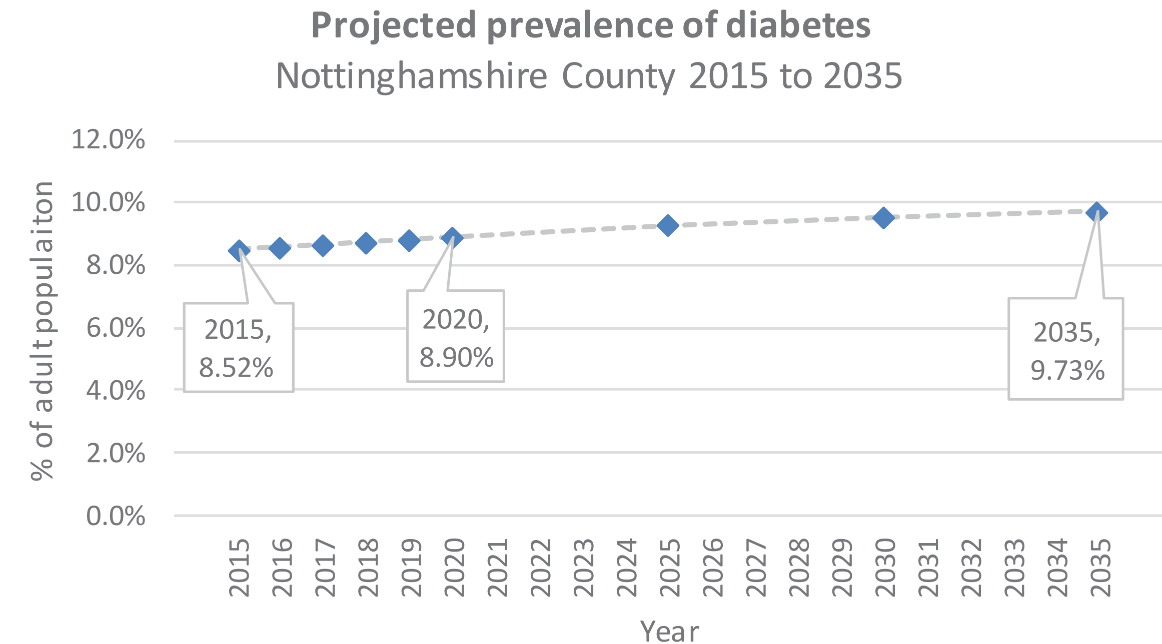
We know from the Marmot report and other studies that it is a combination of the issues highlighted in earlier chapters that contribute to ill health and in turn drive demand for the NHS and care services. To illustrate this point this chapter will use the example of type 2 diabetes to show how the various aspects come together.

The risk factors for type 2 diabetes are well known although we don't know why some people develop type 2 diabetes and others don't. The main risk factors are obesity, low physical activity levels, poor diet and nutrition. These risk factors are all associated with deprivation. 47% of Type 2 diabetes in England is attributable to obesity[43]. The risk of developing diabetes is 13 times higher in obese women and 5 times higher in men.[44]

Type 2 Diabetes. When your body can't produce enough insulin, or when the insulin that is produced doesn't work properly. It tends to develop in later life although increasingly we are seeing children developing this. Diabetes is usually diagnosed following the results of a blood test that measures the average of a person's blood glucose levels over the past 3 months.

It is an imbalance between our calorie intake compared with our energy expenditure (how active we are) that causes obesity/excess weight. Earlier in this report, we highlighted how where we lived shaped and influenced our levels of activity and our food environment. This report has also described some of the other work underway locally to encourage and support people to make behavior change such as being more active and selective about what we eat and drink. Yet it is apparent from figure 18 that we are still expecting an increase in the number of people developing this type of diabetes. This is based on our understanding of current levels of physical activity and our diet.

Figure 18: Predicted prevalence of diabetes in adults in Nottinghamshire



Source: Public Health England diabetes 2016 prevalence models
http://www.yhpho.org.uk/resource/view.aspx?RID=154049

Once a diagnosis of diabetes is made then that individual is placed on a Diabetes Register at their GP practice. The GP practice is then responsible for ensuring the delivery of evidence based interventions to help manage that individual's diabetes. GP Practices are incentivised to do this through the Quality and Outcomes Framework. (Whilst the example here is diabetes, similar registers exist for other diseases such as heart disease)

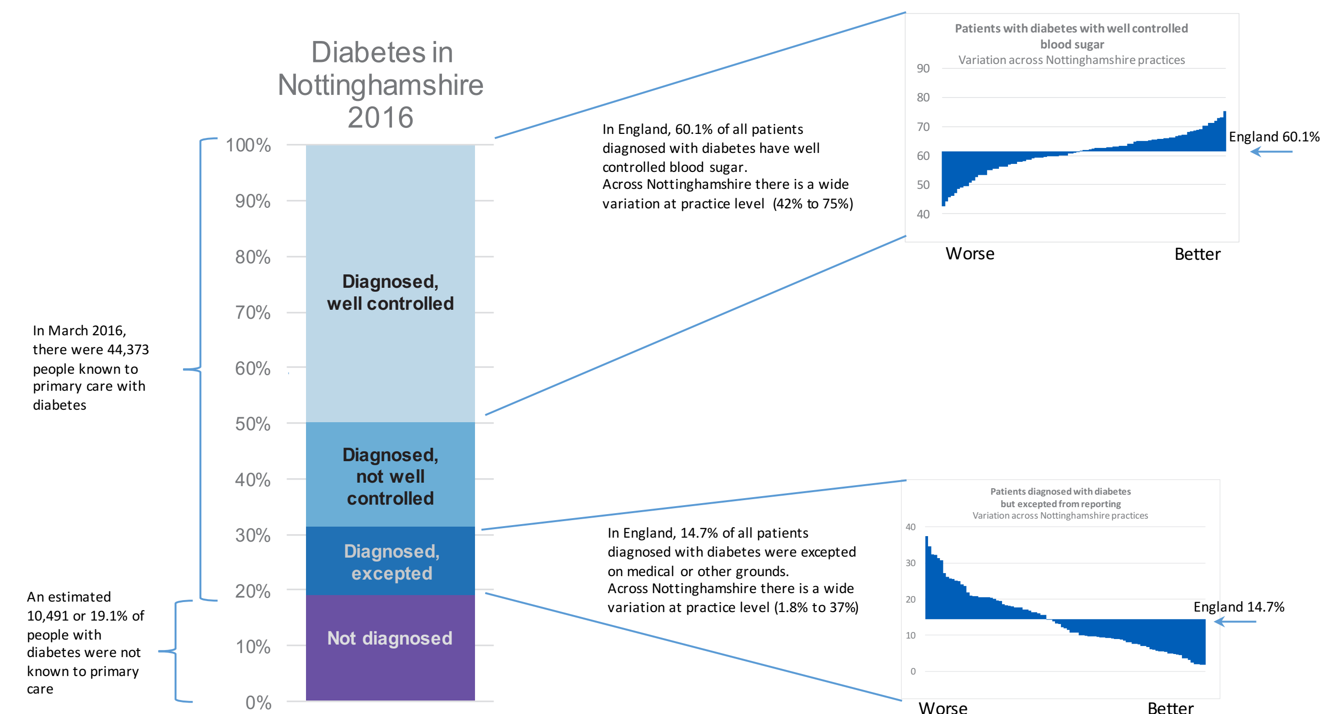
Figure 19 below shows the current position regarding diabetes in Nottinghamshire. There are issues apparent from the figures:

1. Missing population: approximately 20% of the diabetes population is not diagnosed and therefore does not appear on diabetes registers (that's approx. 10,500 citizens).
2. 14.7% of all patients diagnosed with diabetes have been 'Excepted' by their practice either on personal or medical grounds from performance reports (that's approx. 6,500 citizens). This figure masks the wide variation at practice level (from 1.8% to 37% of the practice's diagnosed patients).
3. Diagnosed but not well controlled: this group of people are being managed by their practice however their blood glucose levels are outside of what is described as well controlled levels.

All three groups above together represent approximately 50% of the diabetes population (that's approx. 27,500 citizens). This means that 50% of people with diabetes are either not identified or not well controlled. They are at greater risk of all the complications of poorly managed diabetes e.g. sight loss, amputations, kidney failure and hospitalisation, as they are either not identified, aren't accessing evidence based interventions or are not being well managed.

If all practices in Nottinghamshire were performing at the England average or better, then an additional 2,000 patients would have well controlled diabetes and therefore fewer complications and hospitalisation.

Figure 19: Diabetes in Nottinghamshire 2016



Ways of reducing variation for the identification and care of patients with diabetes include identifying and sharing the ways that the better performing GP practices are achieving optimal results; and implementing these methods in the poorer performing practices, through mentorship, pairing of practices and training; systematic audit and performance management.

Recommendation: CCGs and GP practices should reduce variation for the identification and care of patients with diabetes, with the aim of all practices achieving at least the national average

Recommendation: A similar approach to identification and care of patients is rolled out across the other long term conditions that contribute most to ill health and demand for the use of NHS and care services

Chapter 6

Summary of recommendations

I hope that you have found this report interesting. The combination of where we live and how we live creates a snowball effect, it starts small and gathers momentum so you need to make sure you are on the right path. The report highlights what we have already done as well as where future opportunities lie. In next year's report, I will be reporting on how much we have been able to seize these opportunities as well as covering the other aspects of the Marmot report.

The table below summarises for ease of reference all the recommendations made in the report. Next year the DPH annual report will report on progress made against these.

For those of you who would like further information on what is happening regarding the health of the public in Nottinghamshire, I would advise you to have a look at the following excellent resources.

- The Joint Strategic Needs Assessment (JSNA) provides a picture of the current and future health and wellbeing needs of the local population available at http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA.aspx
- The Public Health Outcomes Framework, a set of desired outcomes and the indicators that helps us understand how well public health is being improved and protected. Information relating to Nottinghamshire is available at http://www.phoutcomes.info/

Recommendations:

Continue to invest in safe walking and cycling infrastructure developments linking people to jobs, training and services (including the development and delivery of a joined up, safe and well connected cycle network across the County).

Target travel behaviour change campaigns to inform, encourage and enable people to make more walking and cycling trips more often.

Continue to protect, increase and improve green space particularly in our most deprived communities, and to improve access to open and green space for local residents.

All public sector organisations should provide healthy food for staff and visitors in line with what the NHS is doing

Continue to increase the proportion of fast food businesses who take part in the Nottinghamshire HOT merit scheme.

Planning teams should:

- Ensure that planning applications for new developments prioritise the need for both adults and children to be physically active as part of their daily life
- Work with developers to promote active travel and ensure that developments are appropriately designed
- Work with developers to provide new green, safe, accessible and pedestrian-only spaces and to improve the quality of existing green spaces
- Utilise planning powers to restrict the number of fast food outlets in line with NICE guidelines
- Encourage house builders to use the Building for Life 12 government endorsed industry standard for well-designed houses and neighbourhoods.
- Encourage housing developers to sign up to the Building Research Establishment (BRE) Home Quality Mark (HQM) scheme.

Local authorities should:

- Endorse the Spatial Planning for Health and Wellbeing of Nottinghamshire
- Secure support for the Nottinghamshire 'Planning and Health Engagement Protocol'.

Continue to support the voluntary and community sector in order to improve health and wellbeing

Enhance social prescribing and related initiatives to help individuals and communities to tackle challenges affecting their health and wellbeing and reduce social isolation

The development of community capacity, empowerment and resilience should be a key component of the next version of the Joint Health and Wellbeing Strategy.

Protect resources which enable the ongoing delivery of activities related to diet and exercise, alcohol and tobacco use.

All those organisations represented on the Nottinghamshire HWB Board have an implementation plan that secures the delivery of Making Every Contact Count to include:

- Identification of a Board Level Public Health Champion with responsibility for MECC
- Inclusion of MECC in the mandatory training programme for all appropriate frontline staff
- Working with local Health Education providers to include MECC in local graduate and post-graduate training programmes for relevant staff

GP practices target those on their patient lists eligible for the appropriate health check that are most likely to be at high risk (5 yearly NHS Health Check for those aged 40-74).

GP practices systematically and consistently invite relevant individuals from their patient lists for annual Learning Disability health checks.

CCGs and GP practices should reduce variation for the identification and care of patients with diabetes, with the aim of all practices achieving at least the national average.

A similar approach to identification and care of patients is rolled out across the other long term conditions that contribute most to ill health and demand for the use of NHS and care services.

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Director of Public Health's

Annual Report 2016

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Nottinghamshire County Council

Report to the Public Health Committee

1 December 2016

Agenda Item: 8

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH SERVICE PLAN 2016/17 - PROGRESS REPORT

Purpose of the Report

1. The 2016/17 Public Health service plan was submitted to Public Health Committee on 19 May 2016. This report provides an update on progress against the plan for noting by the Committee.

Background

2. As a division within the Adult Social Care, Health and Public Protection Department, Public Health has an operational-level annual service plan. This was submitted to Committee for information on 19 May 2016. Performance continues to be reported to Committee in the form of the quarterly contracts and performance report on commissioned services, which has been expanded to encompass performance on all the areas supported through Public Health grant, including the realigned Public Health grant supporting activity in other parts of the Council.

Information and Advice

3. Information on progress against the actions contained in the service plan is contained in Annex 1. The report concentrates on performance in implementing the plan, and so it focuses on identified activities and whether they have been completed.

4. Actions in the Annex have been marked Green, Amber or Red in line with whether they are on track to be completed to schedule, delayed but expected to be recovered to time, or delayed and unable to be recovered to time. The majority of actions are marked Green and on track to be completed to schedule.

5. In the case of the two actions marked red - unable to be recovered to time - decisions have been taken to postpone these actions in order to ensure that work is coordinated with other bodies or with other parts of the Council. This has affected the refresh of the Health and Wellbeing strategy, deferred pending completion of the Sustainability and Transformation Plan, and the development of aligned plans to tackle mental health and homelessness, which impacts on a number of contracts held by other parts of the Adult Social Care, Health and Public Protection department. Delay of these activities will in the long term ensure a more strategic approach with the coordination of activities.

Other Options Considered

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

Reason for Recommendation

7. In May 2016, the Public Health Committee agreed to receive a six month update reports on progress in implementing the Service Plan 2016/17.

Statutory and Policy Implications

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

Financial Implications

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

RECOMMENDATION

1) That Committee notes the update on progress.

Barbara Brady
Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments

10. This report is for noting only and no Constitutional comments are required.

Financial Comments (DG 08/11/2016)

11. The financial implications are contained within paragraph 9 of the report.

Background Papers and Published Documents

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

Report to Public Health Committee, 19 May 2016, Public Health Departmental Plan 2015/16 and Service Plan 2016/17

Electoral Divisions and Members Affected

- All

Annex 1
Public Health Service Plan 2016/17: Six month monitoring

Action	Measures	Status	Six month update	Q3 and Q4 planned activity
1 Deliver health improvements and identify opportunities to make VFM improvements whilst still delivering PH outcomes in the recommissioning of NHS Health checks IT service and childrens PH services 0-19	NHS healthchecks IT and childrens 0-19 procurements are completed by 31 March 2017	AMBER	NHS Health Check IT procurement is underway. There has been a short delay to allow due diligence to take place, however the new service is expected to go live as planned on 1st April 2017.	Mobilisation of NHS Health Check IT service between 12/12/16 and 31/3/17.
		GREEN	Children's 0-19 procurement – contract award approved by Public Health Committee 29 September 2016	Mobilisation of 0-19 Integrated healthy child and public health nursing programme between 10/10/16 and 31/3/17
2. Review and manage existing contracts (including contracts due to start 1 April 2016 and activities supported through PH grant realignment) to deliver financial savings targets contained in OFC APH002 and OFC APH003	£ financial savings achieved on commissioned services	GREEN	Financial forecasting up to Period 5 shows that expenditure will be contained within budget and savings targets met.	Continued financial monitoring and expenditure control.
	Submission of health contracts and performance reports to PH Committee containing detailed performance data on commissioned and realigned services	GREEN	Contract and performance monitoring takes place regularly to collate data with Performance and Quality Report submitted to PH Committee 29 September 2016. PH Committee received Q4 data 2015/16 in July 2016 and Q1 data 2016/17 in September 2016	Committee Work Programme identifies schedule of future reports: Q2 1 December 2016 Q3 30 March 2017 Q4 20 July 2017
3. Strengthen Clinical governance and quality arrangements for commissioned services	Quality standards are contained in individual commissioned service specifications and quality schedules	GREEN	Quality standards are monitored as part of regular contract and performance monitoring.	Continued quality and performance monitoring.
	Senior Managers receive training in quality and clinical governance within six months of restructure	GREEN	Quality report submitted to Public Health Committee, July 2016, to highlight quality arrangements to elected Members. Clinical Governance Process and	Training for senior managers is in planning with delivery due before end Feb 2017.

	taking place		Protocol refreshed and submitted to Public Health SLT for approval, September 2016.	
4. Refresh the health and wellbeing strategy	Refresh of HW strategy to be completed by end March 2017 for implementation commencing 1 April 2017	RED	Postponed in order to take account of STP and ensure work is coordinated and joined up.	Paper being presented to Nov 2016 HWB proposing delay to refresh till Q2/Q3 2017/18 pending agreement of the Sustainability and Transformation Plan.
5. Continue to work with partners to promote joint and aligned strategy to tackle tobacco use, focusing on the implementation of action plans related to the Nottinghamshire Declaration on Tobacco Control and the expansion of the declaration to third parties	Tobacco control and smoking cessation contract: no of four week quitters reported	AMBER	6800 target set in original service specification was reduced to 5000 after negotiation with provider, to allow time for services to commence with new provider. Actual activity reports were 575 in Q1 and 440 (provisional) for Q2.	Close performance monitoring in place but provider is unlikely to meet targets. Contract structure is for payment by results, so the lower than anticipated performance will deliver a cost saving.
	HWB members and named key partners have signed the Nottinghamshire declaration on tobacco control	GREEN	Target: 82% at outset rising to 100% by year end. At end Q1, 100% of named key partners had signed the declaration.	Target met end Q1. Signatories include Notts Police and PHE.
	HWB members and named key partners have a tobacco declaration action plan agreed by their organisation	GREEN	Target: 41% at outset rising to 100% by year end. At end Q1, 73% of members and named key partners had agreed a tobacco declaration action plan for their organisation, performance was ahead of schedule.	Performance for Q2 will be captured in Q3 alongside wider work with Strategic Tobacco Alliance Group and establishing Tobacco Declaration Working Groups
	HWB members and named key partners are actively implementing their Tobacco Declaration	AMBER	New target. Starting from 0, rising to 100% by year end. In quarter two we have focussed on preparation for wider work that is due to start in October with the	Performance to be captured in Q3 alongside wider work with Strategic Tobacco Alliance Group and establishing Tobacco Declaration Working Groups

	action plans as evidenced by a quarterly self-assessment template		Strategic Tobacco Alliance Group. This work will involve establishing Tobacco Declaration Working Groups that will take this work forward with partners.	
6. Develop proposals for council wide approaches to the delivery of mental health services	Improvement in Mental Wellbeing score WEMWBS with PH realignment mental health services	GREEN	Target: - Cumulative 50% increase in WEMWBS recording by year end - 80% increase in WEMWBS score at 12 months from baseline	Performance captured in Q2: WEMWBS assessments done after 12 months showed - 80% increase in WEMWBS scores - 13.3% went down - 6.7% stayed the same
	Proposals developed for a Council wide approach to mental health services by Q3	RED	Review of contract timeframes undertaken to enable future single approach to be developed. Public Health Committee approved one contract extension in June 2016.	Activity will need to be delayed owing to the need to align timeframes for a number of separate elements.
7. Implement the first year of the Young People's Health Strategy Action Plan (three year strategy)	Year 1 of the Young People's Health Strategy Action Plan is implemented by end March 2017	GREEN	An external provider of the Nottinghamshire young peoples' health website has been identified. A multi-agency YP health strategy steering group has met regularly and has identified priority areas for action.	HWB event Dec 2016 to celebrate progress of the YP Health strategy and showcase initiatives. Mobilisation of the YP health website with a focus on local services Development of a 'you're welcome' assessment process for YP services commissioned by NCC and others
8. Refresh the memorandum of understanding with CCGs	Refreshed MoU setting out levels of service to CCGs is in place by October 2016	GREEN	MoU shared with partners through Public Health Grant partner engagement group. Revised MoU submitted to Clinical Congress 14 September 2016 with deadline for feedback end September.	Expected to be completed by end October.
9. Maximise the health gains that the planning system can offer through the	Partner engagement between health and spatial planning is established by the end	AMBER	Spatial planning and health document approved at the HWB in May 2016. Districts to take the document to relevant committees	Encourage districts to endorse spatial planning and health document via Nottinghamshire planning groups and the TEWS

development of protocols for closer working relations between planners and health	of December 2016 through development of an agreed spatial planning and health document and an engagement protocol.		for endorsement. To date this has been endorsed by Gedling. Draft engagement protocol has been developed.	group. Consultation on the engagement protocol to take place Oct/Nov. To take to HWB in Feb 17 for approval and endorsement.
10. Engage partners and plan for future budget reductions in light of reducing Public Health grant	Budget plan is developed to deliver required savings from 2017	GREEN	Public Health grant working group established with representation from Council departments, PHE and CCGs. Series of meetings held and budget reviews undertaken. Reports back to CLT, Clinical Congress. Public Health Committee received report in September and agreed identified budget alterations. With use of reserves, there is sufficient resource to address commitments up to March 2018.	Action complete by end Q2.
11. Complete the restructure of Public Health in line with OFC APH001 and follow this by refreshing the Public Health workforce development plan	Restructure of PH is implemented by end of Q2	GREEN	Extended consultation completed June 2016. Public Health Committee approved new structure 14 July 2016. New structure implemented with effect from 1 August 2016.	Workforce development plan refresh to be completed during Q3.
12. Achievement of budgetary savings identified in OFCs APH001 (staffing), 002 (commissioned services) and 003 (realigned grant).	Financial savings are achieved in line with OFCs	GREEN	Implementation of restructure has achieved savings target in OFC APH001. Implementation of realignment changes to achieve savings in OFC APH003. Contract management, monitoring and control of procurement is forecasting savings will be achieved in OFC APH002.	Continued financial monitoring of expenditure to achieve budgetary savings as anticipated.

Nottinghamshire County Council

Report to the Public Health Committee

1 December 2016

Agenda Item: 9

REPORT OF DIRECTOR OF PUBLIC HEALTH

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

QUARTER 2 of 2016/17

Purpose of the Report

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

Background

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

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

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

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

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

Information and Advice

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

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

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

Key Issues in Performance in Quarter 2 of 2016-17

9. Quarter 2 generally sees a slowing down of activity across services as potential service users are not available to take up services during the summer months. This is especially acute in those services aimed at children and young people and based around academic settings.

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

11. The tobacco control and smoking cessation provider is not performing to plan. There was an expectation that it would take time for a new provider to embed services and therefore low numbers in the first two quarters were to be expected. However, the numbers are lower than anticipated which means it will be very difficult for the provider to get back on track even though performance generally improves in the last two quarters of a contract year because of Stoptober and New Year resolutions. The Public Health team are working closely with the provider to maximise performance in the second half of the year.

12. The Obesity Prevention and Weight Management provider is performing to plan in a number of key areas. However, whilst the numbers are improving for the children's and maternity

services and in post-bariatric reviews, the numbers are still below target. Action plans have been provided to address these issues and the public health team will continue to robustly monitor this.

13. The numbers of adults supported in the Domestic Abuse service has dropped in this second quarter report. However, the report does not explain that Quarter 2 heralds the end of the first year for this contract. Over the contract year the providers have exceeded annual targets. In the north of the county the provider performed at 103%, and in the south the provider performed at 105%.

14. The number of interventions are reported as down in the social exclusion contract. However, the provider has stated that demand is higher now than at any time previously. A new client monitoring system has been put in place since the last quarter and therefore data may not yet be accurate. The PH team will closely monitor this.

15. The correct services and pathways have yet to be agreed with the provider of the Young Peoples substance misuse services. The performance indicators may change as a result and therefore performance monitoring information is not available as yet. However, service user feedback has been provided which is positive, with the service being well received by the young people and their carers.

Statutory and Policy Implications

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

Financial Implications

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

Public Sector Equality Duty implications

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

Implications for Service Users/Safeguarding of Children and Vulnerable Adults Implications

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

RECOMMENDATION

The recommendations are:

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

Barbara Brady
Interim Director of Public Health

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

Constitutional Comments

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

Financial Comments

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

Background Papers and Published Documents

None

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

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

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

Symbol	Meaning
⬆ (green)	Change from previous month > 5%
⬌ (amber)	Equal to previous month by +/- 5%
⬇ (orange)	Change from previous month < 5%

Service, Provider and Outcome	Contract Value Category	Public Health Outcomes Indicator	Performance Indicators	Q1	Q2	Q3	Q4	2016/17 Total Achieved	Annual Target	% of target met	Notes	Trend
National Child Measurement Programme To achieve a sustained downward trend in the level of excess weight in children by 2020	Medium High	2.06	% of children in Reception with height and weight recorded	Academic year 2016+C16/17 published end of Nov/Dec by HSCIC				0%	n/a	n/a		
			% of children in Year 6 with height and weight recorded	Academic year 2016+C16/17 published end of Nov/Dec by HSCIC				0%	n/a	n/a		
			Parents/Carers receive the information regarding their child within 6-weeks post measurement	Academic year 2016+C16/17 published end of Nov/Dec by HSCIC				0%	n/a	n/a		
NHS Health Check Assessments To reduce early mortality and improve quality of life for individuals with Long Term Conditions (LTC) **County & Bassetlaw GP's**	Medium High	2.22	No. of eligible patients who have been offered health checks	8539	⬌ 8539			17078	51,497	33%		
			No. of patients offered who have received health checks	5299	⬌ 5292			10591	33,988	31%		
			No. of patients who have been identified as high risk and referred to other services as a result of a health check	291	⬌ 250			541	n/a	n/a	No target as there is no 'good' or 'bad' direction	
Integrated Sexual Health Services Promotion of the prevention of Sexually Transmitted Infections including HIV Increased knowledge and awareness of all methods of contraception amongst all groups in the local population	**Doncaster and Bassetlaw Hospitals**											
	High	2.04, 3.02, 3.04	Total number of filled appointments	2431	⬌ 2426			4857	Baseline	n/a		
			Total number patients who receive full sexual health screen	527	⬆ 622			1149	TBA	n/a		
			Number and % new service users accepting a HIV test	613 (30%)	⬇ 498(44%)			37%	60%	62%		
			% 15-24 year olds in contact with the service accepting a chlamydia screen	68%	⬆ 77%			73%	75%	97%		
			Number and % screens with a positive Chlamydia result	88 (9%)	⬌ 79(8%)			9%	7.50%	113%		
			% of women aged 15-24 receiving contraception who accept LARC	42%	⬌ 44%			43%	30%	143%		
			Number of women accessing Emergency Hormonal Contraception accept LARC	25	⬆ 43			68	Baseline	n/a		
	Sherwood Forest Hospital Trust											
	High	2.04, 3.02, 3.04	Total number of filled appointments	5763	⬌ 5964			11727	Baseline	n/a		
			Total number patients who receive full sexual health screen	1344	⬌ 1388			2732	TBA	n/a		
			Number and % new service users accepting a HIV test	1363 (36%)	⬆ 1424 (30%)			33%	60%	55%		
			% 15-24 year olds in contact with the service accepting a chlamydia screen	56%	⬇ 44%			50%	75%	67%		
			Number and % screens with a positive Chlamydia result	355 (18%)	⬇ 251(12%)			15%	7.50%	200%		
			% of women aged 15-24 receiving contraception who accept LARC	49%	⬌ 47%			48%	30%	160%		
			Number of women accessing Emergency Hormonal Contraception accept LARC	29	⬆ 45			74	Baseline	n/a		

Nottingham University Hospital											
High	**2.04, 3.02, 3.04**	Total number of filled appointments	3043	↑ 7653			10696	Baseline	n/a		
		Total number patients who receive full sexual health screen	1089	↑ 1312			2401	TBA	n/a		
		Number and % new service users accepting a HIV test	1272 (74%)	↔ 1352(76%)			75%	60%	125%		
		% 15-24 year olds in contact with the service accepting a chlamydia screen	55%	↑ 58%			57%	75%	75%		
		Number and % screens with a positive Chlamydia result	11 (12%)	↓ 6(6%)			9%	7.50%	120%		
		% of women aged 15-24 receiving contraception who accept LARC	33%	↔ 34%			34%	30%	112%		
		Number of women accessing Emergency Hormonal Contraception accept LARC	55	↑ 81			136	Baseline	n/a		
Community Pharmacies - Nottinghamshire County & Bassetlaw LCPHS - Emergency Hormonal Contraception (EHC)											
Medium	**2.04, 3.02, 3.04**	Number of women under the age of 20 accessing EHC from Community Pharmacies within the county	63	↑ 88			151	n/a	n/a		
GP's - Nottinghamshire County & Bassetlaw LCPHS - Sub Dermal Implants/Long Acting Reversable Contraception (LARC)											
Medium High	**2.04, 3.02, 3.04**	Total number of LARC insertions	1014	↓ 768			1782	n/a	n/a		

Alcohol and Drug Misuse Services Reduction in Alcohol related admissions to hospital Reduction in mortality from liver disease Successful completion of drug treatment **Change Grow Live**	High	1.05, 1.03, 1.15, 1.04,2.18, 1.13	Number of successful exits (ie planned)	285	242			527	April-June Target 150	190%	Targets set quarterly
			Number of new treatment journeys	1406	1647			3053	April-June Target 1566	195%	
			Number of unplanned exits	144	167			311	n/a	n/a	
			Total number of service users	3814				3814	10301	37%	50% 9954 year 2 50% 10,647 year 3
Tobacco Control and Smoking Cessation Reduce adult (aged 18 or over) smoking prevalence Behaviour change and social attitudes towards smoking Prevalence rate of 18.5% by the end of 2015/16 **Solutions4Health**	**Four-week smoking quitter rate**										
	High	2.9, 2.3, 2.14	Pregnant Smokers	31	5			36	500	7%	Total quits 1,024 as these figures include 53 out of area clients. Overall Annual target 5,000 20.48% of overall target reached in quarter 2. Will increase due to paperbased system
			Routine and Manual Workers	150	142			292	1500	19%	
			Under 18 Smokers	8	4			12	200	6%	
			Other Smokers	396	341			737	2800	26%	
Obesity Prevention and Weight Management (OPWM) To achieve a downward trend in the level of excess weight in adults by 2020 A sustained downward trend in the level of excess weight in children by 2020 Utilisation of green space for exercise/health reasons **Everyone Health**	**Number of new assessments**										
	High	1.16, 2.06, 2.11, 2.12, 2.13	Adults - Tier 2	134	68			202	258	78%	
			Adults - Tier 3	222	133			355	400	89%	
			Children & Young People - Tier 2	17	28			45	108	42%	
			Children & Young People - Tier 3	15	14			29	98	30%	
			Maternity	5	8			13	104	13%	
			Post-bariatric reviews	5	13			18	60	30%	
			Adults, Children & Young People combined service users	1509	6704			8213	6,794	121%	
Domestic Abuse Services Reduction in Violent crime Reduction in Domestic violence **WAIS & NWA**	Medium	1.11	No of adults supported	572	392			964	2504	38%	
			No of children, young people & teenagers supported	114	136			250	776	32%	
Seasonal Mortality Reduction in excess winter deaths **Nottingham Energy Partnership - Healthy Housing**	Medium	4.15	Number of people from the target groups given comprehensive energy efficiency advice and/or given help and advice to switch energy supplier or get on the cheapest tarrif	30	56			86	288	30%	
			Number of individuals trained to deliver Brief Interventions i.e. number of people attending the training courses	19	56			75	185	41%	
Social Exclusion To improve outcomes for older people by reducing risk and health impacts of loneliness **The Friary Drop-in Centre**	Medium	1.18	Number of one-to-one specialist advice interviews undertaken	2042	1447			3489	n/a	n/a	
			Number of emergency parcels provided	1294	1091			2385	Baseline Q1	n/a	
Public Health Services for Children and Young People aged 0-19	High	1.01, 1.02, 2.02, 2.03, 2.05, 2.06	% of mothers who receive a face to face antenatal contact	73%	76%			75%	75%	99%	
			Number of brief interventions offered by school nurses and delivered with children and young people by public health topic	1830	562			2392	n/a	n/a	
			% of children who received a 2.5 year review	88%	88%			88%	95%	93%	
			% of under 18 years or low income mothers who qualify for Healthy Start that have received Healthy Start advice	75%	65%			70%	75%	93%	
			% of family nurse partnership clients enrolled by 16th week of pregnancy	64%	100%			82%	60%	137%	
Oral Health Promotion Services	Medium	4.02	% of service users surveyed who receive oral health advice/resources who report that it is very useful.	93%	92%			93%	80%	116%	
			% of frontline staff trained who say they have gained knowledge and confidence in delivering oral health brief interventions.	100%	100%			100%	80%	125%	

			% of parents/carers with a child aged 1 year who receive oral health brief advice.	74%	59%			67%	75%	89%		
Suicide prevention and Mental Health Awareness Training Kaleidoscope	**Medium**	**2.23, 4.10**	Tier 1 Population based suicide prevention awareness campaign in line with national suicide prevention	0	1			1	2	50%		
			Tier 2 Mental health community workshops focusing on building reslience & preventing mental health problems using Five Ways to Wellbeing	2	4			6	14	43%		
			Tier 3 Recruitment, selection & co-ordination for 1/2 day mental health First Aid LITE course	1	0			1	7	14%		
			Tier 4 Recruitment, selection & co-ordination for 2 day ASIST Suicide Prevention training	0	1			1	2	50%		

Nottinghamshire County Council

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

Service and Outcome	Public Health grant realignment allocation	Actual realignment expenditure 2015/16	Performance Indicators	Q1	Q2	Q3	Q4	2016/17 Total Achieved	Annual Target	% of target met	Notes	Trend
Illicit Tobacco Prevention and Enforcement Reduce adult (aged 18 or over) smoking prevalence behaviour change and social attitudes towards smoking prevalence rate of 18.5% by the end of 2015/16 **Trading Standards and Nottinghamshire Police**	Medium High	2.14	Illicit Cigarettes seized	242760	226620			469380	Increase on 15/16 >575,045	42%		
			Estimated retail value: counterfeit seized products (Based on retail value of £9 cigs and £18 HRT)	£168,840	£116,541			£285,381.00	Increase on 15/16 >£296,091	96%		
Healthy Ageing Schemes Improve health related quality of life for older people	**Handy Person's Adaptation Scheme (contribution)**											
	Medium	2.24, 4.14	Number of adaptations undertaken	934	1051			1985	Maintain volume	Achieved		
	Stroke Association											
	Medium	4.04	Number of clients	54	67			121	320	38%		
	Older Person's Early Intervention Scheme (contribution)											
	Medium High	4.13	Age UK - Number of referrals	354	471			825	n/a	n/a		
			Metropolitan - Number of referrals	451	497			948	n/a	n/a		
			NCHA - Number of referrals	62	81			143	n/a	n/a		
	Notts Help Yourself											
	Medium	4.03, 4.13	Website hits (millions)					0	1.5	0%	Reported annually	
			% satisfaction in user surveys					n/a	n/a	n/a	Reported annually	
Children's Centres To improve school readiness among children, contribute to targets around dental health, breastfeeding, healthy weight, smoking, hospital admissions for non-accidental injury	High	2.05	% of children under five registered with a children's centre	95%	96%			95%	95%	100%		
			Parents completing evidence based parenting programme	1359	856			2215	2,000	111%		
			% of children achievinig a good level of development at end of EYFS		67%			67%	69%	97%	Reported annually in Q2	
Family Nurse Partnership Improve breastfeeding initiation rates and prevalence; contribute to outcomes around smoking status at time of delivery, birth weights, hospital admissions for non-accidental injury	Medium High	2.02	Percentage of clients enrolled by 16th week of pregnancy	64%	100%			82%	60%	137%		
			Percentage of mothers initiating breastfeeding	44%	61%			53%	70%	75%		
Young People's Sexual Health: C-Card scheme Reduce teenage conceptions	Low	2.04	Number of young people returning to use the scheme	823				823	1700	48%		
			No of new sites established	9				9	20	45%		
Young Carer's Reduce the number of young people in poverty	Medium	1.01	Number of young carers referred to the service who receive an assessment of need using the EHAF and the MACCA/PANOC assessment.	45	32			77	na	na		
			Young Carers report a reduction in the caring role and/or a reduction in the negative impact of caring					0	na	na	Survey undertaken annually	
Young People's Substance Misuse Services Successful completion of drug treatment Reduce numbers of young people not in education, employment or training	Medium High	2.15	% of planned exits	96%	95%			96%	80%	119%		
Young People's Supported Accommodation Reduce the number of young people in poverty	Medium	1.01	% of young people maintaining their tenancy or moving on successfully	92%	89%			91%	95%	95%		

Youth Violence Reduction Reduction in young people offending, First time entrants to youth justice system. Reductions in violent crime	**Medium**	**1.04**	First time entrants to youth justice system	49				49	na	na		
Supporting People: Homelessness Support Reduction in statutory homelessness, impacts on alcohol related admissions to hospital	**High**	**1.15**	Total Number of Individual Service Users Receiving Support	317	328			645	n/a	n/a	Target is 75% of those moving on in a planned way	
			People moving on in a planned way	68	87			155	75%	24%		
			People Who Have Moved on in an Unplanned Way:	10	20			30	n/a	n/a		
			Utilisation of accommodation	99.80%	100.40%			100.10%	n/a	n/a		
Mental Health Self reported wellbeing, Adults in contact with secondary mental health services who live in stable and appropriate accommodation **CoProduction**	**Medium**	**4.09**	% Improvement in mental health and wellbeing from entry and at 12 months (based on WEMWBS) - mean WEBWBS score	50%	80%			65%	increase over year	achieved		
			% of clients with improvement in WEMWBS scores	50%	80%			65%	increase over year	achieved		
			% of clients in stable accommodation	100%	100%			100%	increase over year	Achieved		
Reduction in statutory homelessness Adults in contact with mental health services who live in stable and appropriate accommodation **Moving Forward**	**Medium**	**1.15**	Number of clients entered the service by quarter	134	142			276	n/a	n/a		
			Number and % of entry clients completing WEMWBS on entry in to the service	78 (58%)	100 (70%)			64%	Q1 40% Q2 60%	58% 70%		
			Number of clients exited the service by quarter	218	140			358	n/a	n/a		
			Number and % of entry clients completing WEMWBS on exit from the service	7 (3%)	8 (6%)			4.5%	Q1 40% Q2 60%	3% 6%		
			On exit WEMWBS score had increased by 3 or more from entry	5	4			9	n/a	n/a		

Complaints, Serious Incidents & Freedom of Information Requests **Quarter 2 2016/17**

	Complaints relating to Health Contracts			Summary of Serious Incidents (SI's)			Freedom of Information
Public Health Area	**No.of new Complaints in period**	**No.of Complaints under investigation in period**	**No.of Complaints concluded in period**	**No.of new SI's in period**	**No.of SI's under investigation in period**	**No.of SI's concluded in period**	**Freedom of Information Requests relating to Public Health Functions and Health Contracts**
Alcohol and Drug Misuse Services				2		1	1
Pharmacy							1
Mental Health							
Information relating to management functions							4
Sexual Health							
Cross Departmental							2
Obesity Prevention							3
NHS Health Checks							
Tobacco Control							
CYP				1	1		3
Domestic Abuse							1

Public Health Outcomes Framework 2016–2019
At a glance

VISION

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

Outcome measures

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

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

Alignment across the Health and Care System

- * Indicator shared with the NHS Outcomes Framework.
- ** Complementary to indicators in the NHS Outcomes Framework
- † Indicator shared with the Adult Social Care Outcomes Framework
- †† Complementary to indicators in the Adult Social Care Outcomes Framework

1 Improving the wider determinants of health

Objective

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

Indicators

- 1.01 Children in low income families
- 1.02 School readiness
- 1.03 Pupil absence
- 1.04 First time entrants to the youth justice system
- 1.05 16-18 year olds not in education, employment or training
- 1.06 Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation† *(ASCOF 1G and 1H)* ***(NHSOF 2.5ii)*
- 1.07 Proportion of people in prison aged 18 or over who have a mental illness
- 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services **(i-NHSOF 2.2)* ††*(ii-ASCOF 1E)* ***(iii-NHSOF 2.5i)* †† *(iii-ASCOF 1F)*
- 1.09 Sickness absence rate
- 1.10 Killed and seriously injured casualties on England's roads
- 1.11 Domestic abuse
- 1.12 Violent crime (including sexual violence)
- 1.13 Levels of offending and re-offending
- 1.14 The percentage of the population affected by noise
- 1.15 Statutory homelessness
- 1.16 Utilisation of outdoor space for exercise / health reasons
- 1.17 Fuel poverty
- 1.18 Social isolation † *(ASCOF 1I)*

2 Health improvement

Objective

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

Indicators

- 2.01 Low birth weight of term babies
- 2.02 Breastfeeding
- 2.03 Smoking status at time of delivery
- 2.04 Under 18 conceptions
- 2.05 Child development at 2 – 2 ½ years
- 2.06 Child excess weight in 4-5 and 10-11 year olds
- 2.07 Hospital admissions caused by unintentional and deliberate injuries for children and young people under 25
- 2.08 Emotional well-being of looked after children
- 2.09 Smoking prevalence – 15 year olds
- 2.10 Self-harm
- 2.11 Diet
- 2.12 Excess weight in adults
- 2.13 Proportion of physically active and inactive adults
- 2.14 Smoking prevalence – adults (over 18s)
- 2.15 Drug and alcohol treatment completion and drug misuse deaths
- 2.16 Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison
- 2.17 Estimated diagnosis rate for people with diabetes mellitus
- 2.18 Alcohol-related admissions to hospital
- 2.19 Cancer diagnosed at stage 1 and 2***(NHSOF 1.4v 1.4vi)*
- 2.20 National Screening Programmes
- 2.22 Take up of the NHS Health Check programme – by those eligible
- 2.23 Self-reported well-being
- 2.24 Injuries due to falls in people aged 65 and over

3 Health protection

Objective

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

Indicators

- 3.01 Fraction of mortality attributable to particulate air pollution
- 3.02 Chlamydia diagnoses (15-24 year olds)
- 3.03 Population vaccination coverage
- 3.04 People presenting with HIV at a late stage of infection
- 3.05 Treatment completion for TB
- 3.06 Public sector organisations with board approved sustainable development management plan
- 3.08 Antimicrobial Resistance

4 Healthcare public health and preventing premature mortality

Objective

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

Indicators

- 4.01 Infant mortality* *(NHSOF 1.6i)*
- 4.02 Proportion of five year old children free from dental decay** *(NHSOF 3.7i)*
- 4.03 Mortality rate from causes considered preventable ***(NHSOF 1a)*
- 4.04 Under 75 mortality rate from all cardiovascular diseases (including heart disease and stroke)* *(NHSOF 1.1)*
- 4.05 Under 75 mortality rate from cancer* *(NHSOF 1.4)*
- 4.06 Under 75 mortality rate from liver disease* *(NHSOF 1.3)*
- 4.07 Under 75 mortality rate from respiratory diseases* *(NHSOF 1.2)*
- 4.08 Mortality rate from a range of specified communicable diseases, including influenza
- 4.09 Excess under 75 mortality rate in adults with serious mental illness* *(NHSOF 1.5i)*
- 4.10 Suicide rate ***(NHSOF 1.5iii)*
- 4.11 Emergency readmissions within 30 days of discharge from hospital* *(NHSOF 3b)*
- 4.12 Preventable sight loss
- 4.13 Health-related quality of life for older people
- 4.14 Hip fractures in people aged 65 and over
- 4.15 Excess winter deaths
- 4.16 Estimated diagnosis rate for people with dementia * *(NHSOF 2.6i)*

Nottinghamshire County Council

Report to Public Health Committee

1 December 2016

Agenda Item: 10

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

NHS HEALTH CHECK IT SERVICE PROCUREMENT UPDATE

Purpose of the Report

1. This report provides an update on the tender for an IT Solution to support the GP-led NHS Health Check Service. The Public Health Committee is requested:
   a. To note the progress of the procurement exercise
   b. To note the contents of the Exempt Appendix
   c. To give approval to abandon procurement of the NHS Health Check IT Solution and to proceed with an in-house solution in accordance with the outcomes identified in the Exempt Appendix.

Information and Advice

2. Some information relating to this report is not for publication by virtue of paragraph 3 of Schedule 12A of the Local Government Act 1972. Having regard to all the circumstances, on balance the public interest in disclosing the information does not outweigh the reason for exemption because the information comprises commercially sensitive and confidential information about the tender process that the Council is conducting. The exempt information is set out in the Exempt Appendix.

3. Members received and approved procurement updates on 30th September 2015 and 19th May 2016:
   a. The Council had received bids in 2015 for an IT Solution to support delivery of both the GP-led and a Targeted Outreach service (Lot 1), however no bids were received in respect of Targeted Outreach (Lot 2). The two lots were inextricably linked therefore it was agreed on 30th September 2015 not to award the IT Solution in isolation, and to re-tender for an IT Solution to support only the GP-led programme.
   b. On 19th May 2016, members approved the proposal to go out to tender formally for an IT Solution to support delivery by GP practices of the NHS Health Check programme and enable the required data flow in fulfilment of the LA mandate, from April 2017.

4. The budget for the IT Solution for 2016/17 is £60,000 and the proposed duration of the new contract is 4 years. This contract value required that the IT solution contract was tendered in accordance with the UK Public Contract Regulations 2015.

5. This procurement was undertaken as an EU Open Process. Bidders had to submit a General Questionnaire and a Technical Questionnaire as a single stage bid.

6. The Council received bids that were evaluated using the Most Economically Advantageous Tender criteria. This enables the Council to evaluate bids based on quality and price of the tender submission. This is standard best practice for the procurement of services. The weighting of the scoring between price and quality was 40% and 60% respectively. Tenders were evaluated in accordance with the process set out in the information to tenderers.

7. The Tender Questionnaire included questions in respect of service delivery, service implementation, management and staffing, governance, and price for the provision of services. Responses were evaluated against set criteria with a threshold set on some but not all of the questions.

8. Before the final recommendation to Public Health Committee had been made, it came to light that IT system partners have been developing capabilities that could meet the essential requirements of NHS Health Check IT support. This would represent an in-house solution.

Recommendation

9. The tender evaluation process has completed and the outcome of the tender evaluation panel is included in the exempt appendices.

Options Considered

10. Option 1 is to award the contract to the most economically advantageous bidder – see Exempt Appendix.

11. Option 2 is to abandon the procurement process and to proceed with the in-house solution – see Exempt Appendix.

Reason for Recommendation

12. The current contract ends on 31st March 2017. It is considered that there are sufficient grounds to abandon the procurement process.

Statutory and Policy Implications

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

RECOMMENDATIONS

1. To note the progress of the procurement exercise.
2. To note the contents of the Exempt Appendix.
3. To give approval to abandon procurement of the NHS Health Check IT Solution and to proceed with an in-house solution in accordance with the outcomes identified in the Exempt Appendix.

Barbara Brady
Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (EP 17.11.2016)

14. The recommendations fall within the remit of the Public Health Committee by virtue of its terms of reference.

Financial Comments (DG 18.11.2016)

15. The financial implications are contained within paragraph 4

Background Papers and Published Documents

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

- None.

Electoral Divisions and Members Affected

- All.

Report to Public Health Committee

1 December 2016

Agenda Item: 11

REPORT OF CORPORATE DIRECTOR, RESOURCES

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

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

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

Other Options Considered

5. None.

Reason/s for Recommendation/s

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

Statutory and Policy Implications

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

RECOMMENDATION/S

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

Jayne Francis-Ward
Corporate Director, Resources

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

Constitutional Comments (HD)

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

Financial Comments (NS)

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

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Public Health Committee Work Programme 2016 - 17

Meeting Dates	PH Committee	Lead Officer	Supporting Officer
26 January 2017	Provision of Public Health advice to CCGs and Memorandum of Understanding	Barbara Brady	Kay Massingham
	Future in Mind update	Kate Allen	Lucy Peel
30 March 2017	Public Health Services Performance and Quality Report for Health Contracts – October - December 2016	Jonathan Gribbin	Nathalie Birkett
	Public Health Service Plan 2017/18	Barbara Brady	Kay Massingham
	Public Health review of statutory responsibilities	Barbara Brady	Kay Massingham
8 June 2017	Contract Management in Public Health	Nathalie Birkett	
	Public Health Service Plan 2016/17 – Final report	Barbara Brady	Kay Massingham
20 July 2017	Public Health Services Performance and Quality Report for Health Contracts – January to March 2017	Jonathan Gribbin	Nathalie Birkett