Nottinghamshire County Council

Adult Social Care and Public Health Select Committee

Monday, 09 September 2024 at 10:30

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

AGENDA

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 Katherine Harclerode (Tel. 0115 854 6047) 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	ADULT SOCIAL CARE AND PUBLIC HEALTH SELECT COMMITTEE
Date	3 June 2024 (commencing at 10.30am)

Membership

COUNCILLORS

John Ogle (Chairman)
David Martin (Vice Chairman)

Reg Adair
Callum Bailey
Steve Carr
Dr John Doddy
Sybil Fielding
Paul Henshaw
Eric Kerry
Philip Owen
Mike Pringle

OTHER COUNTY COUNCILLORS IN ATTENDANCE

Cllr Anne Callaghan BEM
Cllr Scott Carlton, Cabinet Member for Communities and Public Health
Cllr Roger Jackson
Cllr Tom Smith, Deputy Cabinet Member for Adult Social Care
Cllr Tracey Taylor, Cabinet Member for Children and Young People
Cllr Jonathan Wheeler, Cabinet Member for Adult Social Care

OFFICERS IN ATTENDANCE

Safia Ahmed	-	Specialty Registrar, Public Health
Katy Ball	-	Service Director, Commissioning and Integration
Martin Elliott	-	Senior Scrutiny Officer
Dan Godley	-	Senior Commissioning Officer, Adult Social Care
Katherine Harclerode	-	Democratic Services Officer
Lucy Jones		Senior Public Health and Commissioning Manager
Ainsley MacDonnell	-	Service Director, Living Well
Rachel Miller	-	Service Director, Commissioning and Resources
Helen Neville	-	Service Improvement Development Manager
Anna Oliver	-	Commissioning Manager, Adult Social Care
Catherine Pritchard	-	Consultant in Public Health
Vivienne Robbins	-	Interim Director of Public Health
Melanie Williams	-	Corporate Director, Adult Social Care and Public Health

OTHERS IN ATTENDANCE

Sarah Fleming	-	Programme Director for System Development, ICB
Pam Hill	-	Our Voice
Dean Thomas	-	Making it Real Forum
Marion Wardill		Making it Real Forum

The Chairman noted his thanks to Councillor Roger Jackson as the previous Chairman of the Committee.

1. MINUTES OF THE LAST MEETING HELD ON 4 March 2024

The minutes of the last meeting of the Adult Social Care and Public Health Select Committee held on 4 March 2024, having been previously circulated, were confirmed and signed by the Chairman.

2. APOLOGIES FOR ABSENCE

Apologies were received from Cllr Carr for other reasons and from Cllr Kerry due to Other County Council Business, with Cllr Roger Jackson substituting.

3. DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

There were no declarations of interest.

4. ALL AGE CARERS STRATEGY

Consideration was given to a presentation in respect of the All Age Carer Strategy of the Council. The presentation was introduced by the Cabinet Member for Adult Social Care, who highlighted the contributions of unpaid carers to the development of the strategy. Particular acknowledgement was given to the contributions of longstanding partner and Carer, Pam Hill of Our Voice which had helped to shape the strategy. The involvement in co-production from the beginning phase of the strategy was emphasised and had been part of the development of services that carers themselves wanted and needed. This dispelled assumptions around the needs of carers prior to putting together the service specification and tendering process. Continued involvement ensured these services stayed on track. The Carers Strategy was regarded as a living document that must be at the heart of every service going forward.

The Strategy included the needs of all ages. A video was also presented to highlight a few of the considerations affecting young carers daily. The activities, support and skills gained through the Young Carers Programme were also described. The Cabinet member mentioned that the support allows young carers to be able to continue caring for their loved ones.

The Chairman thanked the Cabinet Members and officers for bringing this Strategy for discussion. In the discussion that followed, Members raised the following points:

- Additional information was requested around how the Strategy was improving access to technology and aids that make caring easier, especially for carers of multiple people.

- Further assurances were sought regarding support provided to male carers and female carers.

- Greater understanding was sought around more around coordinated efforts with partners, such as the British Red Cross.

- Members sought to know how the number of carers at large had changed over time.

- Members also requested more details around how the data had informed the Strategy.

- Gratitude was expressed to Pam Hill for sharing with the committee valuable insights as a Carer.

- Additional clarification was sought around the numbers of young carer referrals.

- Further information was requested around how the Service was reaching carers from diverse backgrounds and communities.

- Interest was expressed in knowing more about how complexity is managed and supported through the Strategy.

- Further evidence was requested that the Council is a carer friendly organisation.

In response to the points raised in discussion, the Cabinet Members for Adult Social Care and Children and Young People; Service Director, Commissioning and Integration (Adult Social Care); Service Director Commissioning and Resources (Children and Family Services) and ICB Programme Director for System Development advised:

- Everyone around a Carer had a part to play in ensuring that the principles of the strategy were being implemented and that there was growing understanding of who the carers are and what their needs are. The responsibility was not down only to attention of the health care professionals such as GPs, physios, reception, etc. There was work to do together as a team to bring everyone on board with the culture of identifying and supporting carers. This included working with Pam and other colleagues to understand and co-produce the support needed.
- Awareness work was ongoing to helping individuals become aware that they were carers, which led to access to assessments and grants for equipment. Linking with others to enable this was part of the support offer.
- The Carers Hub was designed to connect carers to further strength based support beyond the Council. Increased support was available for carers who came for an assessment who were supported with technology to help avoid carer breakdown. Further examples included support with medicine management or short respite.
- Some carers did not think of themselves as being carers. Therefore, the Service was engaging with colleges and primary care surgeries to help these individuals know that there was help available if they want it.
- A person's GP would log on the system that they were a carer so they could be signposted to the Carers Hub. This was because it was understood that they will have additional needs.
- The Integrated Care Network and all parts of the system recognised that within the workforce there were carers whose needs were considered.

- The Cabinet Member for Adult Social Care reaffirmed that if any particular circumstances became known to councillors, these could be referred to the service for additional information and signposting.
- There was a partnership approach hosted by the British Red Cross to share equipment.
- There were more female identified carers. The Services did not discriminate on the basis of sex. The support offer was extended to both male and female carers. Carers could also identify as a couple and both get the care assessment. The offer was not by household. There could be multiple carers in a home. Carers groups met outside working hours to ensure everyone who was a carer could attend, no matter their age or gender.
- It was understood that some individuals had gotten new caring duties since the pandemic. The programme relied on people self-identifying.
- The service had raised the profile of young people with caring responsibilities, with between thirty and forty new young carers coming forward each month. This was helping the service achieve the goal of reaching all young carers. Outreach work was being done with schools. 110 schools had already taken up this outreach, and work was ongoing to target the 16-24 age bracket.
- There was a deaf community carers group, a Black carers group, and a group supporting people with carers. These groups helped ensure conversations with doctors and other groups were effective. This was a co-produced priority that continued into next year.
- Between thirty and forty referrals were being received each month for young people previously not known to services, who were being identified as carers.
- The Cabinet Member for Adult Social Care described scenarios where carers could be involved and how support would be managed. It was felt to be important to ensure that the Service continued to work in flexible ways to support the work.
- The Cabinet Member for Children and Young People noted that the Service was cognizant that there were a lot more young carers out there. The goal was improving the recognition and support to help them come to understand that they are carers.
- Across Adult Social Care and Children's Social Care, there were Young Carer Champions. When an adult came into contact with Adult Social Care, the staff working with the family looked to see if the children were young carers. Social workers and family support staff knew what to do when a young carer was identified.
- The Council had some carers among its workforce and the Service was working closely with Human Resources have good supportive practices in place. This involved working closely with personnel to ensure that managers in their one to one conversations with direct reports have this culture of understanding and support.
- There was more to do to ensure the Strategy principles were implemented internally and externally. This required understanding the experience of the workforce. The Council was actively putting policies in place to support this. There was a need to understand through the staff survey who were carers and what needs this entailed.

RESOLVED: 2024/05

1) That the progress made in implementing the Nottingham and Nottinghamshire All-Age Carers Strategy be noted.

2) That the following issues raised by the Committee in its consideration of the report on Nottingham and Nottinghamshire All-Age Carers Strategy be progressed:

   a) That the Nottinghamshire Joint Strategic Needs Assessment on Carers be circulated to the members of the Adult Social Care and Public Health Select Committee.

5. NOTTINGHAM AND NOTTINGHAMSHIRE SELF HARM AND SUICIDE PREVENTION STRATEGY

Consideration was given to a summary presentation by the Cabinet Member for Communities and Public Health and the Public Health Specialty Registrar which described the development of the Nottingham and Nottinghamshire Suicide Prevention and Self Harm Strategy.

In the discussion that followed, the following points were raised:

- Members sought additional information regarding the support to councillors around mental health first aid in a crisis.

- Homelessness due to relationship breakdown had been an issue. More assurances were sought that the support networks were able to help a person in crisis.

- It was felt that the groups and support available were of great help where these were available, and to actively engage more with schools was vital to expanding the reach of the prevention agenda.

- Further elaboration was desired around how the Joint Strategic Needs Assessment (JSNA) data had informed the development of the Strategy.

- Further support was expressed that suicide prevention training be mandatory.

The Chairman acknowledged the good work that had been done and the strong support for this to continue and for the training to be taken up. In response to these points, the Cabinet Member for Communities and Public Health and the Senior Public Health and Commissioning Manager, Public Health advised:

- The Cabinet Member affirmed support for all Councillors to consider taking up the training offer, and a cross party motion on this subject was felt to be appropriate.

- When individuals were in crisis, sometimes more impactful than the relevant websites, text messaging services, and posters, was having an authority figure checking in. Universal coverage within schools was desired, and the commitment was to continue these conversations.

- Serving communities well required being prepared and ensuring that district and borough colleagues were engaged also. Mandatory participation to establish a baseline knowledge across the whole system was being explored within public health commissioning. Suicide prevention and mental health training was open to the whole system. Colleagues in local authorities did take up some of the training as well. Work was also progressing around Making Every Contact Count.

- Support for community leadership on this agenda was noted, with councillors encouraged to prioritise the training.

- The Strategy had come from the Joint Strategic Needs Assessment for Nottingham and Nottinghamshire, including the increased risk factors amplified by the pandemic. People who took part in the strategy workshops were asked what they will bring back to implement

in the work. It was noted that online content had been directly related to 8 percent of instances. Additionally, many people were not known to services.

- Online harm was an issue and advice was needed for schools, parents and for children themselves. Teams were tackling threats to children by training young people and children in online harms. There was a lot of interest in this training.

- It was acknowledged that language around mental health issues varied between generations.

- A single pathway for mental health and substance abuse had been created. There continued to be challenges within the system currently, yet the Change Grow Live programme had achieved progress, and the Health and Wellbeing Board had an opportunity to continue work in this area.

RESOLVED: 2024/06

1) That the Council's approach to suicide and self-harm prevention be noted.

2) That the feedback provided by members on the draft Nottingham and Nottinghamshire Suicide Prevention and Self-harm Strategy be noted.

3) That members of the Adult Social Care and Public Health Select Committee be encouraged to promote the mental health awareness, self-harm awareness, suicide prevention and suicide bereavement training within their communities, to staff and volunteers working with people across Nottinghamshire.

4) That the Adult Social Care and Public Health Select Committee note their support for the completion of suicide awareness training by councillors becoming mandatory.

6. ADULT SOCIAL CARE AND PUBLIC HEALTH PERFORMANCE, RISKS AND FINANCIAL POSITION – QUARTER 4 2023/24

Consideration was given to a report presented by the Cabinet Member for Adult Social Care and the Cabinet Member for Communities and Public Health and the Corporate Director for Adult Social Care and Health. The report provided an update on the financial position of Adult Social Care and Public Health Services up to quarter four of the 2023/24 municipal year. The Local Account had been shaped through the process of co-production. The Co-Chairs of the co-production group were introduced and thanked for the significant contribution of the co-production group in shaping the Local Account and ensuring the aims were developed in conversation with residents who receive social care support and carers about their needs. The Local Account described the priorities of focus for the year.

The Making it Real Forum also played a part in holding the Council to account for delivery of the priorities selected in the Account. The Co-Chairs of Making it Real spoke on the co-production of the Local Account, ensuring that people who interact with the services understand what services are available and how these are delivered.

Making it Real Co-Chair Marion Wardill noted that the Local Account was designed to be a live, ongoing document and resource that enables people to be more aware of what work was going

on, and how individuals who needed adult social care could contribute to this work. The Co-chairs had been instrumental in to bringing lived experience to the issues raised by the people in conversations around their daily lives. The accountability comes with producing this report. The priorities that had been selected included rapid solutions when there was a problem around equipment use. This required the physios and occupational therapists to work together with the person who required the solution. The work with Carers was also a priority and the importance of conducting reviews with people who are in receipt of support through the services to ensure the goals of wellbeing, independence and quality of life. Working with social workers under the auspices of the principal social worker required significant training, and listening was a vital part of this. Raising the profile of co-production of policy and practice was the purpose of the Making it Real Board, which ensured the ambitions of the local account were being acted upon. 'You said, we did' examples were an effective way to show that the services were meeting the needs.

Making it Real Co-Chair Dean Thomas noted that the Local Account was reviewed every year to provide an opportunity to chart progress and move to address other issues that come up as time goes by. Priorities were Improving two-way communication with between the authority and the people they serve, including in the areas of financial reviews. Direct payments were a way to improve this and make life better for the people who need the service and for staff alike.

The report identified some successes of the Making it Real Forum. The quality of the service was captured in the stories of difference. There had also been strong interest in appointments for training and social engagement. Through these, many people had been supported into employment and skills. For those who wanted this opportunity, this had been done.

In discussion, members raised the following points:

- Gratitude was expressed for the contributions of Co-Chairs Marion and Dean and the Making it Real Forum.

- It was noted that the charts could be designed for viewing in grayscale.

- It was felt to be important that capacity for appointments continued to be assured.

The Chairman noted that a comparison in a year's time would be of interest to members and thanked the Cabinet Members, officers and guests for their contributions.

RESOLVED: 2023/07

1. That the report be noted.

2. That a further report on Adult Social Care and Public Health Performance, Risks and Financial Position be brought to the September 2024 meeting of the Adult Social Care and Public Health Select Committee.

7. WORK PROGRAMME

Consideration was given to an outline programme of scrutiny work for the municipal year 2023/24. Further areas of focus that would be examined from September onwards would be developed in the work programming session which would be scheduled in July.

Members expressed support for the work programme to include the areas that had been discussed today in this meeting.

RESOLVED: 2023/08

1. That the work programme be noted.

2. That the recommissioned Integrated Sexual Health Service be considered for inclusion in the 2024/25 Work Programme.

3. That committee members make any further suggestions for consideration by the Chairman and Vice-Chairman for inclusion on the work programme in consultation with the relevant Cabinet Member(s) and senior officers, subject to the required approval by the Chairman of Overview Committee.

The meeting closed at 12.57 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Adult Social Care and Public Health Select Committee

9 September 2024

Agenda Item:

REPORT OF THE CABINET MEMBER, COMMUNITIES AND PUBLIC HEALTH

NOTTINGHAMSHIRE HEALTHY FAMILIES PROGRAMME: LONG-TERM DELIVERY

Purpose of the Report

1. To consider the options available to the Council to ensure delivery of the Nottinghamshire Healthy Families Programme beyond 30 September 2025.

2. To seek engagement from Select Committee and invite feedback on the emerging preferred option for the long-term delivery of the Nottinghamshire Healthy Families Programme, to ensure children and young people in Nottinghamshire are supported to have the best start in life.

3. To set out plans to commence soft market testing.

Information

4. The Nottinghamshire Healthy Families Programme (HFP) is a public health nursing service that supports families to provide their children with the best start in life through a range of nursing and health interventions. The service promotes early intervention by identifying and delivering targeted support to families in need. Critical to identifying opportunities to support families is the programme of health and development reviews by public health nurses. As nursing professionals, they provide guidance which is relevant and effective in supporting child development, parenting, and healthy choices. Nottinghamshire Healthcare NHS Foundation Trust is the current provider of the Nottinghamshire HFP.

5. On 8 May 2024, the Cabinet Member for Communities and Public Health took a key decision to extend the Council's contract with Nottinghamshire Healthcare NHS Foundation Trust (NHFT) for delivery of the Nottinghamshire Healthy Families Programme (HFP) until 30th September 2025. The extension was approved to give the Council time to take into account the Care Quality Commission (and any other regulatory bodies) actions and recommendations relating to NHFT, and to consider the best way of delivering the Nottinghamshire HFP in the future. This was to include undertaking a full and thorough appraisal of all re-commissioning/procurement options that are available to the Council.

6. This report presents the options available to the Council for delivery of the Nottinghamshire HFP beyond 30th September 2025, and invites feedback on these options, ahead of a Cabinet key decision.

Statutory responsibilities

7. Local Authorities have a statutory responsibility, under the Health and Social Care Act of 2012, to provide public health nursing services to their local population of children, young people, and families, including the Healthy Child Programme (HCP) and the National Child Measurement Programme which weighs and measures children in school. More specifically, as part of the HCP, five universal health visitor reviews, from late pregnancy to age 2.5 years, are mandated for delivery. The Nottinghamshire HFP is the local delivery mechanism for these responsibilities.

The current Nottinghamshire Healthy Families Programme

8. A key role of the Nottinghamshire HFP is to identify children with specific health and care needs and risks and ensure these families receive targeted, personalised care at the earliest opportunity to prevent escalation to other services. The Nottinghamshire HFP works in partnership with a wide range of services as part of a joined-up health, social care, and early year's system to build resilience in families. The Nottinghamshire HFP are uniquely placed to intervene early, building therapeutic relationships to prevent issues escalating by identifying and supporting families in need. The Nottinghamshire HFP deliver preventative and early help work to reduce the need for specialist interventions from a range of health and social care services.

9. The Nottinghamshire HFP consistently performs well for delivery of the mandated health visitor reviews when compared to both the England average and statistical comparators.

10. The Nottinghamshire HFP is a core delivery partner in the multi-agency Family Hub Networks. This means that the Nottinghamshire HFP:
    - Supports the development of an enhanced 'front door' and 'Early Help' operating environment,
    - Plays a key role in connecting families to information, support, and services via Family Hub networks,
    - Actively engages in Family Hub development work and governance forums at all levels,
    - Are core members of Family Hub allocation meetings,
    - Shares and receives relevant information about the individual needs of children, young people, and families with Family Hub partners,
    - Integrates engagement and co-production activity within Family Hubs to ensure this is developed and delivered in partnership,
    - Co-ordinates the provision of information and advice including national and local campaigns with Family Hub networks. The Nottinghamshire HFP digital offer will be aligned with the Virtual Family Hub,
    - Participates in the Family Hub network workforce development matrix to best share knowledge and skills including delivering relevant knowledge and skills exchange.

11. Ensuring that the Nottinghamshire HFP is fully integrated with the delivery of Family Hubs Networks is (and will continue to be) a priority area of focus in the delivery of the Nottinghamshire HFP.

12. The service model also includes two-way referral pathways between the Nottinghamshire HFP and NHS organisations at a place level, including, but not limited to:
    - General Practices
    - Hospital paediatric, urgent care and emergency departments
    - Maternity and neonatal services
    - School aged immunisation and child health information system services commissioned by NHS England
    - Public health services commissioned from NHS, independent and voluntary sector services, such as for domestic abuse, integrated health and wellbeing, sexual health, oral health, and substance use services.

13. A culture of partnership and multi-agency working is now embedded across the service model, meaning that the Nottinghamshire HFP works in close partnership with a wide range of children's and family services at a place-based level. That will remain the case in the future, and these requirements are considered in detail within the options appraisal for the long-term delivery of the Nottinghamshire HFP.

Service design and development activity, and enhanced scrutiny

14. A programme of service design and development activity was undertaken over 2023-24, in partnership with colleagues from NHFT and the wider system, to refresh the service model for the Nottinghamshire HFP, including:
    - A programme of engagement/co-production with children, young people and families, policy leads across public health and children's services, and with system partner organisations,
    - Joint work with the Council's Children and Families' services to further explore opportunities to strengthen or integrate early support for families,
    - A review of the evidence base and policy guidance and development of a new service specification, along with revised key performance indicators, outcome measures and quality monitoring requirements,
    - Work to ensure the current contract was sufficiently robust, while reflecting the intention that the service would be subject to ongoing transformation and change in light of best available evidence at the time,
    - Work to ensure the Nottinghamshire HFP addresses the need for close integration with the Council's early help offer,
    - Work to assess the potential equalities impact of the Nottinghamshire HFP and the revised service model on people with protected characteristics,
    - Consultation with stakeholders.

15. In response to the 'rapid review' of mental healthcare provision at NHFT by the Care Quality Commission (CQC), the current contract with NHFT has been changed to establish greater quality assurance during the contract extension period. These arrangements include further performance management and quality assurance mechanisms, delivery of financial scrutiny through the continuation of open book accounting arrangements, and appropriate changes to the contractual arrangements to facilitate the management of any contractual issues that could

arise from the outcome of the 'rapid review' Section 48 inspection. These enhanced contractual levers and arrangements will carry forward into the new contract for delivery of the Nottinghamshire HFP, to enable continued performance and quality assurance.

16. The ambition for the future of the Nottinghamshire HFP is to improve outcomes for children, young people, and families by maintaining positive performance, working as part of an integrated early help system, and continually improving and transforming the service in line with evidence and best practice.

Member scrutiny of the Nottinghamshire HFP

17. A joint scrutiny working group was established by Overview Committee on 7th September 2023 to examine the design of the refreshed Nottinghamshire HFP and inform a series of recommendations. All recommendations made by Overview Committee were accepted, and proposed actions against each recommendation were agreed by Cabinet on 28th March 2024. Adult Social Care and Health Select Committee are now invited to feedback on the proposed options for the procurement approach to the Nottinghamshire HFP after 30th September 2025, rather than the service model/ specification.

18. On 17th April 2024, Members of Overview Committee and the joint scrutiny working group were briefed on the current position and the planned next steps in relation to the delivery of the Nottinghamshire HFP.

Options Appraisal

19. An extensive assessment of the available options for the long-term delivery of the Nottinghamshire HFP has been carried out. This supersedes the previous appraisal that reported to Cabinet in June 2023. It reflects the current landscape including the new Health Care Service (Provider Selection Regime) regulations that were introduced in late 2023 which the Council must adhere to. This removed the procurement of health care services from the scope of the Public Contracts Regulations 2015, and has replaced the National Health Service (Procurement, Patient Choice, and Competition) No 2 Regulations 2013, both of which were in place when the options were previously considered.

20. The appraisal reviews the options of service delivery (i.e. how the service is delivered) and procurement, rather than options for the model of the service (i.e. what is delivered). It is assumed that the service model for the Nottinghamshire HFP will reflect the model that underwent consultation with members of the public and Elected Members via Overview Committee.

21. To inform the options appraisal, evidence was obtained about methods of delivery of the Healthy Child Programme across the country. Ten other local authorities, who are using a variety of delivery methods for their Healthy Child Programme, were then consulted during May and June 2024. HR, finance, legal, and procurement departments across the Council were also consulted regarding the practicality and feasibility of each option. From an initial longlist of options, a finalised shortlist was developed in conjunction with legal and procurement colleagues.

22. A summary of the options is provided below, and further detail can be found in the full options appraisal contained in Appendix 1.

23. **Option 1A: Procure via competitive tender - tender a single, integrated service for 0-19's**
This option describes a competitive tender process that invites bidders to tender for the delivery of the full Nottinghamshire HFP, with bids evaluated against a set of fixed criteria. All services would be delivered under a single contract. Soft market testing would be conducted to engage with potential providers as per best practice. The soft market testing would begin ahead of Cabinet's key decision in November in order to maintain momentum given the challenging timescales. Cabinet would still fully consider all options. The provider that is successful in the process would be awarded a contract for a defined period.

24. **Option 1B: Procure via competitive tender - tender the service as separate lots**
This option describes dividing the currently integrated Nottinghamshire HFP into component parts or 'lots'. Each lot would have a competitive tender process that invites bidders to tender for the delivery of that lot. The appraisal considers two ways that the service could be split into separate lots aligned to the Healthy Child Programme: (i) services for 0-5 years are delivered in one lot, whilst services for 5-19's could be delivered in another lot, or (ii) services for 0-11's are delivered in one lot, whilst services for 11-19's are delivered in another lot. This may result in multiple providers delivering the Nottinghamshire HFP. The provider(s) that are successful in the process would be awarded a contract for a defined period.

25. **Option 2: Award the contract via the Provider Selection Regime most suitable provider process**
The most suitable provider selection process provides a robust and transparent process through which the Council, when commissioning healthcare services, can assess which provider is most suitable to deliver the proposed contracting arrangements. This is based on consideration of key criteria defined under the Provider Selection Regime. This approach can only be used if the Council is confident that it can, acting reasonably, clearly identify all likely providers capable of providing the service. Following robust assessment of all likely providers, the successful provider would be awarded a contract for a defined period. This includes the potential for a short contract term.

26. **Option 3: Provide the 0-19 Healthy Families Programme from within the Council (whole service**)
This option describes transferring the full Nottinghamshire HFP 'in house', to be provided directly by Nottinghamshire County Council (NCC). This option would not require a procurement exercise. Instead, in addition to the thorough process carried out for this options appraisal, there would need to be more work carried out into the detail of feasibility and deliverability to enable a robustly informed decision to be made. The process would include setting up a multidisciplinary project management team including HR, Legal, Governance, Asset Management, and IT, and would require external consultancy support with experience in in-sourcing. This team would oversee the further detailed feasibility work and, if a decision was taken to in-source, would oversee the transition of the service from the incumbent provider into direct local authority control.

27. **Option 4A: Split the service, providing elements in-house with others provided externally (0-5 provided externally, 5-19 provided in-house)**
This option explores the division of the Nottinghamshire HFP into two services, to be delivered by two mechanisms. The 0-5 element would be delivered by an external provider. This consists of the health visiting service, provision of 5 mandated reviews, an early intervention

offer, and the Family Nurse Partnership. For the 0-5 element, this would require a decision to be made between competitive procurement (Option 1A) or the Provider Selection Regime most suitable provider process (Option 1B). The 5-19 element of the Nottinghamshire HFP would be transferred 'in house', including the delivery of school nursing services and the national child measurement programme. These elements would be provided directly by NCC. Dissolution of the current approach, which integrates provision across the 0-19 age range, and has been in place since 2017 will require additional work to separate and align the new service. The process of moving the 5-19 element in-house would require project management and external consultancy support with experience in in-sourcing, though to a lesser extent than Option 3.

28. **Option 4B: Split the service, providing elements in-house with others externally (0-11 provided externally, 11-19 provided in-house)**
This option also explores the division of the Nottinghamshire HFP into two services, to be delivered by two mechanisms. The 0-11 element would be delivered by an external provider. For the 0-11 element, this would also require a decision to be made between competitive procurement (Option 1A) or the Provider Selection Regime most suitable provider process (Option 1B). The 11-19 element, which is primarily the delivery of secondary school nursing services, would be delivered in-house. These elements would be provided directly by NCC. Dissolution of the current approach, which integrates provision across the 0-19 age range, and has been in place since 2017 will require additional work to separate and align the new service. The process of moving the 5-19 element in-house would require external consultancy support with experience in in-sourcing, though to a lesser extent than both Option 3 and Option 4A.

29. In the options appraisal, each option describes key features of the model with respect to service delivery, financial impact, implementation timescales, workforce and HR, clinical governance arrangements, safeguarding procedures and additional considerations including risk to the Council, estates, and information technology. A 'SWOT' analysis of each options' respective strengths, weakness, opportunities, and threats has been carried out.

30. A robust scoring framework was developed comprising of a set of 12 criterion grouped into three themes: desirability, viability, and feasibility. Each option was independently scored against the 12 criteria on a scale of 0 to 3 (0 = unsatisfactory, 1 = some concerns, 2 = acceptable, and 3 = good) by the options appraisals' authors, a separate and impartial colleague within Public Health, and a colleague from the Children and Families directorate. The scoring criteria was developed and agreed with input from public health, legal and procurement departments.

31. As set out above, the options have been scored against the three themes of desirability, viability, and feasibility:
    - **Desirability**: the extent to which the option aligns with NCC preferences for the HFP, which includes improved outcomes for service users, integration with NCC services, integration with local NHS services, and flexibility to respond to change.
    - **Viability**: the ability of the option to work successfully which includes, short- and medium-term financial impact, workforce recruitment and retention and reputational risk.
    - **Feasibility:** the extent to which the option can be accomplished successfully which includes implementation timescales, safeguarding procedures, clinical governance and CQC arrangements, and considerations around estates and IT.

32. Based on the overall score from the agreed criteria, options 1A: Competitive tender of a single, integrated service and option 2: Most Suitable Provider, emerge as the preferred approaches.

33. It is acknowledged that all options come with strengths, weaknesses, opportunities, and threats. Undertaking a competitive tender process for a single, integrated service (option 1A) would provide assurance that the market has been fully assessed via a well-recognised and transparent process. It would enable an objective assessment of potential providers' ability to deliver a service that is integrated with both the wider Council's early help system and the relevant NHS services.

34. A competitive tender process for a single, integrated service would fulfil the Council's requirements in that it enables flexibility for the service to adapt or respond to changing need, new opportunities and/or emerging evidence, in agreement with the Council as commissioners. A competitive process allows authorities to engage in dialogue or negotiate with providers who have bid for the contract prior to awarding the contract, with a view to improving on an initial offer. This process could also include the development of consortia arrangements (where two or more suppliers come together to bid for the contract). Additionally, a dialogue process could be used to consider exploration of new models of shared service ownership, governance or partnership.

35. There is a risk that, under the Most Suitable Provider process (option 2), the Council may be unable to identify a 'most suitable provider', and in that case a competitive tender process would be required. The timescales do not allow for this. Options which would involve bringing the service (or elements of it) in-house (options 3, 4A and 4B would be very challenging to achieve in the timescales required and are likely to present increased risks to workforce recruitment and retention. Finally, options which involve splitting the service (options 1B, 4A and 4B) would present additional challenges for integration and safeguarding. Therefore, a competitive tender process for a single, integrated service (option 1A) is likely to emerge as the preferred approach.

36. Further detail on the development of the options appraisal, its' methodology, the relative strengths, weakness, opportunities and threats of each option, and the final scores can be found in the full appraisal contained in Appendix 1.

Other Options Considered

37. All viable options are laid out in paragraphs 23 to 28. Further detail on the options considered, including detail of the longlist of options not taken forward for detailed analysis, and the rationale for this, can be found in Appendix 1.

Reasons for Recommendations

38. To enable scrutiny regarding the available options for the procurement approach of the Nottinghamshire HFP before the development of a recommendation to the Cabinet.

Statutory and Policy Implications

39. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human

rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability, and the environment 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

40. The contract value is £15,473,968 per annum. It is likely to be proposed that a contract of 3 + 2 years would be awarded, bringing the total maximum contract length to five years. The annual financial envelope is based on the funding that is needed to ensure that the Council can fulfil its statutory responsibility to provide public health nursing services, including the Healthy Child Programme and the National Child Measurement Programme.

41. The options appraisal includes an assessment of the financial impact of each potential option across the short term (0 to 2 years): the ability of the service to remain within the agreed financial enveloped, and the medium to long-term (2 plus years): the ability of the service to remain within the agreed financial envelope with the possibility of increasing efficiencies, in line with the Council's medium term financial strategy, whilst maximising outcomes. Further detail can be found in Appendix 1.

Public Sector Equality Duty implications

42. The equality implications of the Nottinghamshire HFP's service model have been considered and no adverse impacts identified. The protected characteristics most impacted by the Nottinghamshire HFP as a whole are pregnancy and maternity, gender, and disability (mental and learning disabilities). The Nottinghamshire HFP will include dedicated support for families during pregnancy, support for the non-birthing parent, regardless of gender as well as additional support for families experiencing parental mental ill-health and/or learning disability. This element of the service will have a positive impact on these protected characteristics.

43. In summary, delivery of the Nottinghamshire HFP is not considered likely to have either disproportionate or negative impacts on individuals with protected characteristics. The equality implications of the likely procurement approach are also being reviewed in order to inform any decision that Cabinet may take.

Safeguarding of Children and Adults at Risk Implications

44. Safeguarding children is a core statutory responsibility of all Local Authorities, and the Nottinghamshire HFP supports the Council to fulfil this statutory duty. The Nottinghamshire HFP plays an important role in the identification of families in need of additional support, and in identifying children who are at risk of harm.

45. The options appraisal includes an assessment of the safeguarding impact of each potential option, that is the ability of the service to deliver effective safeguarding activity and work as part of a wider, multidisciplinary, multi-agency network to help promote the welfare and safety of children and young people.

46. The Nottinghamshire HFP will continue to work as part of a wider, multidisciplinary, multi-agency network to help promote the welfare and safety of children and young people,

supported by pathways between the Nottinghamshire HFP, children's social care and the Multi-Agency Safeguarding Hub that will support the delivery of effective safeguarding activity.

Implications for Residents

47. The overall aim is of the options appraisal is that the Council delivers the Nottinghamshire HFP in a way that best supports parents and carers to give children the best start in life, keeping children healthy and safe, and enabling them to reach their full potential. The aim is that the service is provided in a way that achieves the best outcomes for children and families. The thorough assessment of desirability, viability, and feasibility undertaken aims to ensure that children, young people, and families continue to receive a high-quality service from the Nottinghamshire HFP after 30th September 2025.

RECOMMENDATION/S

It is recommended that:

1. The report detailing the options appraisal undertaken for the delivery of the Nottinghamshire HFP be received.

2. Members comment and consider if there is any feedback they would like to give, in advance of a Cabinet key decision, on the options appraisal that has been undertaken and the plan to commence soft market testing.

COUNCILLOR SCOTT CARLTON
CABINET MEMBER – COMMUNITIES AND PUBLIC HEALTH

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Constitutional Comments (SF 30/07/2024)

The Adult Social Care and Public Health Select Committee is the appropriate body to consider the content of the report.

Financial Comments (PAA29 09/08/2024)

The financial implications are set out in paragraphs 40 and 41. The contract value for the Healthy Families Programme from 1 October 2024 to 30 September 2025 is £15,473,968 and will be met from the Public Health Grant which for 2024/25 is £45,465,627.

The cost of the Healthy Families Programme once the preferred option has been agreed (including any inflationary increases) will be met by Public Health Grant and Public Health Grant Reserves.

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 Cabinet – Nottinghamshire Healthy Families Programme 2024 and beyond dated 9 March 2023 (published), which had as background papers the following:
    - Healthy Child Programme 0 to 19: health visitor and school nurse commissioning (commissioner guidance), Public Health England, 2016 (updated March 2021), available here.
    - Nottinghamshire's Best Start Strategy, 2015-25, available here.
    - The Best Start for Life, a vision for the critical 1,001 days, HM Government, 2021, available here.
- Report to Cabinet - Outcome of Call-in decision – Nottinghamshire Healthy families Programme – 2024 and beyond dated 20 April 2024 (published)
- Report to Cabinet - Nottinghamshire Healthy Families Programme 2024 and beyond – consideration of call-in outcome dated 20 April 2023 (published).
- Report to Cabinet – Nottinghamshire Healthy families Programme – 2024 and beyond dated 22 June 2023 (published)
- Report to Overview Committee – Outcomes of the Joint Scrutiny Review of the Recommissioned Healthy Families Programme dated 25 January 2024 (published)
- Report to Cabinet – Nottinghamshire Healthy Families Programme dated 28th March 2024(published)
- Report to Cabinet Member for Communities and Public Health – Nottinghamshire Healthy Families Programme dated 8th May 2024(published)

Electoral Division(s) and Member(s) Affected

- All

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

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

July 2024

Contents

1.0. Introduction

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

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

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

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

1.4. Aim

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

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

2.0. Background

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

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

2.3. Commissioning Context

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

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

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

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

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

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

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

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

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

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

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

3.0. Evidence

What is delivered.

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

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

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

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

How the service is delivered.

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

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

4.0 Methodology

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

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

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

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

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

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

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

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

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

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

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

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

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

5.0. Options considered

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

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

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

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

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

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

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

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

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

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

Section A: Brief description of the option

Section B: Key features

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

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

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

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

Table 1: Criteria that each option will be scored against

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

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

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

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

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

Section A: Summary

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

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

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

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

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

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

Section B: Key Features

Service delivery

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

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

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

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

Financial impact

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

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

Implementation timescales

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

Workforce and HR

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

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

Clinical governance and CQC arrangements

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

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

Safeguarding procedures

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

Additional considerations (including reputational risk, estates, IT)

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

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

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

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

Procurement features

The contract would be awarded to a single provider.

Legal features

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

Section C: SWOT Analysis

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

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

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

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

Section A: Summary

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

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

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

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

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

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

Section B: Key Features

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

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

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

Financial impact

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

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

Implementation timescales

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

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

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

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

Section C: SWOT Analysis

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

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

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

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

Section A: Summary

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

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

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

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

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

Section B: Key Features

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

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

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

Financial impact

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

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

Implementation timescales

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

Workforce and HR

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

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

Clinical governance and CQC arrangements

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

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

Safeguarding procedures

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

Additional considerations (including reputational risk, estates, IT)

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

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

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

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

Section C: SWOT Analysis

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

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

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

Section A: Summary

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

Section B: Key Features

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

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

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

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

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

Financial impact

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

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

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

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

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

Implementation timescales

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

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

Workforce and HR

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

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

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

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

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

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

Clinical governance and CQC arrangements

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

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

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

Safeguarding procedures

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

Additional considerations (including reputational risk, estates, IT)

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

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

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

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

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

Section C: SWOT Analysis

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

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

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

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

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

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

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

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

Section A: Summary

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

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

Or

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

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

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

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

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

Section B: Key Features

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

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

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

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

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

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

Financial impact

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

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

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

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

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

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

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

Implementation timescales

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

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

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

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

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

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

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

Workforce and HR

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

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

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

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

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

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

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

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

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

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

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

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

Procurement features

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

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

Legal features

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

Section C: SWOT Analysis

Strengths	Weaknesses

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

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

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

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

Section A: Summary

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

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

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

    Or

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

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

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

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

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

Section B: Key Features

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

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

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

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

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

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

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

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

Implementation timescales

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

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

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

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

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

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

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

Workforce and HR

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

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

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

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

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

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

Clinical governance and CQC arrangements

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

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

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

Safeguarding procedures

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

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

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

Additional considerations (including reputational risk, estates, IT)

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

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

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

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

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

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

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

Section C: SWOT Analysis

Strengths	Weaknesses

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

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

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

5.5. Overview of options against criteria.

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

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

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

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

The table below illustrates the average score for each option.

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

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

6.0. Conclusions and recommendations

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

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

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

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

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

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

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

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

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Nottinghamshire County Council

Report to Adult Social Care and Public Health Select Committee

9 September 2024

Agenda Item:

REPORT OF THE CABINET MEMBER FOR ADULT SOCIAL CARE

ADULT SOCIAL CARE AND HEALTH PERFORMANCE, RISKS AND FINANCIAL POSITION – QUARTER 1 2024/25

Purpose of the Report

1. To provide the Committee with a summary of Adult Social Care and Health's performance against the priorities set out in the Local Account.

2. To provide the Committee with a summary of Adult Social Care and Health's Vital Signs and key departmental risks.

3. To provide the Committee with a summary of Adult Social Care and Health's financial position as at Period 3 2024/25.

Information

Performance against the priorities set out in the Local Account

4. The Local Account is the department's Adult Social Care Strategy for 2024/25. It is a one-year report and will be refreshed in 2025. It is structured around the six Making It Real themes and each theme has several identified priorities. The Local Account has been co-designed with the Our Voice co-production group and the 21 priorities draw on what local people said was important to them in the Big Conversation held in 2023. This report provides an update on progress against these priorities in the first quarter of 2024/25.

Making It Real Theme 1: Wellbeing and Independence

5. The **Strengths-Based Approach** (SBA) is being used to support a more person-centred and empowering form of social care in Nottinghamshire and this continues to be embedded across the department, led by the SBA team. Conversations have started with external providers to support this culture shift and the Reviews Strategy is being updated with a focus on SBA reviews. The approach is being used in the joint funded review work with Health and it has been one of the key principles underpinning the Adult Social Care Redesign.

6. New prioritisation guidance for community teams has been introduced to address **waiting times**, and regional work with the East Midlands Association of Directors of Adult Social Services (ADASS) is providing 'waiting well' toolkits for staff and citizens. The Adult Social Care redesign aims to use staffing resources more flexibly to reduce waiting times, and

some areas are implementing Social Care Clinics for people and carers to build on community connections. The possibility of self-serve assessments and review is being explored.

Story of Difference: Collaboration with partners

Mr B is an 83-year-old man living alone in the community. There is evidence of cognitive decline and confusion. His property was in a poor state, no cooking facilities, no heating and evidence of self-neglect and neglect of the home.

Ageing Well Bassetlaw worked with Mr B to arrange a mobile phone, deep clean, repairs, key safe and a package of support. New electric heaters from Bassetlaw Action Centre and warm/thermal clothing were provided. Joint work was undertaken with Environmental Health to address issues with heating. Meals at home service was arranged.

The Social Worker worked collaboratively with Mr B and partner agencies to support him to reduce and mitigate risks and enable him to remain in own home.

7. To increase **local housing options** a cross-cutting housing strategy group has been established, and a workshop specifically looking at options for mental health services has been arranged with colleagues from the Integrated Care System, Mental Health services and local district councils. Market engagement events have also taken place to explore more general supported housing solutions. Additionally, a joint post with Health has been successful in transitioning individuals from secure settings into the community. Research with other local authorities has been conducted to understand different approaches, and Housing with Support may become a part of the upcoming tender for Care and Support Services.

Performance Measure: Long term care	2023/24 Actual	Apr 2024	May 2024	June 2024	2024/25 target	Red/ Amber / Green (RAG) status
% people who receive long term support who live in their home or with family (18-64 year olds	76.9%	76.8%	77.0%	77.0%	78%	**Green**
Number of older adults aged 65 and over supported in residential or nursing placements	2,235	2,255	2,234	2,207	2,135	**Amber**

8. The use of **Technology Enabled Care (TEC)** has been promoted to support people's independence at home, resulting in a 39% increase in referrals since the launch of the TEC Strategy in March 2024. Additionally, the development of the Disabled Facilities Grant policy with District and Borough Councils is underway to further support home adaptations.

9. To enable **better collaboration in supporting emotional and mental health** and wellbeing, the Improving Lives portfolio has been developed. This brings together mental health-focused teams and services for more coordinated and responsive support. The department continues to work with the Integrated Care Board (ICB), Nottinghamshire Healthcare Foundation Trust (NHFT) and experts by experience to transform NHS mental health services delivery. Work is also ongoing with Public Health colleagues to develop a Joint Strategic Needs Analysis for adult mental health. The first cohort of participants has now completed the Think Ahead fast track programme for mental health social workers. The evaluation of the Making Every Adult Matter programme is in progress to help inform future commitments.

Story of Difference: Making Every Adult Matter (MEAM) Project

'Pam', a woman experiencing domestic abuse and homelessness was heavily pregnant with her third child and Children's Social Care expected that the child would need to be removed. Her outcome has been very different thanks to the heroic efforts of the team to establish a relationship and advocate for Pam, along with brilliant championing of MEAM and strong advocacy with Office for Health Improvement and Disparities (OHID) and Department for Levelling Up, Housing and Communities (DLUHC) to push them to fund something not on their 'menu of interventions'. The MEAM team are gaining some amazing insight and learning for the system as well as making life changing interventions in individuals' lives.

"You have given Pam a chance at life she wouldn't have had …. I hope the project expands…it's been invaluable for better outcomes [for] Pam and all vulnerable adults and thus positive impacting their children too."

Compliment from Children's Social Worker

Making It Real Theme 2: Information and Advice

10. To ensure people have **accessible information to support well informed decisions** about their care and support, the department has been working with corporate colleagues to improve the Council's website, including developing Easy Read versions of online content. The Notts Help Yourself platform is being updated and a new platform is expected by March 2025, which should offer significant improvements. Following the implementation of the Carers Strategy last year, there has been a 17% reduction in Carers needing a full assessment due to better early-stage advice. British Sign Language videos and a Deaf advocate have been introduced to improve communication for the Deaf community.

11. To meet our aim of providing accurate, timely, and transparent **information on finances and benefits** a Group Manager has been appointed to the new Financial Services and Operational Services portfolio, with a key objective to review this service area and recommend future improvements.

12. The department continues to work closely with the Customer Services Centre to promote it as the main telephone access point, while also providing an online form for digital contact, so that people know **how to get in touch with us**. There has been a particular focus in the past quarter with carers, promoting greater awareness of the Carers Hub as part of the implementation of the Carers Strategy.

Story of Difference: Compliment for Newark and Sherwood Social Worker

"I understand you are Gail's manager, I just wanted to drop an email explaining how brilliant Gail has been during a really difficult time for us personally with my wife's ill health.

She has been dealing with a complex issue with our family and unfortunately, we still haven't been able to find a solution yet, but during the whole process Gail has been brilliant, always replying to emails, professional but also friendly when out to visit us. Helpful and caring, she just genuinely made a really bad situation that bit more bearable knowing someone is actually trying to help. People often complain when they are not happy, but I don't think enough people show appreciation when things are done well so I just wanted her manager to be aware of the brilliant work she tried to do for us."

13. People can **share information with us** over the phone via the Customer Services Centre and the Emergency Duty Team, or digitally through an online form. Following feedback from the Big Conversation, a project has been initiated to explore the use of Social Circles to enable people to engage with staff face-to-face in a community setting. The department is also working on introducing an online self-assessment of care needs. Contracts are in place with Signvideo and Nottinghamshire Deaf Society to provide communication support for the Deaf community.

Making It Real Theme 3: Active and Supportive Communities

14. In 2023/24, there was a 48% increase in the number of people supported to engage in further **education, employment or volunteering**, from 363 to 756, with an even higher target set for 2024/25. A review of the departmental approach is planned for later in the year, which will align with the corporate employment and health strategy.

Performance Measure: Employment and training	2023/24 Actual	Apr 2024	May 2024	June 2024	2024/25 target	RAG status
Number of adults aged 18-64 supported to access employment, education, training or volunteering	756	591	613	632	800	**Green**

15. The new model for Day Opportunities provided by the Council includes the development of Community Hubs, which will **help people access mainstream or supported activities in their local area**, developing links and sharing resources with local community and voluntary sector services. These hubs will also serve as a 'One Stop Shop' for information

about local services and provide support hubs for informal carers, offering information and peer support.

16. The department has not yet scoped the work to **improve transport options to support connections** with family, friends and the things that matter to people. However, as part of this it plans to develop greater access to appropriate and accessible transport options and increase opportunities for people to learn to travel independently.

Story of Difference: Lancaster Grange Care Home

As part of community engagement at Lancaster Grange, Flying Officer Dave visits residents every month, building a friendship. Many of our residents like to chat and reminisce having served in the RAF or Armed Forces themselves.

To our surprise and pleasure, Dave invited residents for a VIP tour of RAF Syerston, visiting the glider hangars and having lunch in the mess. Flt Lt Annabel, a glider instructor, shared her experiences of flying with our resident Keith, who also used to fly his own plane.

Keith started his career by joining the RAF as a young man and aeronautics became a lifelong interest and passion. His career developed into engineering and designing airports around the UK.

Our visit was arranged to fall on Keith's birthday but had to be cancelled at the last moment due to poor weather conditions. Keith was elated when we finally were able to visit RAF Syerston, connecting with Flt Lt Annabel as both Keith and she owned the same aeroplane.

At the time we didn't know that this would be his final trip out and Keith passed away peacefully less than a week after his visit. We felt that he had been waiting for this last moment to be reunited with his beloved passion for flight.

Making It Real Theme 4: Flexible and Integrated Care and Support

17. To **improve reviews**, some areas have been using Social Care Clinics for people and carers to build on community connections. The Reviews Strategy is being updated with a focus on Strength-Based Approach reviews and the department is exploring the potential for self-serve assessments and reviews. A Strengths-Based Approach has also been taken with the ongoing joint funded reviews work with Health.

Performance Measure: Reviews	2023/24 Actual	Apr 2024	May 2024	June 2024	2024/25 target	RAG status
% reviews of people (in receipt of services for 12 months) who have received a review in the last 12 months	79.2%	77.4%	77.7%	77.3%	100%	**Red**

18. The **Direct Payments** Team continues to work with operational teams to share good practice and promote Direct Payments. A plan has been coproduced for a new Direct Payments Working Group. This group will help to implement a Direct Payment Support Network and identify other areas for further coproduction such as rewriting the Direct Payment Policy and staff guidance.

Performance Measure: Direct Payments	2023/24 Actual	Apr 2024	May 2024	June 2024	2024/25 target	RAG status
Proportion of adults receiving direct payments	39.8%	39.5%	39.4%	39.3%	42.0%	**Amber**

19. Consultation has taken place to develop a new model of **short breaks provision** delivered by the Council, alongside other short breaks developments being delivered as part of the Carers Strategy. The next step is to further consult on a proposed new model in the coming months.

Making It Real Theme 5: When Things Need to Change

20. The new Adult Social Care redesign provides a new service offer which will enable the department to use staffing resources more flexibly to increase r**esponsiveness in a crisis**. Accessible information is provided by Community Teams when people need it, for example during a significant life change and this includes Occupational Therapy input and equipment.

Story of Difference: Mavis' story following an emergency move of care home

Mavis was admitted to hospital due to severe mental health issues. She moved into a residential care home when she left. Multiple safeguarding concerns were raised about her (and others') care there, including weeks without her pain patches.

Due to the ongoing level of safeguarding risk, a decision was taken to move everyone out of this care home. When the Mansfield team met Mavis she had no underwear on, was crying, distressed, in significant pain, and frightened of her environment and those around her.

Since moving to a new home, she is back to her old self; happy, smiling and with great relationships with all those around her. Living her best life which includes going on outings, feeding the ducks, reminiscing about her farm and singing.

21. The department has achieved a good level of performance in **supporting people to learn or regain skills after being unwell** - reablement completions are at 98.8% and enablement completions at 130% of 2024/25 targets at the end of May 2024. Further work is underway to review capacity against demand and there is engagement with NHS partners on the wider Pathway 1 modelling. Pathway 1 is one of the four pathways under the discharge to assess model and relates to hospital discharges home or to a usual place of residence with new or additional health and/or social care needs.

Performance Measure: Hospital Discharge	2023/24 Actual	Apr 2024	May 2024	June 2024	2024/25 target	RAG status
Average number of days between Hub decision and Discharge (Social Care supported discharges)	2.7	2.2	1.8	1.8	2	**Green**

22. To support young people in **preparing for adulthood** the department has updated the Information, Advice and Guidance Document for young people and their families, increased staffing within the Preparing for Adulthood team, increased Promoting Independence resources for young people and improved links with schools to provide a more consistent approach to information sharing, prevention and support.

Making It Real Theme 6: Workforce

23. To **recruit colleagues who have the right skills, values and behaviours** the department is developing a workforce academy, including an increased apprenticeship opportunity. The recruitment systems are also being developed to ensure value-based recruitment and access through different channels such as Indeed. To support the external social care workforce, an external workforce learning and celebration event is being planned for November 2024 and a grant has been securely from the Rayne Foundation to develop an online platform to support social care career progression. Skills for Care have completed a deep dive into the social care workforce in Nottinghamshire and this has helped give a better understanding of the local workforce, with new priorities established.

24. To **support colleagues and streamline ways of working**, the new 'all age' and place-based service offer is being implemented. This includes co-designed community social work and therapy teams, more consistent approaches to conversations with people, professional supervision for regulated staff (Occupational Therapy and Social Work), responding to feedback, learning from compliments and complaints and undertaking regular quality assurance audits. The department has also implemented the new organisation-wide approach to Employee Performance and Development Review (EPDR) and supervision.

Story of Difference: Mental Health Support

"This is going to sound so dramatic, but Connie saved my life. I had written each of my family members a goodbye letter, got all my finances in order and was at peace with ending my life. I convinced myself I had tried everything! Connie rang to offer me a stay at Lombard, I sat and thought about it…. I told myself that if the offer was on the table, then I can't say I have tried everything; I owe it to my children to try everything. I moved into Lombard 2 days later, without them and without Connie I wouldn't be here."

M's quality of life and mood significantly improved during her support with both Lombard Street supported living and Nottingham Community Housing Association, as well as her re-gaining some of her independence and improvement with managing anxiety in the community. She began re-developing relationships with friends and family that she had

cut off for a significant period and re-developing parent-child relationships with her children.

M is a massive credit to herself and her journey shows what having the right support can achieve. M will soon to be stepping down from intensive mental health support to generalised support from the Maximising Independence Service due to the significant improvements made with her mood and wellbeing to continue the progress she's made and is currently on track to return to her job.

25. To provide **equal opportunities for all colleagues**, the department has developed the career pathway across adult social care, increased the apprenticeship offer and reviewed the Talent Management approach. Training and development opportunities are being reviewed as part of the workforce redesign to ensure that colleagues maintain the necessary skills to support people. A number of colleagues have accessed the Black and Asian Leadership Initiative (BALI) programme to explore and overcome barriers facing aspiring Global Majority leaders. The organisation's EPDR, supervision and flexible working processes continue to emphasise the importance of equity and inclusivity.

26. To **support our external providers to work co-productively**, an external provider engagement plan has been co-produced. The department engages with providers through weekly bulletins and regular development events such as the Mental Health Support Pathway which brings together providers, colleagues and people who draw on care and support. Conversations have also begun with providers to drive the Strengths-Based Approach culture shift externally.

Performance Measure: Workforce	2023/24 Actual	Apr 2024	May 2024	June 2024	2024/25 target	RAG status
% residential adult social care providers rated good or outstanding by the Care Quality Commission	N/A	77%	77%	77%	70%	**Green**

Vital Signs and Departmental Risks

Vital Signs across Adult Social Care

27. The departmental Vital Signs identifies the risks within Adult Social Care for our statutory duties, market sustainability and workforce.

28. People waiting for assessment has seen a reduction of 13.9% for the first quarter compared with this time last year, but still remains a very high risk for the department. Reviews were a 'key line of enquiry' for the Making It Real Forum in July and work is underway to bring all work on reviews outlined in **paragraph 17** together to address the required improvement.

29. Work continues to develop risk dashboards across Mental Health referrals, Safeguarding and Deprivation of Liberty safeguarding statutory duties and the department is in the early stages of refreshing a market sustainability dashboard to support risk in this area.

30. The care market is a Very High risk for the department currently with risks across the following areas:

- Insufficient capacity in residential care with nursing, particularly within mid Notts and also limited capacity in Broxtowe due to contractual sanctions in one home
- Inability to respond to quality improvement needs within residential and residential with nursing care homes
- Care Quality Commission new single assessment framework impacting on public perception of the service
- Increased provider quality concerns in care homes, requiring high levels of oversight and intervention.

31. These are being mitigated by:

- Quality Market Management Team (QMMT) recruiting to additional capacity with creation of a new Provider Improvement Team which will increase capacity in the team
- There will also be additional clinical support which is essential for supporting nursing homes in crisis
- QMMT working with commissioning team on longer term market development plan.

32. The Market Sustainability Fund is supporting care providers to directly support their workforce with 284 bids received so far across the County, equating to approximately £190 benefit per person.

Departmental Risks

33. The department continues to manage key risks. The table below describes the department's very high risks and the mitigating actions being undertaken:

Risk ID & Current Risk (pre mitigation)	Risk Category	Risk Description	Movement	Mitigating actions to reduce risk
A03 Very High	Compliance & Regulation	**People waiting** for a conversation about their needs without an allocated worker and allocated work not yet started	Score improving	Additional capacity agreed to deliver risk tabs for the statutory duty data dashboards by October 2024 New dashboards being developed for safeguarding, carers, mental health and Deprivation of Liberty Safeguards which will include risk tabs Market sustainability dashboard being re-developed

A16 Very High	Service Delivery	Changes by Access Group to how **Mosaic** is hosted	Score improving	Head of Digital working closely with Access Group around timescales, resources and impact on integrated systems. Specification for programme management and recruitment to programme resource in progress to support the changes to the electronic record system
A08 Very High	Financial	DHSC re-alignment for funding for **charging reform**	No Change	Await further Government Guidance to clarify position, following announcement by the new chancellor that charging reform will no longer be implemented.
A18 Very High	Financial	**Reduction in income** for Adult Social Care impacting on current budget overspend	No Change	ICB joint commissioning and oversight group continuing to meet to review IPC roadmap. Working group for the joint funded strengths-based reviews is in place Recruitment to a dedicated team to support this work is underway. A cross departmental 'voids board' is to be established in September to support the reduction of voids seen in Supported Living accommodation. Analysis of our bad debt is underway to inform next actions to reduce.
A02 Very High	Service Capacity	a)Insufficient capacity in residential care with nursing, particularly within mid Notts and also limited capacity in Broxtowe due to contractual sanctions in one home. b). Inability to respond to quality improvement needs within residential and residential with nursing care homes c) Care Quality Commission new single assessment framework impacting on public perception of the service.	Score worsening	Quality Market Management Team recruiting to additional capacity with creation of a new Provider Improvement Team There will also be additional clinical support which is essential for supporting nursing homes in crisis. QMMT Working with commissioning team on longer term market development plan

		d) Increased provider quality concerns in care homes, requiring high levels of oversight and intervention.		

Summary Financial Position as at Period 3 2024/25

Previous forecast Variance £ 000	Change in forecast £ 000	Department	Final Budget £ 000	Actual £ 000	Year-End Forecast £ 000	Latest Forecast Variance £ 000	Var as a % of budget
		ASCH Committee					
(501)	211	Strategic Commissioning and Integration	(35,643)	(16,944)	(35,933)	(290)	0.81%
7,426	1,729	Living Well and Direct Services	167,354	51,403	176,509	9,155	5.47%
(805)	1,576	Ageing Well and Maximising Independence	158,357	42,550	159,128	771	0.49%
6,120	**3,516**	**Forecast prior to use of reserves**	**290,068**	**77,009**	**299,704**	**9,636**	**3.32%**
		ASCH Reserves					
(1)	(0)	Transfer to / (from) Revenue Reserves	(12,158)	-	(12,159)	(1)	0.01%
-	-	Transfer to / (from) Capital Reserves	-	-	-	-	0.00%
-	-	Transfer to / (from) reserves (Ageing Well)	-	-	-	-	0.00%
(1)	**(0)**	**Subtotal**	**(12,158)**	**-**	**(12,159)**	**(1)**	**0.01%**
6,119	**3,516**	**Net Department Total**	**277,910**	**77,009**	**287,545**	**9,635**	**3.47%**

34. The Adult Social Care and Health Revenue Budget is currently reporting a **£9.64 million overspend** as at Period 3.

35. **Integrated Strategic Commissioning** is forecasting a **net underspend** of **£0.29 million** after reserves, a reduced underspend of £0.21m since Period 2. Overspend on staffing is offset by underspend on other overheads including reduced spend on external day services and transport, funding of survivors of sexual abuse contract by Public Health, reduced costs on Out of Area Advocacy and reduced Disclosure and Barring Service (DBS) costs.

36. **Provider Services** is forecasting a reduced **underspend of £1.49 million**, a shift of £0.29m since Period 2. This is due to unbudgeted Continuing Health Care income, vacancies being held pending the Day Services redesign, correction of an error on the Period 2 forecast and underspend on consultants and activities.

37. **Working Age Adults and Older Adults** are reporting **an overspend of £11.5 million**. This is due to the commitments in the system regarding commissioned care. Overspends across all package types (the highest being Long Term Residential, Supported Accommodation and Homecare) and Predicted Needs are partially offset by additional joint funding income, additional client contributions and staffing underspends.

38. The **Maximising Independence Service** (MIS) is forecasting an **underspend of £0.08 million** against a budget of £17 million. This is due to underspend on vacancies, offset by overspend due to inflationary increases on the Home First Response Service contract and Total Mobile contract.

Financial Implications

39. There are no direct financial implications arising from this report.

RECOMMENDATION/S

That the Adult Social Care and Public Health Committee considers and comments on:

1) the summary of Adult Social Care and Health's performance against the priorities of the Local Account.

2) the summary of Adult Social Care and Health's Vital Signs and key departmental risks.

3) the financial position of Adult Social Care and Health, as at Period 3 2024/25.

Councillor Jonathan Wheeler
Cabinet Member for Adult Social Care

For any enquiries about this report please contact:

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Constitutional Comments (SSR 29/08/24)

38. The recommendations fall within the terms of reference for the Adult Social Care and Public Health Select Committee.

Financial Comments (CMER 16/08/24)

39. These financial results are correct, following the forecast and reporting at the end of period 3. The service is in the process of making plans to reduce the overspend in year as well as in subsequent years.

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 Division(s) and Member(s) Affected

All.

AS0016

Nottinghamshire County Council

Report to the Adults Social Care & Public Health Select Committee

9th September 2024

Agenda Item:

REPORT OF THE CABINET MEMBER FOR COMMUNITIES AND PUBLIC HEALTH

PUBLIC HEALTH PERFORMANCE, RISKS AND FINANCIAL POSITION – QUARTER 1 2024/25

Purpose of the Report

1. To provide the Committee with a summary of Public Health performance.

2. To provide the Committee with a summary of Public Health Vital Signs and key departmental risks.

3. To provide the Committee with a summary of Public Health financial position as at the end of June 2024.

Information

4. The Public Health department has moved from Adult Social Care and Health Department into the Place Department in accordance with the decision of the Chief Executive approved on 10th June 2024.

5. **Appendix B** provides full details of Public Health performance, risks and financial position.

6. A slide set at **Appendix A** summarises **Appendix B** and will be used by the Select Committee as the main document.

7. **Appendix C** provides further information on the Public Health Vital Signs performance.

Financial Implications

8. There are no direct financial implications arising from this report.

RECOMMENDATION/S

That Adult Social Care & Public Health Select Committee considers and comments on:

1) the summary of Public Health performance

2) The summary of Public Health Vital Signs and key departmental risks.
3) The financial position of Public Health, as at the end of June 2024.

Councillor Scott Carlton

Cabinet Member for Communities and Public Health

For any enquiries about this report please contact:

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Executive Officer Public Health
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Constitutional Comments

9. The recommendations fall within the remit of the Adult Social Care and Public Health Select Committee by virtue of its terms of reference.

Financial Comments

10. There are no direct financial implications of this report.

Background Papers and Published Documents

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

Electoral Division(s) and Member(s) Affected

All.

Public Health Performance, Risks and Financial Position Quarter 1 (April - June 2024)

ASCPH Select Committee 9th September 2024

Stories of Difference

Weight management, we had our first SMI client achieve their 5% weight loss target. He also managed to reduce his AUDIT-C score from 15 to 4. He's invited us to his home to record a video testimony, but the current summary is:

MR was referred in April for weight management support. He has since had 12 telephone appointments and has made some fantastic changes which has helped him lose 5% of his weight. He has reduced his caffeine intake by going from 10 cups of coffee a day to 2 cups, which has helped with his sleep. He has gone from eating processed foods to cooking all his meals from scratch and is even trying new recipes from our handbook. He has swapped sugar and crisps to bananas, oranges and strawberries. He is now walking for 30 minutes a day and using the resistance band we sent him to exercise at home. MR has struggled with his alcohol intake, as he's received alcohol support via telephone and has reduced his audit C score from 15 to 4

Clients from the Integrated Wellbeing service

Smoking cessation SB attended the Face-to-Face clinic at Bellamy. SB is a 50-year-old female who was smoking 10 cigarettes or roll ups per day. SB said she wanted to quit smoking for health reasons as she has COPD, Asthma, and diabetes. SB said she has quit smoking previously for short periods of time but struggles to maintain the quit. SB said she is unsure if she can quit, and I said I would work with her to achieve her goal of a smoke free life. SB is also partially deaf, so I ensured I spoke clearly and wrote down information. I always checked SB had understood. B attended an appointment one Friday and told me she felt unwell. I could see SB was not well at all, so I called an ambulance. The paramedics arrived quickly and praised me for how quickly I acted. SB was dangerously unwell and was admitted to hospital. SB came to see me a couple of weeks later to thank me and to continue with the program.

Through informed choice SB was using Nicorette gum to assist with her quit but stopped using all NRT after a few weeks as SB felt she didn't need it. SB's CO reading at the first appointment was 22 and at the final appointment it was 2. SB has now been smoke free for 26 weeks and said she is feeling much brighter. SB has noticed her breathing is not as bad and she is coughing less. SB also said she is noticing the financial benefits too which has helped her. SB said she is feeling really happy.

Stories of Difference

Substance Use *The housing team continue to go from strength to strength with the team receiving 351 referrals to date and 158 people have engaged with the team. There are 56 evictions that have been prevented with the support of this team. Noting the low housing stock in Nottinghamshire the impact of this team's worker on the wider system is evident.*

- *Citizens Advice work (Jan-May figures)*
- *50 people worked with*
- *706 individual problems*
- *£183,171 in total financial gains for Service Users*

Domestic Abuse *Mum and daughter attended the '**hands are not for hurting'** eight-week therapeutic group work course. This is delivered to mum and child separately but at the same time.*
Offering a safe space for children, to provide them with the opportunity to disclose, process and understand the abuse they have witnessed. In addition, to help Mothers understand their child's experiences, thoughts and feelings in relation to the abuse and to help rebuild the communication pathways between parent and child.

Child on the programme had witnessed physical and emotional abuse within the family home by father (perpetrator) to mother (survivor).

Survivor feedback to service "I just wanted to say thank you for everything you have done on the course. I really feel like I have benefitted so much over the last 8 weeks, and you have given me some of my confidence back that I lost a long time ago. Made me feel confident as a Mum and made me realise things were not my fault and I would still be stuck in a rut".
Child feedback to service "I have enjoyed coming to the group and making new friends. I like the food and would like to have done more drawing". Programmes like this are key to supporting survivors to rebuild their lives.

Statutory Duties

Sexual Health	Performance against the key sexual health indicators continues to be strong in the context of mobilising the new Nottinghamshire and City sexual health service for October 2024. The mobilisation of the new service is progressing well with a new patient management system being crated, workforce structuring, creation of an online testing offer and the development of a new health promotion team. A new service name is being developed with feedback from local residents. Work is being to develop new key performance indicators to ensure that the service supports the improvement of local sexual health outcomes. The new service is on track to start in October 24.
NHS Health Checks	Overall performance of the NHS Health Check programme has improved in Q1 of 2024 when compared to the same quarter last year. Although the number of invites in Q1 2024 was comparable Q1 2023 (at 7,299 as compared with 7,364 (a 0.01% reduction)), the number of the eligible population completing a Health Check in has increased by 11.9% in the same period (from 4,180 in Q1 in 2023 to 4,676 in Q1 2024.) Reviewing the data trends shows that the number of invites has remained similar over the past 6 quarters except for Q2 2023 when Newgate practices' quality improvement programme targeted Health Checks and invited huge numbers to catch up those not invited during COVID. There has been no change in delivery of the programme so the increase in uptake of Health Checks is due to improved engagement with the programme from the providers and potentially residual impact from remaining from the pandemic last year. A systemwide consultation of providers was also launched in Q1 to better understand the challenges in primary care to delivering Health Checks, as with targeted engagement, some practices have reduced their delivery and are considering stopping delivery altogether due to them not being cost-effective. Nearly 80 responses have been collated and analysis is underway which will inform the updated Health Check specification for the programme in its upcoming procurement exercise due for April 2025 start. The Health Equity Audit of the NHS Health Check programme has been finalised with some key recommendations that will form the basis of an improvement plan for the programme. There are recommendations relating to the improvement of data collection to better understand the impact of the programme. The audit has highlighted some inequities over the last five years where some higher risk groups haven't engaged with the programme. This will need further investigating and work needs be done in embedding the programme into wider health pathways for improved outcomes for residents.

PUBLIC HEALTH PERFORMANCE

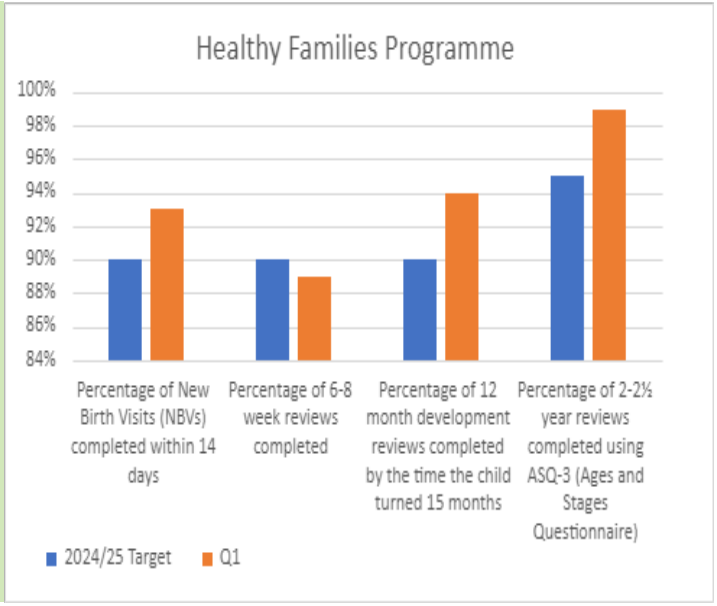
Prescribed Childrens 0-5's Services

Performance against the key Healthy Families Programme indicators continues to be strong. In Quarter 1 of 2024-25 93% of new-borns (1603 new-borns) received a 10-to 14-day health visitor review within 14 days of birth.
A further 107 (6%) were seen after 14 days, usually by day 18. A breakdown of the reasons for parents being seen after 14 days is received. This includes the initial visit being cancelled and re-arranged by parents, parents not being at home (no access), and / or the visit being re-arranged by the service (staff sickness). By the close of the quarter over 99% of parents had received their new birth review.

In Quarter 1, 89% parents (1532 parents) received a 6-to-8-week health visitor review by the time their baby was 8 weeks of age. A further 153 (9%) received this review over 8 weeks. By the close of the quarter 98% of parents had received their 6–8-week review.

In the same quarter, 94% of infants (1674 infants) had received a 1-year health and development review by the age of 15 months. A breakdown of the reasons why parents had not been seen by 15 months of age by the close of the quarter is received. This includes the review being cancelled and re-arranged by parents, parents not attending the review, or parents declining (opting out) of the review. Clear policies guide practitioners as to the appropriate course of action where parents do not engage.

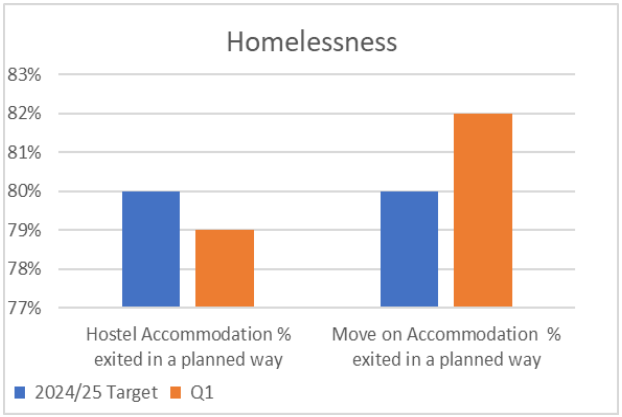
Finally, the proportion of 2-2.5-year reviews that used the evidence-based Ages and Stages Questionnaire to assess development was 99% across Quarter 1, above the locally agreed target of 95%.



Nottinghamshire County Council

Strategic Priorities

Integrated Wellbeing Service	Tobacco service and weight management performance reporting for Quarter 1 is split between reporting final outcomes for 2023/4 reporting year and 2024/5 reporting year. In total 674 people achieved a four-week quit in Quarter 1. This is the highest number of people achieving a 4-week quit over the past five quarters. In addition, 23 people with a Severe Mental Illness were supported to quit smoking at four-weeks. A total of 243 people were supported to achieve a 5% weight loss in Quarter 1. This is the highest number of people achieving a 5% weight loss over the past five quarters. In addition, during Quarter 1 281 people were supported to achieve a 3% weight loss.
Homelessness	Both Hostel and Move on accommodation percentage exited in a planned way targets continue to be well met by the provider. The number of people leaving hostel and move on continues to be lower than ideal. This is reflective of system wide challenges relating to the availability of appropriate housing to move people on to and subsequent 'silting up' of service provision. The provider is actively engaged in wider systems work to identify the range of supported accommodation required to meet local needs. Work is ongoing with local housing authorities to ensure all options for moving people on from the service are thoroughly explored.
Domestic abuse	Vital signs reporting for Domestic Abuse Support Services has improved and this has led to an increase in baseline data. Domestic Abuse Support Services have supported 645 new survivors in quarter one. This is an increase from the previous quarter. Services remain under pressure as referrals are increasing as is the complexity of survivor need. Services have been asked by commissioners to identify the ceiling of need before mitigations are required and a system is being established to ensure reporting processes are in place and mitigations and risk is fully considered
Substance Use	Successful completions within service are increasing with 19.78% completion rate in March 2024 compared to the CGL national performance of 19.28%. 2525 Adults are currently in treatment and 119 young people. The service is over capacity by 406% from the original contract numbers.



Health Protection

Health protection assurance is a statutory duty of the County Council, led by the Director of Public Health (DPH). The multi-agency Nottingham and Nottinghamshire Health Protection Board is the overarching forum for ensuring that relevant organisations have appropriate plans in place and that necessary actions are being taken. The Board is accountable to the Nottinghamshire Health and Wellbeing Board.

In line with its assurance role the Board held a workshop in September 2023, to identify opportunities and gaps to improve health protection and reduce health inequalities across the County and City. Based on the outcomes from the workshop an action plan was agreed which is being jointly led by partners across health and local government and progress reported through the Health Protection Board and up to the County and City Health and Wellbeing Boards.

On 24th July, the HWB formally approved the Heath Protection Annual Report for the previous year which provides assurance that arrangements and outcomes for health protection in Nottinghamshire are satisfactory. Report available at Democratic Management System > Meetings (nottinghamshire.gov.uk) Item 5.

Prev Forecast variance £000	Change in Variance £000	Department	Annual Budget £000	Actual Spend £000	Year-End Forecast £000	Latest Forecast Variance £000
	(64)	**Communities and Public Health** **Public Health**	4,788	(4,076)	4,633	(155)
	(64)	**Communities and Public Health Total**	4,788	(4,076)	4,633	(155)
		Transfers To (From) Reserves				
	64	**Communities and Public Health** **Public Health Reserves**	(4,788)	(164)	(4,633)	155
	64	**Communities and Public Health Total**	(4,788)	(164)	(4,633)	155
	0	**PLACE DEPARTMENT**	0	0	0	0

The above table is the position at period 3 budget monitoring for the financial year 2024/25.

Currently there is an **underspend in year of £155k** which is **0.03%** of the overall budget for the year.

No significant changes to the risk register and Public Health workforce vital signs as found in the ASC&H departmental figures.

APPENDIX B

PUBLIC HEALTH PERFORMANCE, RISKS AND FINANCIAL POSITION – QUARTER 1 2024-25

Information

A) Public Health Performance

Public Health services continue to deliver against the majority of key performance indicators as detailed in their respective contracts. The information below provides additional detail on key areas of success at the end of quarter 1 2024-25 (April-June 2024).

Key successes at end of Quarter 1 2024-25

Sexual Health

Performance against the key sexual health indicators continues to be strong in the context of mobilising the new Nottinghamshire and City sexual health service for October 2024.

The mobilisation of the new sexual health service is progressing well with a new patient management system being created, workforce structuring, creation of an online testing offer and the development of a new health promotion team. A new service name is being developed with feedback from local residents. Work is being to develop new key performance and monitoring indicators to ensure that the service supports the improvement of local sexual health outcomes. The new service is on track to start in October 2024.

NHS Health Checks

Overall performance of the NHS Health Check programme has improved in Q1 of 2024 when compared to the same quarter last year. Although the number of invites in Q1 2024 was comparable Q1 2023 (at 7,299 as compared with 7,364 (a 0.01% reduction)), the number of the eligible population completing a Health Check in has increased by 11.9% in the same period (from 4,180 in Q1 in 2023 to 4,676 in Q1 2024).

Reviewing the data trends shows that the number of invites has remained similar over the past 6 quarters except for Q2 2023 when Newgate practices' quality improvement programme targeted Health Checks and invited huge numbers to catch up those not invited during COVID.

There has been no change in delivery of the programme so the increase in uptake of Health Checks is due to improved engagement with the programme from the providers and potentially residual impact remaining from the pandemic last year.

A systemwide consultation of providers was also launched in Q1 to better understand the challenges in primary care to delivering Health Checks, as with targeted engagement, some practices have reduced their delivery and are considering stopping delivery altogether due to them not being cost-effective. Nearly 80 responses have been collated and analysis is underway which will inform the updated Health Check specification for the programme in its upcoming procurement exercise due for April 2025 start.

The Health Equity Audit of the NHS Health Check programme has been finalised with some key recommendations that will form the basis of an improvement plan for the programme. There are recommendations relating to the improvement of data collection to better understand the impact of the

programme. The audit has highlighted some inequities over the last five years where some higher risk groups haven't engaged with the programme. This will need further investigating and work needs be done in embedding the programme into wider health pathways for improved outcomes for residents.

Prescribed Children's 0-5 Services

Performance against the key Healthy Families Programme indicators continues to be strong.

In Quarter 1 of 2024-25 93% of new-borns (1603 new-borns) received a 10-to 14-day health visitor review within 14 days of birth.

A further 107 (6%) were seen after 14 days, usually by day 18. A breakdown of the reasons for parents being seen after 14 days is received. This includes the initial visit being cancelled and re-arranged by parents, parents not being at home (no access), and / or the visit being re-arranged by the service (staff sickness). By the close of the quarter over 99% of parents had received their new birth review.

In Quarter 1, 89% parents (1532 parents) received a 6-to-8 week health visitor review by the time their baby was 8 weeks of age. A further 153 (9%) received this review over 8 weeks. By the close of the quarter 98% of parents had received their 6–8-week review.

In the same quarter, 94% of infants (1674 infants) had received a 1-year health and development review by the age of 15 months. A breakdown of the reasons why parents had not been seen by 15 months of age by the close of the quarter is received. This includes the review being cancelled and re-arranged by parents, parents not attending the review, or parents declining (opting out) of the review. Clear policies guide practitioners as to the appropriate course of action where parents do not engage.

Finally, the proportion of 2-2.5-year reviews that used the evidence-based Ages and Stages Questionnaire to assess development was 99% across Quarter 1, above the locally agreed target of 95%.

The Integrated Wellbeing Service

For Tobacco services performance reporting for Quarter 1 is split between reporting final outcomes for 2023/4 reporting year and 2024/5 reporting year. In total 674 people achieved a four-week quit in Quarter 1. This is the highest number of people achieving a 4-week quit over the past five quarters.
In addition, 23 people with a Severe Mental Illness were supported to quit smoking at four-weeks.

For the Weight Management Service, performance reporting for Quarter 1 is also split between reporting final outcomes for 2023/4 reporting year and 2024/5 reporting year. A total of 243 people were supported to achieve a 5% weight loss in Quarter 1. This is the highest number of people achieving a 5% weight loss over the past five quarters.

In addition, during Quarter 1, 281 people were supported to achieve a 3% weight loss.

Story of Difference:

Weight management, *we had our first SMI client achieve their 5% weight loss target. He also managed to reduce his AUDIT-C score from 15 to 4. He's invited us to his home to record a video testimony, but the current summary is:*

MR was referred in April for weight management support. He has since had 12 telephone appointments and has made some fantastic changes which has helped him lose 5% of his weight. He has reduced his caffeine intake by going from 10 cups of coffee a day to 2 cups, which has helped with his sleep. He has gone from eating processed foods to cooking all his meals from scratch and is even trying new recipes from our handbook. He has swapped sugar and crisps to bananas, oranges and strawberries. He is now walking for 30 minutes a day and using the resistance band we sent him to exercise at home. MR has struggled with his alcohol intake, as he's received alcohol support via telephone and has reduced his audit C score from 15 to 4.

Smoking cessation *SB attended the Face-to-Face clinic at Bellamy. SB is a 50-year-old female who was smoking 10 cigarettes or roll ups per day. SB said she wanted to quit smoking for health reasons as she has COPD, Asthma, and diabetes. SB said she has quit smoking previously for short periods of time but struggles to maintain the quit. SB said she is unsure if she can quit, and I said I would work with her to achieve her goal of a smoke free life. SB is also partially deaf, so I ensured I spoke clearly and wrote down information. I always checked SB had understood. SB attended an appointment one Friday and told me she felt unwell. I could see SB was not well at all, so I called an ambulance. The paramedics arrived quickly and praised me for how quickly I acted. SB was dangerously unwell and was admitted to hospital. SB came to see me a couple of weeks later to thank me and to continue with the program.*

Through informed choice SB was using Nicorette gum to assist with her quit but stopped using all NRT after a few weeks as SB felt she didn't need it. SB's CO reading at the first appointment was 22 and at the final appointment it was 2. SB has now been smoke free for 26 weeks and said she is feeling much brighter. SB has noticed her breathing is not as bad and she is coughing less. SB also said she is noticing the financial benefits too which has helped her. SB said she is feeling really happy.

Homelessness

Both Hostel and Move on accommodation percentage exited in a planned way targets continue to be well met by the provider. The number of people leaving hostel and move on continues to be lower than ideal. This is reflective of system wide challenges relating to the availability of appropriate housing to move people on to and subsequent 'silting up' of service provision. The provider is actively engaged in wider systems work to identify the range of supported accommodation required to meet local needs.
Work is ongoing with local housing authorities to ensure all options for moving people on from the service are thoroughly explored.

Substance Use

Successful completions within the service are increasing with 19.78% completion rate in March 2024 compared to the Change Grow Live (CGL) national performance of 19.28%, 2525 adults are currently in treatment and 119 young people. The service is currently 22% over capacity as compared to the original contract numbers.

Story of Difference:

The housing team continue to go from strength to strength with the team receiving 351 referrals to date and 158 people have engaged with the team. There are 56 evictions that have been prevented with the support of this team. Noting the low housing stock in Nottinghamshire the impact of this team's worker on the wider system is evident.

Domestic Abuse

Vital signs reporting for Domestic Abuse Support Services has improved and this has led to an increase in baseline data. Domestic Abuse Support Services have supported 645 new survivors in quarter one. This is an increase from the previous quarter. Services remain under pressure as referrals are increasing as is the complexity of survivor need. Services have been asked by commissioners to identify the ceiling of need before mitigations are required and a system is being established to ensure reporting processes are in place and mitigations and risk is fully considered.

Story of difference

Mum and daughter attended the ***'hands are not for hurting'*** *eight-week therapeutic group work course. This is delivered to mum and child separately but at the same time.*
Offering a safe space for children, to provide them with the opportunity to disclose, process and understand the abuse they have witnessed. In addition, to help Mothers understand their child's experiences, thoughts and feelings in relation to the abuse and to help rebuild the communication pathways between parent and child.

Child on the programme had witnessed physical and emotional abuse within the family home by father (perpetrator) to mother (survivor).

Survivor feedback to service "I just wanted to say thank you for everything you have done on the course. I really feel like I have benefitted so much over the last 8 weeks, and you have given me some of my confidence back that I lost a long time ago. Made me feel confident as a Mum and made me realise things were not my fault and I would still be stuck in a rut".
Child feedback to service "I have enjoyed coming to the group and making new friends. I like the food and would like to have done more drawing".

Programmes like this are key to supporting survivors to rebuild their lives.

Health Protection

Health protection assurance is a statutory duty of the County Council, led by the Director of Public Health (DPH). The multi-agency Nottingham and Nottinghamshire Health Protection Board is the overarching

forum for ensuring that relevant organisations have appropriate plans in place and that necessary actions are being taken. The Board is accountable to the Nottinghamshire Health and Wellbeing Board.

In line with its assurance role the Board held a workshop in September 2023, to identify opportunities and gaps to improve health protection and reduce health inequalities across the County and City. Based on the outcomes from the workshop an action plan was agreed which is being jointly led by partners across health and local government and progress reported through the Health Protection Board and up to the County and City Health and Wellbeing Boards.

On 24th July, the HWB formally approved the Heath Protection Annual Report for the previous year which provides assurance that arrangements and outcomes for health protection in Nottinghamshire are satisfactory. Report available at Democratic Management System > Meetings (nottinghamshire.gov.uk) Item 5.

B) Vital Signs and Risk

The departmental vital signs indicators identified within Public Health are statutory duties, market sustainability and workforce. Quarter 1 2024/25 performance for these are detailed in Appendix C to support the narrative above.

C) Workforce

Appendix C covers the workforce vital signs data. This will be reviewed for Quarter 2, when Public Health moved into the Place department.

Specific Public Heath quarter 1 2024/25 workforce updates include;

- a successful Staffing Committee to appoint a Public Health Consultant in May 2024 (this was to replace a team member that had retired.
- All other current vacancies being recruited for and with a continual source of good quality candidates for the posts.
- The Director of Public Health role is continuing to be covered by Vivienne Robbins on an interim basis until permanent recruitment for the post will be carried out in the autumn.

D) Financial Position as at 30 June 2024

Prev Forecast variance £000	Change in Variance £000	Department	Annual Budget £000	Actual Spend £000	Year-End Forecast £000	Latest Forecast Variance £000
		Communities and Public Health				
	(64)	Public Health	4,788	(4,076)	4,633	(155)
	(64)	**Communities and Public Health Total**	4,788	(4,076)	4,633	(155)
		Transfers To (From) Reserves				
		Communities and Public Health				
	64	Public Health Reserves	(4,788)	(164)	(4,633)	155
	64	**Communities and Public Health Total**	(4,788)	(164)	(4,633)	155
	0	**PLACE DEPARTMENT**	0	0	0	0

The above table is the position at period 3 budget monitoring for the financial year 2024/25. The Public Health ringfenced budget is currently underspent in year by £155k, which is 0.03% of the overall budget. A detailed plan to spend the existing Public Health reserves was approved at Cabinet in July 2024. Further detail is available in the link attached. Democratic Management System > Meetings (nottinghamshire.gov.uk) Item 10.

Appendix C: Public Health Vital Signs

				Current Year 2024-25			
Vital Sign	**Theme**	**Measure**	**Services (PH)**	**Q1**	**Yearly Total / Average**	**Frequency**	**Source**
MARKET SUSTAINABILITY	**PH: Risk level 1-4**	Public Health Commissioned Services	1	Low 1	Low 1	Quarterly	PH risk log
STATUTORY DUTIES	**Sexual health services - STI testing and treatment**	Total number of filled appointments	Integrated Sexual Health Services Sherwood Forest Hospital NHS Trust / Nottingham University Hospital NHS Trust / Doncaster and Bassetlaw Hospitals NHS Trust	10641	10641	Quarterly	PH Performance & Contracts
		Average Quality Standard 60 % of new service users accepting a HIV test across all Trusts		73%	73%	Quarterly	PH Performance & Contracts
		Average Quality Standard At least 75% of 15-24 year olds in contact with the service accepting a chlamydia test across all Trusts		67%	67%	Quarterly	PH Performance & Contracts
		Average Quality Standard 30% of women aged 16-24 receiving contraception accepting LARC across all Trusts		44%	44%	Quarterly	PH Performance & Contracts
	Sexual health services - contraception	Number of individuals aged 13-25 registered onto the Young Peoples Sexual Health Service - C Card scheme	Young Peoples Sexual Health Service C Card, NCC	137	137	Quarterly	PH Performance & Contracts
	NHS Health Check programme	No. of eligible patients who have been offered health checks	Health Checks General Practice	7299	7299	Quarterly	PH Performance & Contracts
		No. of patients offered who have received health checks		4676	4676	Quarterly	PH Performance & Contracts
	Local authority role in health protection	Qualitative Input accompanying report (Covid Impact Assessment, Health Protection Board, Flu Coverage, Outbreak Response)		Narrative provided in appendix		Annually - quarter 1	Deputy Director of PH
	Public health advice to NHS Commissioners	Qualitative Input to accompanying report (JSNA, Health Equity Audits, DPH Annual Report, HWB / JHWS/ Integrated Care Strategy)				Annually - quarter 4	Deputy Director of PH
	National Child Measurement programme	Participation rate in National Child Measurement programme in Nottinghamshire (Total)	Healthy Families Nottinghamshire Healthcare Trust			Annually - quarter 2	Fingertips Obesity Profile (PHOF)
	Prescribed children's 0 to 5 services	Percentage of New Birth Visits (NBVs) completed within 14 days		93%	93%	Quarterly	PH Performance & Contracts
		Percentage of 6-8 week reviews completed		89%	89%	Quarterly	PH Performance & Contracts
		Percentage of 12 month development reviews completed by the time the child turned 15 months		94%	94%	Quarterly	PH Performance & Contracts
		Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)		99%	99%	Quarterly	PH Performance & Contracts
STRATEGIC PRIORITIES	**Tobacco**	Percentage of clients quit at 4 weeks following quit date	Integrated Wellbeing Service ABL Health	25%	25%	Quarterly	PH Performance & Contracts
	Homelessness	Hostel Accommodation percentage exited in a planned way	Framework Housing Association	79%	79%	Quarterly	PH Performance & Contracts
		Move on Accommodation percentage exited in a planned way	Framework Housing Association	82%	82%	Quarterly	PH Performance & Contracts
		Leaving hostel accommodation to enter move on accommodation within 18 weeks	Framework Housing Association	9	9	Quarterly	PH Performance & Contracts
		Number of clients exiting the move on accommodation within 12 months of entering the move on service	Framework Housing Association	8	8	Quarterly	PH Performance & Contracts
	Domestic Abuse	Number of new eligible referrals who have engaged and accepted support.	Domestic Abuse Services JUNO, NWAL & Equation	645	645	Quarterly	PH Performance & Contracts
	Alcohol / Substance Use	Number of successful completions (Young People and Adults and Parents)	All Age Substance Use Service Change, Grow, Live	302	302	Quarterly	PH Performance & Contracts
	Weight	The percentage of all adults (excluding pregnant women) who 'start' go onto to lose 5% & 3% weight loss compared with their initial weight	Integrated Wellbeing Service ABL Health	33%	33%	Quarterly	PH Performance & Contracts
	Food	*No current PH performance measure recorded*					
	Air Quality	*No current PH performance measure recorded*					
						Notts/England	
ANNUAL DELIVERY PLAN (PHOF)	**Helping our people live healthier, more independent lives.**	A01a - Healthy life expectancy at birth (Male) - Years			62.4%	2018-20	PHOF
		A01a - Healthy life expectancy at birth (Female) - Years			60.0%	2018-20	PHOF
		A02a - Inequality in life expectancy at birth (Male) Slope Index of Inequality - Years			9.3%	2018-20	PHOF
		A02a - Inequality in life expectancy at birth (Female) Slope Index of Inequality - Years			7.7%	2018-20	PHOF
		C28d - Self reported wellbeing: people with a high anxiety score Proportion - %			20.2%	2022-23	PHOF
		E10 - Suicide rate Directly standardised rate - per 100,000			10.0%	2020-22	PHOF
	Supporting communities and families	B02a - School readiness: percentage of children achieving a good level of development at the end of Reception Proportion - %			51.8%	2022-23	PHOF
	Building skills that help people get good jobs	B05 - 16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known Proportion - %			7.7%	2022-23	PHOF
WORKFORCE	**Public Health (not including commissioned services workforce)**	Vacancies - no / rate (FTE)		9.62 (12.53%)	9.62 (12.53%)	Quarterly	NCC HR
		Turnover rate (as % of ASCH)		2.63%	2.63%	Quarterly	NCC HR
		Avg no of weeks agency staff(wks) on books		Info not currently available	Info not currently available	Quarterly	NCC HR
		Absence rate (days absent per FTE last 12 months)		7.22	7.22	Quarterly	NCC HR
		Sickness absence (average FTE days lost per employee)		6.67	6.67	Quarterly	NCC HR
		Sickness absence due to stress/depression (%)		25.67%	25.67%	Quarterly	NCC HR
		Completed at least one mandatory training course (%)		Info not currently available	Info not currently available	Quarterly	NCC HR

Nottinghamshire County Council

Report to the Adult Social Care and Public Health Select Committee

9 September 2024

Agenda Item

REPORT OF THE CHAIRMAN OF THE ADULT SOCIAL CARE AND PUBLIC HEALTH SELECT COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Adult Social Care and Public Health Select Committee's work programme.

Information

2. The attached work programme will assist the management of the Select Committee's agenda, the scheduling of its business and forward planning.

3. The work programme has been developed using suggestions submitted by Select Committee members, the relevant Cabinet Member(s) and senior officers and has been approved by the Overview Committee. The work programme will be reviewed at each pre-agenda meeting and Select Committee meeting, where any member of the committee will be able to suggest items for possible inclusion.

Other Options Considered

4. To not maintain a work programme for the Select Committee: this option is discounted as a clear work programme is required for the effective management of the Select Committee's agenda, the scheduling of its business and its forward planning.

Reasons for Recommendations

5. To assist the Select Committee in preparing its work programme.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment 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

7. There are no direct financial implications arising from this report.

RECOMMENDATIONS

1) That the work programme be noted.

2) That committee members make any further suggestions for consideration by the Chairman and Vice-Chairman for inclusion on the work programme in consultation with the relevant Cabinet Member(s) and senior officers, subject to the required approval by the Chairman of Overview Committee.

Councillor John Ogle
Chair, Adult Social Care and Public Health Select Committee

For any enquiries about this report please contact:
Martin Elliott, Senior Scrutiny Officer
martin.elliott@nottscc.gov.uk.

Constitutional Comments (HD)

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

Financial Comments (NS)

9. 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 and Published Documents

10. 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 Division(s) and Member(s) Affected

- All

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Meeting Date	Agenda Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions
9 September 2024	Healthy Families Programme	Cabinet Member - Communities and Public Health	To receive a progress report on the progress around the recommissioning of the service.	Work Programming session	Supporting communities and families Keeping children, vulnerable adults, and communities safe
	Adult Social Care Performance, Finance and Risk Update/ Public Health Performance, Finance and Risk Update	Cabinet Member – Adult Social Care/ Cabinet Member – Communities and Public Health	To provide a progress report on departmental performance, risk, and financial position for Adult Social Care and Public Health (two individual reports).	Standing item	Helping our people live healthier, more independent lives Supporting communities and families Keeping children, vulnerable adults, and communities safe

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Meeting Date	Agenda Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions
25 November 2024	Nottinghamshire Adults Safeguarding Board Annual Report 2024/25 and Plan		To receive the Nottinghamshire Adults Safeguarding Board Annual Report and Plan. To be presented by the Independent Chair with other partners also being invited to attend.	Annual item	Keeping children, vulnerable adults, and communities safe
	Progress and implementation of Prevention approach	Cabinet Member – Adult Social Care	To consider the development of the prevention approach and offer in Adult Social Care.	Work Programming session	Helping our people live healthier, more independent lives
	Social Care Market	Cabinet Member – Adult Social Care	Focus around recruitment and retention.	Committee meeting	Helping our people live healthier, more independent lives Supporting communities and families Keeping children, vulnerable adults, and communities safe
	Adult Social Care Performance, Finance and Risk Update/ Public Health Performance, Finance and Risk Update	Cabinet Member – Adult Social Care/ Cabinet Member – Communities and Public Health	To provide a progress report on departmental performance, risk, and financial position for Adult Social Care and Public Health (two individual reports).	Standing item	Helping our people live healthier, more independent lives Supporting communities and families Keeping children, vulnerable adults, and communities safe

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Meeting Date	Agenda Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions
3 March 2025	Technology enabled care	Cabinet Member - Adult Social Care	To examine how technology is being used to support the delivery of Adult Care services.	Work Programming session	Helping our people live healthier, more independent lives A forward looking and resilient Council.
	Discharge to Assess	Cabinet Member - Adult Social Care	To examine the Council's role in the delivery of the discharge to assess service.	Committee meeting/Work Programming session	Helping our people live healthier, more independent lives
	Day Opportunities Strategy	Cabinet Member – Adult Social Care	To receive a progress report on the implementation of the Day Opportunities Strategy	Work Programming session	Helping our people live healthier, more independent lives
	Domestic Abuse Strategy	Cabinet Member - Communities and Public Health	To consider the draft refreshed Domestic Abuse Strategy.	Work Programming session	Keeping children, vulnerable adults, and communities safe
	Adult Social Care Performance, Finance and Risk Update/ Public Health Performance, Finance and Risk Update	Cabinet Member – Adult Social Care/ Cabinet Member – Communities and Public Health	To provide a progress report on departmental performance, risk, and financial position for Adult Social Care and Public Health (two individual reports).	Standing item	Helping our people live healthier, more independent lives Supporting communities and families Keeping children, vulnerable adults, and communities safe

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Meeting Date	Agenda Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions
21 July 2025	Occupational Therapy	Cabinet Member - Adult Social Care	To examine the delivery and performance of the Occupational Therapy Service	Work Programming session	Helping our people live healthier, more independent lives
	Public Health – Community facing activities (including Community Health and Wellbeing Champions)	Cabinet Member - Communities and Public Health	To examine the impact of Public Health – Community facing activities	Work Programming session	Supporting communities and families
	Integrated Sexual Health Service	Cabinet Member - Communities and Public Health	To examine the delivery of the Integrated Sexual Health Service	Work Programming session	Helping our people live healthier, more independent lives
	Integrated Wellbeing Service	Cabinet Member - Communities and Public Health	To examine the delivery and impact of Integrated Wellbeing Service	Work Programming session	Helping our people live healthier, more independent lives
	Adult Social Care Performance, Finance and Risk Update/ Public Health Performance, Finance and Risk Update	Cabinet Member – Adult Social Care/ Cabinet Member – Communities and Public Health	To provide a progress report on departmental performance, risk, and financial position for Adult Social Care and Public Health (two individual reports).	Standing item	Helping our people live healthier, more independent lives Supporting communities and families Keeping children, vulnerable adults, and communities safe

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Items pending scheduling or removal.

Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions
NHS Health Check Programme	Cabinet Member - Communities and Public Health	Resolved at September 2023 meeting: That a further report on the delivery of the NHS Health Check Programme that covers the issues as detailed at a) and (b above, be brought to a future meeting of the Adult Social Care and Public Health Select Committee at a date to be agreed by the Chairman.	Committee meeting	Helping our people live healthier, more independent lives
Best Start Strategy	Cabinet Member - Communities and Public Health	To consider the development of the Best Start Strategy	Work Programming session	Supporting communities and families

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Reviews

Project Start Date	Item	Cabinet Member Responsibility	Purpose of Review	Issue raised by	Nottinghamshire Plan Ambitions
TBC	Transition of service users from Children and Young People's Services to Adult Social Care Services Joint item with Children and Families Select Committee	Cabinet Member – Children and Families Cabinet Member - Adult Social Care	To examine the current procedures surrounding the transition of service users from Children's to Adult Services. To make recommendations on how procedures could be developed to ensure the best possible transition for each service user.	Work Programming 2023/24	Helping our people live healthier, more independent lives Supporting communities and families Keeping children, vulnerable adults, and communities safe
TBC	Preventative work around smoking and vaping.	Cabinet Member – Children and Families Cabinet Member - Communities and Public Health	Resolved at the September 2023 meeting: That a task and finish review takes place to investigate the impact and effectiveness of the preventative work that takes place with schools around smoking and vaping. To be scheduled once new legislation about tobacco sales and vaping comes into force.	Committee meeting	Helping our people live healthier, more independent lives

WORK PROGRAMME 2024/25 – ADULT SOCIAL CARE & PUBLIC HEALTH SELECT COMMITTEE

Items to be scheduled for 2025/26

Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions
Self-Harm and Suicide Prevention Strategy.	Cabinet Member – Communities and Public Health	To examine the implementation and impact of the Self Harm and Suicide Prevention Strategy. September 2025	Committee meeting	Keeping children, vulnerable adults, and communities safe

Items for information briefings for committee members

Item	Cabinet Member Responsibility	Purpose of the report	Issue raised by	Nottinghamshire Plan Ambitions