Nottinghamshire County Council

Adult Social Care and Public Health Committee

Monday, 10 December 2018 at 10:30

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

AGENDA

11	Individual Contributions Towards the Cost of Care and Support	161 - 166
12	Update on the Implementation of the New Home Based Care and Support Services	167 - 176
13	Update on the Development of an Integrated Care System in South Nottinghamshire, Nottingham and Mid Nottinghamshire	177 - 192
14	Establishing an Integrated Care System Board for Nottingham and Nottinghamshire	193 - 200
15	Work Programme	201 - 206

16 EXCLUSION OF THE PUBLIC

The Committee will be invited to resolve:-

"That the public be excluded for the remainder of the meeting on the grounds that the discussions are likely to involve disclosure of exempt information described in Schedule 12A of the Local Government Act 1972 and the public interest in maintaining the exemption outweighs the public interest in disclosing the information."

Note

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

EXEMPT INFORMATION ITEMS

17 Exempt appendix to Item 9 - Adult Social Care and Health Performance for Quarter 2

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

Notes

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

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

should contact:-

Customer Services Centre 0300 500 80 80

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

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Sara Allmond (Tel. 0115 977 3794) 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 COMMITTEE
Date	12 November 2018 (commencing at 10.30 am)

Membership
Persons absent are marked with an 'A'

COUNCILLORS

Stuart Wallace (Chairman)
Tony Harper (Vice-Chairman)
Steve Vickers (Vice-Chairman)

Joyce Bosnjak
Boyd Elliott
Sybil Fielding
David Martin
Francis Purdue-Horan
Andy Sissons
Muriel Weisz
Yvonne Woodhead

OTHER COUNCILLORS IN ATTENDANCE

John Longdon

OFFICERS IN ATTENDANCE

Sarah Allmond, Advanced Democratic Services Officer, Chief Executive's
David Pearson, Corporate Director, Adult Social Care & Health
Sharon Dawn, Project Manager, Transformation Team, Chief Executive's
Jonathan Gribbin, Director of Public Health, Adult Social Care & Health
Paul Johnson, Service Director, Strategic Commissioning Adult Access & Safeguarding, Adult Social Care & Health
Jennie Kennington, Senior Executive Officer, Adult Social Care & Health
Mark McCall, Service Director – Mid Nottinghamshire, Adult Social Care & Health
Jane North, Programme Director – Transformation, Adult Social Care & Health

1. MINUTES OF THE LAST MEETING

The minutes of the meeting of Adult Social Care and Public Health Committee held on 8 October 2018 were confirmed and signed by the Chair.

2. APOLOGIES FOR ABSENCE

Councillor Tony Harper apologised that he would need to leave the meeting early due to another meeting he needed to attend.

3. DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

NEW CORPORATE DIRECTOR – ADULT SOCIAL CARE

The Chairman advised that there had been a successful appointment to the post of Corporate Director – Adult Social Care following David Pearson's announcement of his plan to retire. Melanie Brooks would be taking up the post on 14th January 2019 allowing a one week hand over with David Pearson.

STATEMENT REGARDING ALLIED HEALTHCARE

Paul Johnson advised members that the Council had been in contact with the company including a meeting on Friday. The company was not a large supplier of services to Nottinghamshire County Council, providing services to 12 managed users and some direct payment services. Allied Healthcare disputed the Care Quality Commission's assessment of their finances and had confirmed that their current lender would continue to provide funding until January and discussions were ongoing with other lenders. The situation would be closely monitored.

GREAT BRITISH CARE AWARDS

Councillor Harper advised that he had attended the Great British Care Awards in support of a number of colleagues who had been shortlisted. Whilst the Council did not win any of the awards, being nominated was a big achievement and he expressed his pride in those nominated.

4. SECTOR-LED IMPROVEMENT 2018 – SELF-ASSESSMENT AND REGIONAL CHALLENGE

Councillor Tony Harper and David Pearson introduced the report and responded to questions.

RESOLVED 2018/092

That there were no actions arising from the report.

Following consideration of this item, the Committee adjourned from 10.55am to 11.15am to allow members to attend the Council's Remembrance Day event.

5. EXTENSION OF CONTRACTS FOR SUPPORT TO THE EAST MIDLANDS IMPROVEMENT PROGRAMME IN ADULT SOCIAL CARE

Councillor Tony Harper and David Pearson introduced the report and responded to questions.

RESOLVED 2018/093

That the posts of the East Midlands Improvement Programme Manager (Care and Health) (Band F, 22 hours per week) and Business Support Administrator (Grade 4, 37 hours per week) be extended until 31st March 2020.

6. PROPOSALS FOR ALLOCATION OF ADDITIONAL NATIONAL FUNDING FOR ADULT SOCIAL CARE

Councillor Stuart Wallace and David Pearson introduced the report and addendum and responded to questions.

RESOLVED 2018/094

That Committee approves the proposals for the allocation of the additional funding to support adult social care. The table below shows the maximum number of posts that are requested to the end of March 2019 unless stated otherwise. (As identified in paragraph 8 of the report, additional staffing capacity will be a flexible combination of short-term fixed contracts, agency staffing and current staff undertaking additional hours.)

Post title and grade	**Number of posts (full-time equivalent)**
Community Care Officers (Grade 5)	13
Social Workers (Band B)	8
Approved Mental Health Practitioners (Band C)	2
Occupational Therapists (Band B) Extension of OT contract from Jan-March 2019	15 1
Reablement Support Workers (Grade 2) / Peri Reablement Support Workers (Grade 3)	16.2
Reablement Support Co-ordinator (Grade 4)	1
Community Partnership Officer (Band A)	2
Team Manager (Band D)	0.5
Programme Officer (Workforce) (Band B)	1
Care and Support Centre Senior Care Assistants (Grade 3)	2
Care and Support Centre Care Assistants (Grade 2)	2
Shared Lives Placement Co-ordinator (Grade 5) (for 12 months)	0.5

7. ADULT SOCIAL CARE AND HEALTH – CHANGES TO STAFFING ESTABLISHMENT

Councillor Steve Vickers and Paul Johnson introduced the report and responded to questions.

RESOLVED 2018/095

1) That extension of the posts listed in the table below be approved to support the operational needs and requirements of the Council, and to help achieve planned savings:

Post title	**Number of posts (full-time equivalent)**	**Extension date**
Social Worker (Band B)	3 FTE	March 2020
Community Care Officer (Grade 5)	11.5 FTE	March 2020

Post title	Number of posts (full-time equivalent)	Extension date
Advanced Social Work Practitioner (Band C)	2 FTE	March 2020
Commissioning Officer (CHC) (Band C)	1 FTE	March 2020
Data Technician/Finance Assistant (CHC) (Grade 4)	1 FTE	March 2020
Notts Enabling Service • Promoting Independence Worker (Grade 3) • Community Independence Worker (Grade 3) • Team Leader (Band A) • Team Manager (Band D) • Business Support Officer (Grade 3) • Programme Officer (Band B)	 8 FTE 1 FTE 1 FTE 1 FTE 1.5 FTE 1 FTE	 March 2020 March 2020 March 2020 March 2020 March 2020 December 2019

2) That the establishment of 2 FTE Community Care Officer (Grade 5) posts be approved to support winter pressures in Mid-Nottinghamshire until the end of April 2019

3) That the establishment of 1 FTE Strategic Development Assistant (Grade 5) post be approved until the end of March 2019

4) That the establishment of a temporary 1 FTE Shared Lives Placement Co-ordinator (Grade 5) post be approved until the end of March 2019.

8. YOUR NOTTINGHAMSHIRE, YOUR FUTURE – DEPARTMENTAL STRATEGY: SIX MONTH REVIEW OF PROGRESS (APRIL TO SEPTEMBER 2018)

Councillor Steve Vickers and Jane North introduced the report and responded to questions.

RESOLVED 2018/096

That there were no actions arising from the report.

9. ADULT SOCIAL CARE AND PUBLIC HEALTH EVENTS, ACTIVITIES AND COMMUNICATIONS

Councillor Stuart Wallace and Jonathan Gribbin introduced the report and responded to questions.

RESOLVED 2018/097

That the plan of events, activities and publicity set out in the report be approved.

10. ADULT SOCIAL CARE STRATEGY TEAM BRIEFING TOOLKIT AND EMPLOYEE VIDEO

Councillor Stuart Wallace, Jane North and Sharon Dawn introduced the report and responded to questions.

RESOLVED 2018/098

That the launch of the toolkit and the sharing of the video with relevant stakeholders in wider meetings in order to promote the work of the Council's Adult Social Care and Public Health department be approved.

11. WORK PROGRAMME

Councillor Stuart Wallace introduced the report.

A proposal to receive a future report on the impact of the changes to the way the council circulates individual contributions to the cost of care and support would be considered.

RESOLVED 2018/099

That the work programme be accepted.

The meeting closed at 12.24 pm.

CHAIR

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 4

REPORT OF DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH OUTCOMES IN NOTTINGHAMSHIRE

Purpose of the Report

1. To identify how public health outcomes are measured at a national and local level
2. To describe how Nottinghamshire public health outcomes compare to those for England
3. To describe how health outcomes vary between communities within the County
4. To ensure elected representatives and officers are kept up to date with health outcomes within and across the Authority and consider opportunities for incorporation into agendas that impact on the wider determinants of health.

Information

Background and context

5. Public health can be defined as:

> "the art and science of preventing disease, prolonging life and promoting health through the organised efforts of society"[1]

To further this work, the Director for Public Health leads work within the Authority and with partner organisations to improve the long-term health and wellbeing of the population. These objectives can take years – or even decades – of sustained, collective effort to achieve. This is reflected in the methods used to monitor public health outcomes and the frequency of reporting.

6. The main tools used to assess public health outcomes are described below. Each of these is updated on an annual basis.

- **The Public Health Outcomes Framework (PHOF)**
  This is the principal focus of this report, and is explained below.

[1] Acheson D. *Public health in England*. The report of the committee of inquiry into the future development of the public health function. London, HMSO, 1988

- **The Public Health Dashboard**
  This resource was released by Public Health England in 2018. It is intended to be a resource to support local councillors and senior council officers to prioritise resource allocation across a range of public health service areas.

- **National and local assessments of inequalities in health**
  The PHOF includes measures of how health and factors that influence health and wellbeing differ between communities across England. This national view is complemented by local reports that identify how health and wellbeing varies between communities within Nottinghamshire County.

7. The approaches described above relate to population based outcomes. These differ from public health contract data which are related to service outputs and service quality.

Public Health Outcomes Framework

8. The Public Health Outcomes Framework (PHOF) for England was introduced in 2013. The vision for the PHOF is "to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest".

9. The framework is based on two high-level outcomes that are a national focus: increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities.

   These outcomes reflect a balance between how long we live – life expectancy – but also how well we live, or healthy life expectancy.

10. A set of supporting public health indicators underpins the high level outcomes. These indicators are grouped into four domains:

    - **Improving the wider determinants of health**
      An assessment of wider factors that affect health and wellbeing, and health inequalities

    - **Health improvement**
      How people are helped to live healthier lifestyles, make healthy choices and changes in health inequalities

    - **Health protection**
      How the population's health is protected from major incidents and other threats, whilst also reducing inequalities

    - **Healthcare public health and preventing premature mortality**
      Citizens living with preventable ill health or dying early and the gap between communities

11. Data for each of the of the high-level and supporting indicators is published by Public Health England. Data for indicators are updated annually and are included:

    - for all upper-tier and where possible lower-tier authorities in England;
    - to show trends over time;

- to allow comparisons to outcomes for England, as well as statistical and regional neighbour authorities.

12. The PHOF includes data from many sources and organisations. This reflects the wide range of influences that the NHS, social care, public health services and others have on improvements to health and differences in outcomes between places, people and communities.

Current public health outcomes: Nottinghamshire compared to England

13. The Public Health Division considers an overview of all PHOF outcomes twice each year. The most recent report is included as Appendix 1. Current data can be found at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0/gid/1000049/pat/6/par/E12000004/ati/102/are/E1000002

14. The majority of indicators within PHOF show Nottinghamshire as 'significantly better than' or 'similar to' England.

15. Two factors are used to identify indicators of concern:

- indicators where Nottinghamshire is significantly worse than England and/or;
- the trend for the Authority is worsening over time.

16. There are currently thirteen indicators that are indicators of concern and for which the Public Health Division has a high level of influence in changing outcomes. These indicators are listed in Appendix 2. For each of these an action plan is in place, which is monitored by Public Health senior leadership team twice a year.

17. Some PHOF indicators of concern are not the direct responsibility of Public Health or the Authority. Most of these within Nottinghamshire relate to cancer screening coverage, and vaccination coverage. These issues are considered as part of the workplan for the Nottinghamshire Health Protection Strategy Group, which holds NHS England and Public Health England to account as appropriate.

18. High-level PHOF outcomes, including healthy life expectancy, life expectancy and associated inequalities are addressed through partnership working across the local health and care system.

Public health outcomes: differences within Nottinghamshire

19. The Public Health Division uses data published by electoral ward[2] to identify inequalities in health within the County and how these compare to other Local Authorities. The conclusions are summarised in Appendix 3.

Other Options Considered

20. No other options were considered.

[2] http://www.localhealth.org.uk/

Reason for Recommendations

21. The Public Health Outcomes Framework and work to identify local health inequalities is a source of consistent data about the health of Nottinghamshire's population. These data are collected in a systematic and standardised way. As many issues are affected by the wider determinants of health, this information forms a useful tool across Council and system partners to assess long term health impact.

Statutory and Policy Implications

22. 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.

Crime and Disorder Implications

23. Where PHOF indicators include crime and disorder elements, these are included with other local intelligence in the Police and Crime Commissioner's Police and Crime Needs Assessment process.

Data Protection and Information Governance

24. No data protection implications, all data is published and publically available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0/gid/1000049/pat/6/par/E12000004/ati/102/are/E10000024

Financial Implications

25. There are no financial implications related to this report.

Implications in relation to the NHS Constitution

26. No direct implications related to the NHS Constitution. The NHS duty to 'reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care' has been considered where relevant.

Implications for Service Users

27. Improvements in Public Health Outcomes affect all Nottinghamshire citizens and service users.

Implications for Sustainability and the Environment

28. No environmental or sustainability implications

RECOMMENDATIONS

1) To review public health outcomes for residents of Nottinghamshire County and identify any additional work required by the authority or system partners to address where current outcomes or trend are unfavourable compared to England
2) That members agree to receive an update report in the next 12 months and that this be included in the work programme.

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
David Gilding, Senior Manager, Public Health Intelligence
david.gilding@nottscc.gov.uk
0115 977 2587

Constitutional Comments (LMcC 08.11.2018)

29. The Adult Social Care and Public Health Committee is the appropriate body to consider the contents of the report. Members will need to consider any actions they require in respect of the issues contained in the report.

Financial Comments (DG 08.11.2018)

30. The financial implications are contained within paragraph 25 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.

'None'

Electoral Division(s) and Member(s) Affected

'All'

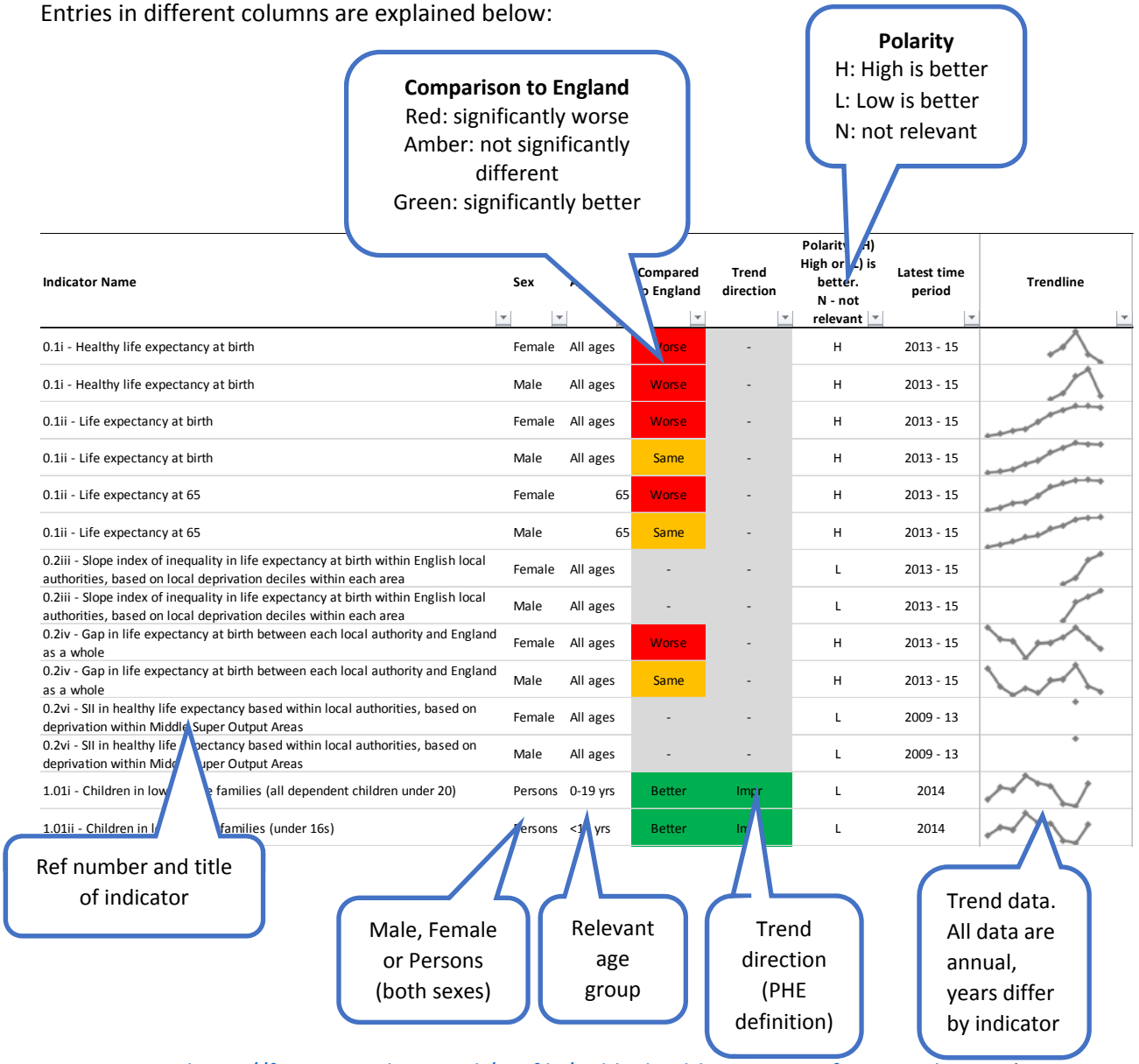
PHOF review for Nottinghamshire: update October 2018

The purpose of this document is to provide an overview of the Nottinghamshire County in relation to the Public health Outcomes Framework (PHOF).

This is provided as tables on the following pages, grouped by indictors where Nottinghamshire outcomes are significantly better than England (green), where there is no significant difference (amber) or significantly worse (red). Some comparisons (including those related to screening, vaccinations and chlamydia detection rate) are based on target thresholds rather than a comparison to England.

The 'trend direction' column uses the PHE designation, which is based on the most recent 5 values. This is not calculated for all indicators (grey background)

Entries in different columns are explained below:

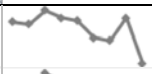


Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity (H) High or (L) is better. N - not relevant	Latest time period	Trendline
0.1i - Healthy life expectancy at birth	Female	All ages	Worse	-	H	2013 - 15	
0.1i - Healthy life expectancy at birth	Male	All ages	Worse	-	H	2013 - 15	
0.1ii - Life expectancy at birth	Female	All ages	Worse	-	H	2013 - 15	
0.1ii - Life expectancy at birth	Male	All ages	Same	-	H	2013 - 15	
0.1ii - Life expectancy at 65	Female	65	Worse	-	H	2013 - 15	
0.1ii - Life expectancy at 65	Male	65	Same	-	H	2013 - 15	
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	Female	All ages	-	-	L	2013 - 15	
0.2iii - Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles within each area	Male	All ages	-	-	L	2013 - 15	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Female	All ages	Worse	-	H	2013 - 15	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Male	All ages	Same	-	H	2013 - 15	
0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas	Female	All ages	-	-	L	2009 - 13	
0.2vi - SII in healthy life expectancy based within local authorities, based on deprivation within Middle Super Output Areas	Male	All ages	-	-	L	2009 - 13	
1.01i - Children in low families (all dependent children under 20)	Persons	0-19 yrs	Better	Impr	L	2014	
1.01ii - Children in families (under 16s)	Persons	<16 yrs	Better	Impr	L	2014	

Data extract: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework October 2018

David Gilding, Public Health Intelligence Team

1. Indicators where Nottinghamshire is significantly better than England

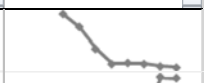
Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity: H(igh) or L(ow) is better. N(ot relevar	Latest time period	Trendline
1.01i - Children in low income families (all dependent children under 20)	Persons	0-19 yrs	Better	Impr.	L	2015	
1.01ii - Children in low income families (under 16s)	Persons	<16 yrs	Better	Impr.	L	2015	
1.03 - Pupil absence	Persons	5-15 yrs	Better	Impr.	L	2016/17	
1.05 - 16-17 year olds not in education, employment or training (NEET) or whose activity is not known - current method	Persons	16-17 yrs	Better	-	L	2016	
1.05 - 16-18 year olds not in education employment or training - historical method	Persons	16-18 yrs	Better	Impr.	L	2015	
1.14i - The rate of complaints about noise	Persons	All ages	Better	No trend	L	2015/16	
1.15i - Statutory homelessness - Eligible homeless people not in priority need	Persons	Not applicable	Better	-	L	2016/17	
1.15ii - Statutory homelessness - households in temporary accommodation	Persons	Not applicable	Better	-	L	2016/17	
2.01 - Low birth weight of term babies	Persons	>=37 weeks gestationa	Better	Impr.	L	2016	
2.05ii - Proportion of children aged 2-2Â½yrs receiving ASQ-3 as part of the Healthy Child Programme or integrated review	Persons	2-2.5 yrs	Better	-	H	2016/17	
2.06ii - Child excess weight in 4-5 and 10-11 year olds - 10-11 year olds	Persons	10-11 yrs	Better	Impr.	L	2016/17	
2.15iv - Deaths from drug misuse	Persons	All ages	Better	-	L	2015 - 17	
2.20i - Cancer screening coverage - breast cancer	Female	53-70 yrs	Better	Worsening	H	2017	
2.20ii - Cancer screening coverage - cervical cancer	Female	25-64 yrs	Better	Worsening	H	2017	
2.20iii - Cancer screening coverage - bowel cancer	Persons	60-74 yrs	Better	-	H	2017	
2.20iv - Abdominal Aortic Aneurysm Screening - Coverage	Male	65	Better	-	H	2016/17	
2.22iv - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	Persons	40-74 yrs	Better	-	H	2013/14 - 17/18	

Continued …

… Continued: Indicators where Nottinghamshire is significantly better than England

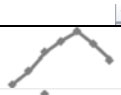
Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity: H(igh) or L(ow) is better. N(ot relevar	Latest time period	Trendline
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old)	Persons	1 yr	Better	No trend	H	2016/17	
3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old)	Persons	2 yrs	Better	Worsening	H	2016/17	
3.03ix - Population vaccination coverage - MMR for one dose (5 years old)	Persons	5 yrs	Better	Impr.	H	2016/17	
3.03v - Population vaccination coverage - PCV	Persons	1 yr	Better	No trend	H	2016/17	
3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old)	Persons	2 yrs	Better	Worsening	H	2016/17	
3.03vi - Population vaccination coverage - Hib / Men C booster (5 years old)	Persons	5 yrs	Better	Impr.	H	2016/17	
3.03vii - Population vaccination coverage - PCV booster	Persons	2 yrs	Better	Impr.	H	2016/17	
3.03viii - Population vaccination coverage - MMR for one dose (2 years old)	Persons	2 yrs	Better	Impr.	H	2016/17	
3.03xii - Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old)	Female	12-13 yrs	Better	-	H	2016/17	
3.03xiii - Population vaccination coverage - PPV	Persons	65+ yrs	Better	Impr.	H	2016/17	
3.03xiv - Population vaccination coverage - Flu (aged 65+)	Persons	65+ yrs	Better	Worsening	H	2017/18	
3.03xv - Population vaccination coverage - Flu (at risk individuals)	Persons	6 months-64 yrs	Better	Impr.	H	2017/18	
3.03xvi - Population vaccination coverage - HPV vaccination coverage for two doses (females 13-14 years old)	Female	13-14 yrs	Better	-	H	2016/17	
3.03xvii - Population vaccination coverage - Shingles vaccination coverage (70 years old)	Persons	70	Better	-	H	2016/17	
3.03xviii - Population vaccination coverage - Flu (2-3 years old) - current method	Persons	2-3 yrs	Better	-	H	2017/18	
3.03xviii - Population vaccination coverage - Flu (2-4 years old) - historical method	Persons	2-4 yrs	Better	-	H	2016/17	
3.05ii - Incidence of TB	Persons	All ages	Better	-	L	2015 - 17	
4.02 - Proportion of five year old children free from dental decay	Persons	5 yrs	Better	-	H	2016/17	
4.04i - Under 75 mortality rate from all cardiovascular diseases	Persons	<75 yrs	Better	-	L	2014 - 16	
4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable	Persons	<75 yrs	Better	-	L	2014 - 16	
4.07ii - Under 75 mortality rate from respiratory disease considered preventable	Persons	<75 yrs	Better	-	L	2014 - 16	
4.09ii - Proportion of adults in the population in contact with secondary mental health services	Persons	18-74 yrs	Better	-	L	2014/15	
4.10 - Suicide rate	Persons	10+ yrs	Better	-	L	2014 - 16	
4.11 - Emergency readmissions within 30 days of discharge from hospital	Persons	All ages	Better	-	L	2011/12	
4.12i - Preventable sight loss - age related macular degeneration (AMD)	Persons	65+ yrs	Better	Impr.	L	2016/17	
4.12ii - Preventable sight loss - glaucoma	Persons	40+ yrs	Better	No trend	L	2016/17	
4.12iv - Preventable sight loss - sight loss certifications	Persons	All ages	Better	Impr.	L	2016/17	
4.16 - Estimated dementia diagnosis rate (aged 65+)	Persons	65+ yrs	Better	-	H	2018	

2. Indicators where Nottinghamshire is similar to England

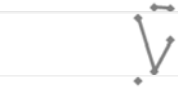
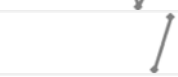
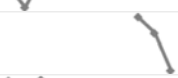
Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity: H(igh) or L(ow) is better. N(ot relevar	Latest time period	Trendline
1.04 - First time entrants to the youth justice system	Persons	10-17 yrs	Similar	Impr.	L	2017	
1.06i - Adults with a learning disability who live in stable and appropriate accommodation	Persons	18-64 yrs	Similar	Impr.	H	2016/17	
1.08iv - Percentage of people aged 16-64 in employment	Persons	16-64 yrs	Similar	Impr.	H	2016/17	
1.09i - Sickness absence - the percentage of employees who had at least one day off in the previous week	Persons	16+ yrs	Similar	-	L	2014 - 16	
1.09ii - Sickness absence - the percentage of working days lost due to sickness absence	Persons	16+ yrs	Similar	-	L	2014 - 16	
1.10 - Killed and seriously injured (KSI) casualties on England's roads	Persons	All ages	Similar	-	L	2014 - 16	
1.16 - Utilisation of outdoor space for exercise/health reasons	Persons	16+ yrs	Similar	-	H	Mar 2015 - Feb 2016	
1.18i - Social Isolation: percentage of adult social care users who have as much social contact as they would like	Persons	18+ yrs	Similar	-	H	2016/17	
2.04 - Under 18 conceptions	Female	<18 yrs	Similar	Impr.	L	2016	
2.04 - Under 18 conceptions: conceptions in those aged under 16	Female	<16 yrs	Similar	Impr.	L	2016	
2.06i - Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds	Persons	4-5 yrs	Similar	Impr.	L	2016/17	
2.09i - Smoking prevalence at age 15 - current smokers (WAY survey)	Persons	15 yrs	Similar	-	L	2014/15	
2.09ii - Smoking prevalence at age 15 - regular smokers (WAY survey)	Persons	15 yrs	Similar	-	L	2014/15	
2.09iii - Smoking prevalence at age 15 - occasional smokers (WAY survey)	Persons	15 yrs	Similar	-	L	2014/15	
2.11i - Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)	Persons	16+ yrs	Similar	-	H	2016/17	
2.11ii - Average number of portions of fruit consumed daily (adults)	Persons	16+ yrs	Similar	-	H	2016/17	
2.11iii - Average number of portions of vegetables consumed daily (adults)	Persons	16+ yrs	Similar	-	H	2016/17	
2.11iv - Proportion of the population meeting the recommended """""""""5-a-day""""""""" at age 15	Persons	15 yrs	Similar	-	H	2014/15	
2.11vi - Average number of portions of vegetables consumed daily at age 15 (WAY survey)	Persons	15 yrs	Similar	-	H	2014/15	
2.13i - Percentage of physically active adults	Persons	19+ yrs	Similar	-	H	2016/17	
2.13ii - Percentage of physically inactive adults	Persons	19+ yrs	Similar	-	L	2016/17	
2.14 - Smoking Prevalence in adults - current smokers (APS)	Persons	18+ yrs	Similar	-	L	2017	
2.17 - Estimated diabetes diagnosis rate	Persons	17+ yrs	Similar	-	H	2017	
2.23ii - Self-reported wellbeing - people with a low worthwhile score	Persons	16+ yrs	Similar	-	L	2016/17	
2.23iii - Self-reported wellbeing - people with a low happiness score	Persons	16+ yrs	Similar	-	L	2016/17	
2.23iv - Self-reported wellbeing - people with a high anxiety score	Persons	16+ yrs	Similar	-	L	2016/17	

Continued …

… continued: Indicators where Nottinghamshire is similar to England

Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity: H(igh) or L(ow) is better. N(ot relevar	Latest time period	Trendline
3.03x - Population vaccination coverage - MMR for two doses (5 years old)	Persons	5 yrs	Similar	Impr.	H	2016/17	
3.04 - HIV late diagnosis	Persons	15+ yrs	Similar	-	L	2015 - 17	
3.06 - NHS organisations with a board approved sustainable development management plan	Not applica	Not applicable	Similar	No trend	H	2015/16	
4.01 - Infant mortality	Persons	< 1 yr	Similar	-	L	2014 - 16	
4.03 - Mortality rate from causes considered preventable	Persons	All ages	Similar	-	L	2014 - 16	
4.05i - Under 75 mortality rate from cancer	Persons	<75 yrs	Similar	-	L	2014 - 16	
4.06i - Under 75 mortality rate from liver disease	Persons	<75 yrs	Similar	-	L	2014 - 16	
4.06ii - Under 75 mortality rate from liver disease considered preventable	Persons	<75 yrs	Similar	-	L	2014 - 16	
4.07i - Under 75 mortality rate from respiratory disease	Persons	<75 yrs	Similar	-	L	2014 - 16	
4.08 - Mortality rate from a range of specified communicable diseases, including influenza	Persons	All ages	Similar	-	L	2014 - 16	
4.12iii - Preventable sight loss - diabetic eye disease	Persons	12+ yrs	Similar	No trend	L	2016/17	
4.15i - Excess winter deaths index (single year, all ages)	Persons	All ages	Similar	-	L	Aug 2015 - Jul 2016	
4.15ii - Excess winter deaths index (single year, age 85+)	Persons	85+ yrs	Similar	-	L	Aug 2015 - Jul 2016	
4.15iii - Excess winter deaths index (3 years, all ages)	Persons	All ages	Similar	-	L	Aug 2013 - Jul 2016	

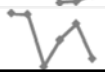
3. Indicators where Nottinghamshire is significantly worse than England

Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity: H(igh) or L(ow) is	Latest time period	Trendline
0.1i - Healthy life expectancy at birth	Male	All ages	Worse	-	H	2014 - 16	
0.1ii - Life expectancy at birth	Female	All ages	Worse	-	H	2014 - 16	
0.1ii - Life expectancy at 65	Female	65	Worse	-	H	2014 - 16	
0.1ii - Life expectancy at 65	Male	65	Worse	-	H	2014 - 16	
0.2iv - Gap in life expectancy at birth between each local authority and England as a whole	Female	All ages	Worse	-	H	2014 - 16	
1.02i - School Readiness: the percentage of children achieving a good level of development at the end of reception	Persons	5 yrs	Worse	Impr.	H	2016/17	
1.02i - School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of reception	Persons	5 yrs	Worse	Impr.	H	2016/17	
1.02ii - School Readiness: the percentage of Year 1 pupils achieving the expected level in the phonics screening check	Persons	6 yrs	Worse	Impr.	H	2016/17	
1.02ii - School Readiness: the percentage of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check	Persons	6 yrs	Worse	Impr.	H	2016/17	
1.06ii - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	Persons	18-69 yrs	Worse	-	H	2016/17	
1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate	Persons	16-64 yrs	Worse	-	L	2016/17	
1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate	Persons	18-64 yrs	Worse	-	L	2016/17	
2.03 - Smoking status at time of delivery - current method	Female	All ages	Worse	Impr.	L	2016/17	
2.03 - Smoking status at time of delivery - historical method	Female	All ages	Worse	-	L	2016/17	
2.08ii - Percentage of children where there is a cause for concern	Persons	5-16 yrs	Worse	-	L	2016/17	
2.11v - Average number of portions of fruit consumed daily at age 15 (WAY survey)	Persons	15 yrs	Worse	-	H	2014/15	
2.12 - Percentage of adults (aged 18+) classified as overweight or obese	Persons	18+ yrs	Worse	-	L	2016/17	
2.15i - Successful completion of drug treatment - opiate users	Persons	18-75 yrs	Worse	Worsening	H	2016	
2.15ii - Successful completion of drug treatment - non-opiate users	Persons	18-75 yrs	Worse	Worsening	H	2016	
2.15iii - Successful completion of alcohol treatment	Persons	18-75 yrs	Worse	No trend	H	2016	
2.16 - Adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison	Persons	18+ yrs	Worse	-	H	2016/17	
2.22iii - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check	Persons	40-74 yrs	Worse	-	H	2013/14 - 17/18	
2.22v - Cumulative percentage of the eligible population aged 40-74 who received an NHS Health check	Persons	40-74 yrs	Worse	-	H	2013/14 - 17/18	
3.02 - Chlamydia detection rate (15-24 year olds)	Persons	15-24 yrs	Worse	Worsening	H	2017	
3.05i - Treatment completion for TB	Persons	All ages	Worse	Impr.	H	2016	
3.08 - Adjusted antibiotic prescribing in primary care by the NHS	Persons	All ages	Worse	-	L	2017	
4.05ii - Under 75 mortality rate from cancer considered preventable	Persons	<75 yrs	Worse	-	L	2014 - 16	
4.13 - Health related quality of life for older people	Persons	65+ yrs	Worse	-	H	2016/17	
4.15iv - Excess winter deaths index (3 years, age 85+)	Persons	85+ yrs	Worse	-	L	Aug 2013 - Jul 2016	

4 Other indicators – no statistical comparison

Indicator Name	Sex	Age	Compared to England	Trend direction	Polarity: H(igh) or L(ow) is better. N(ot relevar	Latest time period	Trendline
0.2i - Inequality in life expectancy at birth ENGLAND	Female	All ages	-	-	L	2014 - 16	
0.2i - Inequality in life expectancy at birth ENGLAND	Male	All ages	-	-	L	2014 - 16	
0.2iii - Inequality in life expectancy at birth LA	Female	All ages	-	-	L	2014 - 16	
0.2iii - Inequality in life expectancy at birth LA	Male	All ages	-	-	L	2014 - 16	
0.2iii - Inequality in life expectancy at 65 LA	Female	65	-	-	L	2014 - 16	
0.2iii - Inequality in life expectancy at 65 LA	Male	65	-	-	L	2014 - 16	
0.2vi - Inequality in healthy life expectancy at birth LA	Female	All ages	-	-	L	2009 - 13	
0.2vi - Inequality in healthy life expectancy at birth LA	Male	All ages	-	-	L	2009 - 13	
1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	Persons	18-69 yrs	-	-	L	2016/17	
1.11 - Domestic abuse-related incidents and crimes - current method	Persons	16+ yrs	-	-	N	2016/17	
1.11 - Domestic abuse - historic method	Persons	16+ yrs	-	-	N	2014/15	
1.12i - Violent crime (including sexual violence) - hospital admissions for violence	Persons	All ages	-	-	L	2014/15 - 16/17	
1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population	Persons	All ages	-	Getting higher	N	2016/17	
1.12iii - Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	Persons	All ages	-	Getting higher	N	2016/17	
1.13i - Re-offending levels - percentage of offenders who re-offend	Persons	All ages	-	Getting lower	N	2014	
1.13ii - Re-offending levels - average number of re-offences per offender	Persons	All ages	-	Getting higher	N	2014	
1.13iii - First time offenders	Persons	All ages	-	Getting lower	N	2017	
1.14ii - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	Persons	All ages	-	-	L	2011	
1.14iii - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	Persons	All ages	-	-	L	2011	
1.17 - Fuel poverty	Persons	All ages	-	Impr.	L	2015	
2.02i - Breastfeeding initiation	Female	All ages	-	-	H	2016/17	
2.02ii - Breastfeeding prevalence at 6-8 weeks after birth - current method	Persons	6-8 weeks	-	-	H	2016/17	
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years)	Persons	<15 yrs	-	-	L	2016/17	
2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	Persons	0-4 yrs	-	-	L	2016/17	
2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24 years)	Persons	15-24 yrs	-	-	L	2016/17	
2.08i - Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months on 31st March	Persons	5-16 yrs	-	-	L	2016/17	

… continued: Indicators where there is no statistical comparison to England

2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	Persons	All ages	-	-	L	2016/17	
2.18 - Admission episodes for alcohol-related conditions - narrow definition	Persons	All ages	-	-	L	2016/17	
2.19 - Cancer diagnosed at early stage (experimental statistics)	Persons	All ages	-	-	N	2016	
2.20v - Diabetic eye screening - uptake	Persons	12+ yrs	-	-	H	2016/17	
2.20vii - Infectious Diseases in Pregnancy Screening - HIV Coverage	Female	All ages	-	-	H	2016/17	
2.20x - Sickle Cell and Thalassaemia Screening - Coverage	Female	All ages	-	-	H	2016/17	
2.20xi - Newborn Blood Spot Screening - Coverage	Persons	< 1 yr	-	-	H	2016/17	
2.20xii - Newborn Hearing Screening - Coverage	Persons	< 1 yr	-	-	H	2016/17	
2.20xiii - Newborn and Infant Physical Examination Screening - Coverage	Persons	< 1 yr	-	-	H	2016/17	
2.23i - Self-reported wellbeing - people with a low satisfaction score	Persons	16+ yrs	-	-	L	2016/17	
2.24i - Emergency hospital admissions due to falls in people aged 65 and over	Persons	65+ yrs	-	-	L	2016/17	
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79	Persons	65-79 yrs	-	-	L	2016/17	
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+	Persons	80+ yrs	-	-	L	2016/17	
3.01 - Fraction of mortality attributable to particulate air pollution	Persons	30+ yrs	-	-	L	2016	
3.02 - Chlamydia detection rate (15-24 year olds)	Female	15-24 yrs	-	Getting lower	H	2017	
3.02 - Chlamydia detection rate (15-24 year olds)	Male	15-24 yrs	-	Getting lower	H	2017	
3.03i - Population vaccination coverage - Hepatitis B (1 year old)	Persons	1 yr	-	-	H	2016/17	
3.03i - Population vaccination coverage - Hepatitis B (2 years old)	Persons	2 yrs	-	-	H	2016/17	
3.03ii - Population vaccination coverage - BCG - areas offering universal BCG only	Persons	1 yr	-	-	H	2016/17	
3.03iv - Population vaccination coverage - MenC	Persons	1 yr	-	-	H	2015/16	
4.09i - Excess under 75 mortality rate in adults with serious mental illness	Persons	18-74 yrs	-	-	L	2014/15	
4.14i - Hip fractures in people aged 65 and over	Persons	65+ yrs	-	-	L	2016/17	
4.14ii - Hip fractures in people aged 65 and over - aged 65-79	Persons	65-79 yrs	-	-	L	2016/17	
4.14iii - Hip fractures in people aged 65 and over - aged 80+	Persons	80+ yrs	-	-	L	2016/17	

Appendix 2: Action plan for PHOF indicators of concern, where Public Health has influence over outcomes

Identified PHOF Indicator	Previous PHOF Status compared to England, plus trend direction	Targets (where applicable)	Report lead	Actions undertaken / progress in Q1 2018/19	Actions undertaken / progress report for Q2 2018/19	Forward plan of planned actions 2018/19 (updated at end Q2)
3.02 Chlamydia detection rate, 15-24 year olds	WORSE/ Improving	Included in Service Plan. Base target: reverse downward trend Stretch target: move towards national average. Baselines: 1423 (2016) Notts rate 1882 (2016) England rate 1820 (2016) East Midland rate. 2017: Q2 1632.07 Q3 1712.99 Q4 1762.45 2018 Q1 1789.43	Gill Oliver	The current detection for Q1 of 2018 is 1789.43, and has been increasing steadily over the last 12 months (while the England average has been dropping). An online chlamydia testing service has been commissioned to increase access (started November 2017). Quality Assurance visits with service providers are focusing on chlamydia and HIV testing.	The current detection rate for Q2 is 1987.2 which is higher than the East Midland and England rate for the quarter. There has been an increase in the number of online tests and tests classified as 'other'. This 'other' classification captures a variety of testing sites such as outreach, internet and community. Over 300 Smartkits that were ordered for the youth service are being reassigned to sexual health promotion teams. Pharmacies that have high Emergency Hormone Contraception activity are being invited to express interest in taking part in a chlamydia testing pilot project. Quality Assurance visits with service providers are focusing on chlamydia and HIV testing.	Scoping potential pilot projects of increased chlamydia testing with the Emergency Hormone contraceptive contract Work with service providers to increase the offer and uptake of testing Working with Healthy Families Partnership to make it easier to offer and provide chlamydia tests Attend chlamydia pathway training Work with service providers to increase the offer and uptake of testing
1.02 School readiness	WORSE/ Improving	Included in Service Plan. Target: increase proportion of children aged 2 – 2 ½ offered ASQ -3. Baseline: 77.8%	Kerrie Adams	Review of the evidence of 1001 days /support for school readiness to support targeted work Ongoing discussions at HFP contract meeting/service review to increase uptake of 2 year review Review of performance in relation to integrated 2 year review with early years settings Development of 'ready for school' guidance booklet for parents in partnership with CFCS and NHFT Scoping of target audience to receive a 3 year targeted review from HFT's to support school readiness Review and re-model perinatal mental health care pathway with key stakeholders to ensure early identification and management of issues.	Review of 1001 days evidence complete and shared with Early Years attainment group. Slight increase seen in uptake for Q1. Notts in line with regional data .Integrated 2 year review data explored at QCRM. Performance is reflective of the % of children not achieving good level of development in ASQ3 . Ready for school booklet complete and shared with parents at key checkpoint reviews Multi-agency teering group to determine target audience for 3 year review and review content meeting regularly Perinatal mental health group meeting regularly. New pathway not yet implemented due to challenges within IAPT services. Perinatal work feeding in to local maternity system transformation board	Review of PH/CCG commissioned SLT pathway to support communication/literacy outcomes: ONGOING Formal introduction of a targeted 3-3.5 year review: ONGOING Increased PH input (co-chair) into NCC Early Years Attainment group with shared ownership of Early years improvement plan (available on request) and effective parental engagement plan : COMPLETE Define interventions offered by HFT's for children not meeting developmental milestones identified through ASQ3 at 1year and 2.5 years: ONGOING Implementation of new perinatal mental health pathway.: ONGOING

2.22 Cumulative percentage of NHS Health Checks offered which were taken up	WORSE / No change or trend	Originally included in Service Plan. Target: 75%. Baseline: 57.1% (2013/14 Q1 – 2017/18 Q3) Updated in Council Plan report: Proportion of eligible population who are offered / invited an NHS Health Check. Cumulative offered a health check: 61.9% Cumulative uptake (offered and received a health check) 57.5% (2013/14 Q1 – 2017/18 Q3) Targets set: 60% (invites) 66% (uptake)	Geoff Hamilton	• Practice liaison visits undertaken, targeted at lowest performing and/or lowest compliance practices • Practices reminded of 'top tips' on how to increase uptake and e-learning available for practitioners • New, simpler template launched (except in Bassetlaw) to encourage both activity and compliance • Improved invitation letter added to e-Healthscope	• Resolution of IT invitation issue Increase in payments to GP practices from 1 July 2018, primarily for high risk patients • Five practice liaison visits undertaken • Roll out of new template into Bassetlaw; all county practices also now have access - compliance has improved as a result • Six workplace health check sessions undertaken	Alert protocol to be launched on SystmOne • Further targeted practice liaison visits planned, incl. liaison with CCG leads once CCG restructure complete • Develop more robust performance and quality improvement framework • Transfer of Bassetlaw to e-Healthscope
2.22 Cumulative percentage of eligible population who have received a health check (coverage)	WORSE / No change or trend	Included in Service Plan. Target: increase compared to previous. Baseline: 35.6% (2013/14 Q1 – 2017/18 Q3) Updated in Council Plan report – see above row.	Geoff Hamilton	Actions incorporated in those listed to improve uptake as above	Actions incorporated in those listed to improve uptake	Actions incorporated in those listed to improve uptake
2.12 - Percentage of adults (aged 18+) classified as overweight or obese - current method	WORSE / No change or trend	Baseline: 2015/16 – 65% adults obese in Nottinghamshire; vs. 61.3% in England. Latest data: 2016/17 - 64.4% vs. 61.3%	John Wilcox	Obesity Prevention & Weight Management Service (OPWM) – work to firm up outcome measurement & reporting with the Provider. First quarter that the service is implementing additional targeted Prevention work instead of tier 3 weight management. Health & Wellbeing Strategy – Food Environment - Development of new Plans and Board workshop . Health & Wellbeing Strategy – Spatial Planning & Health – ongoing work to refresh the Framework and Protocol. Healthy Options Takeaway Scheme – Additional capacity added for engaging businesses as part of OPWM service.	Obesity Prevention & Weight Management Service (OPWM) – Implementation of a rnmage of new targetted prevention workstreams including bespoke offers to each district. Health & Wellbeing Strategy – Food Environment - New Plans being prepared. Health & Wellbeing Strategy – Spatial Planning & Health – ongoing work to refresh the Framework and Protocol. Healthy Options Takeaway Scheme – Businesses signed up increased to 183 from 150 in Q1.	OPWM –Ensuring the quality of the implemation of new targetted prevention initiatives. Ensuring outcomes of adult weight mangement are acurately reported. Health & Wellbeing Strategy – Food Environment/ Physical Activity/Planning & Health – Coordinate Plans via Health & Sustainavble Places Coordination Group.

2.15i Successful completion of drug treatment- opiate users	WORSE / worsening	The national published statistics known as the PH Outcomes Framework only measures successful completions from a clinical treatment aspect. Therefore, if members were to check the PH outcomes framework, Nottinghamshire would be shown as red and therefore below the national average. This is due in part to the fact that the figures are based on 2016 data. The Nottinghamshire SMS contract measures a different indicator to the framework.	Sarah Quilty	Successful completions from the whole service as defined by the contract have been consistently good and have been exceeded by the provider. PH and the provider work closely together and the service offers very good value for money to the Council and taxpayers with very positive feedback from service users. Overall Completion rates for opiates from CGL are on an upward trajectory in Nottinghamshire (7.8%) which is above the PHE national average of 6.76% and the CGL national average of 6.81%. Even with a low number of expected successful completions (15 per month) Nottinghamshire will move into the top quartile of its comparator neighbours (LOC) and above its comparator neighbours at a high number of completion per month. Quarter 4 report from NDTMS data (there is a slight difference between NDTMS data and the provider data) shows that successful completions for opiates have improved from5.3% up to 7% (150) which means Nottinghamshire has gone from Red to Amber . In order for Nottinghamshire to have gone into the top quartile of Local Authorities there would have needed to be a completions rate of 7.8% which equates to 172 individual successful completions.	**Service Data from CGL - for Q1 but received in Q2** Overall Completion rates for opiates from CGL are above the PHE national average of 6.41% and the CGL national average of 6.13% with an average over a three month period (April, May and June) of 7.3% . In order to move into the top quartile for Local Authorities CGL require a completion rate of 8.3% which equates to 13 individuals per month instread of the current 10 individuals per month.	
2.15ii Successful completions of drug treatment- non-opiate users	WORSE / worsening	As above - line 8	Sarah Quilty	Quarter 4 2017-2018 from NDTMS data shows an improvement in successful completions for non-opiate from 32.9% to 33.3% successful completion (219 successful completions out of a possible 658 in treatment) Again this means we have gone from Red to Amber in terms of performance. Top quartile for Local Authorities is 38.71%, which equates to 255 individual successful completions. However it is important to note that not all Local Authorities can reach the top quartile, it is only the top 8 best performing local Authorities out of 32 and in addition this is a moving target depending on completion rates elsewhere within the 32.	Service Data from CGL - received during Q2 but relates to Q1. Suessful competion data from CGL for non-opiates show that over a three month period (April, May and June) that there is a completion rate of 39.5% which above the CGL national average of 38.4% and the PHE national average of 39.04%. Successful completions for non-opiate are on an upward trajectory and to move into the top quartile range of Local Authorities completions will have to improve from 8 to 11 individuals per month	
1:06 ii Adults in contact with secondary mental health services who live in stable and appropriate accommodation	WORSE / No change or trend	Baseline 2016/17 Notts 42.0 E Mids 61.0 (above England average) England 54.0	Susan March	June 2018 procurement for Supported Accommodation for Homeless people commence with the plan to have the service in place by Sept 2018.	September 2018 contract awarded to Framework Housing Association. Working with the provider implement community asset based approaches to support people to move onto stable accommodation	From Sept 2018 outcomes based monitoring will be place with performance targets that will indicate if a homeless person with mental health problems has moved on to stable/appropriate accommodation.
1:08 i Gap in the employment rate between those with a long-term health condition and the overall employment rate	WORSE / No change or trend	Baseline Gap in employment rate for Notts compared to East Mids and England averages 2015/16: LTCs Notts 36.1 E Mids 31.8 England 29.6	Susan March	Scoping of availability of funding options and current provision that address employment option for people with long-term conditions and LD	No further action	Submit a funding proposal with Economic Enterprise that increase employment opportunities

1:08 ii Gap in the employment rate between those with a learning disability and the overall employment rate	WORSE / No change or trend	Baseline Gap in employment rate for Notts compared to East Mids and England averages 2015/16: LD Notts 71.0 E Mids 70.9 England 68.1	Susan March	As per 1:08 i	No further action	As per 1:08 i
1:18 ii Social Isolation: percentage of adult carers who have as much social contact as they would like	WORSE / No change or trend	Connect Service commissioned and performance managed by ASCH Baseline (2012/13) Notts 32.1 East Mids 37.6 England 41.3	Susan March	Supporting Maun Valley Citizen UK in the identification and the development of a targeted programme to prevent loneliness in Mansfield and Ashfield.	Collaborative work with Place has commenced with the view to extend the reach of Age Friendly Nottinghamshire interventions to reduce loneliness	Undertake a review of social prescribing models that will reduce social isolation Offer Public Health support and advice in the commissioning of a social prescribing model
4.15 iv Excess winter deaths index (3years, age 85+)	WORSE / No change or trend	Nottinghamshire Energy Partnership (NEP) contract being novated from the city to NCC Baseline Aug 2013 – July 2016 Notts 30.9 East Mids 25.9 England 24.6	Susan March	Fragmented pathways between BCF Warm Home on Prescription (WHOP) service and NEP.	WHOP and NEP worked collaborative in developing an information pamphlet on referral pathways and offer with the intention to avoid service duplication. Ongoing evaluation is required to ensure ongoing collaboration between providers continues. Winter warmth campaign due to be launched in November 2018	Public Health working with NEP and WHOP providers to ensure pathways are easily accessible for a person to get advice, information, housing insulation and heating installed. Improve contract monitoring to ensure NEP delivery is targeting those most at risk and offers a County Wide service
2.03 Smoking At The Time of Delivery (SATOD)	WORSE / Improving	National target 6% by 2021/22 2016/17 Baselines: 10.5% England average 14.5% Nottinghamshire Within County range from 20.9% (Mansfield and Ashfield) to 4.3% (Rushcliffe). Updated Baselines based on local analysis for 2017/18 – 10.8% England average 14.7% Nottinghamshire Within County range from 21.9% (Mansfield & Ashfield) to 5.7% (Rushcliffe). NB Calculation methodology changed from April 2017 and now excludes 'Status not Known' from calculation – results in higher values that Historic method (previous values 2016/17). PHE in PHOF will conduct more involved analysis – 2017/18 not yet published.	Lindsay Price	SATOD rates are reducing across the county on a consistent downward trend following significant work with maternity services across the county.	SATOD rates continue to reduce across the county. Q1 2018/19 county data ranges from 20.6% in Mansfield and Ashfield to 5.8% in Rushcliffe. Re evaluation of the Risk Perception model at SFHFT is in progress.	Full Implementation of Saving Babies Lives Care Bundle by 31st March 2019.Planned reduction of 1% per year (part of Local Maternity System Transformation trajectories with City). This will be monitored at the Local Maternity System Board. Community Maternity hub in Ashfield Village and Newark planned and launched March 2019. Plan to run the Love Bump Smoking in Pregnancy Campaign across Nottinghamshire Local Maternity System.

Appendix 3. Health inequalities within Nottinghamshire County

This work used data from Local Health, an online resource developed by Public Health England (http://www.localhealth.org.uk/). This tool presents health, demographic and healthcare data for small areas, including electoral ward.

Inequalities across the County were calculated for each indicator using the Slope Index of Inequality, a measure of the social gradient in an indicator that shows how much the indicator varies with deprivation.

High levels of inequality reflect where there is a large difference *between* communities within the County; low levels of inequality relate to issues where there are small differences across the County. Please note that the level of inequality does not necessarily relate to the overall measure for the County; any of the issues listed below might have a high, middle or low measure when Nottinghamshire is compared to England values.

High levels of inequality in Nottinghamshire were found for:

- Child poverty
- Child development at age 5
- Carers (50 hours a week or more)
- Residents who indicate that their health is ‘bad’ or ‘very bad’
- Overweight or obese children – ages 4/5 and 10/11 years old
- Hospital admissions for injury; all age groups under 24
- Emergency hospital admissions, children aged 5 or younger
- Emergency hospital admissions (all ages, all causes)
- Planned hospital admissions for heart disease
- Life expectancy at birth for males
- Death rates – all causes
- Early deaths from coronary heart disease
- Deaths from respiratory diseases

Particularly low levels of inequalities were found for:

- Carers (one hour a week or more)
- A&E attendances (aged under 5)
- Emergency hospital admissions for coronary heart disease
- Emergency hospital admissions for heart attack
- Planned hospital admissions for knee replacement

Nottinghamshire County Council

Report to the Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH PERFORMANCE AND QUALITY REPORT FOR CONTRACTS FUNDED WITH RING-FENCED PUBLIC HEALTH GRANT JULY TO SEPTEMBER 2018

Purpose of the Report

1. To enable Members to scrutinise the performance and quality of services commissioned by Public Health (PH)

Information

2. The Health and Social Care Act 2012 confers general duties on local authorities to improve and to protect the health of their local populations, including specific statutory duties to commission certain mandatory services for residents[1], the provision of specialist advice to the local NHS, and health protection advice to organisations across the local system.

3. In discharging these duties, the Council is currently supported by a ring-fenced grant which must be deployed to secure significant improvements in health, giving regard to the need to reduce health inequalities and to improving uptake and outcomes from drug and alcohol treatment services.

4. Services commissioned by public health contribute to a number of Council commitments (in particular, Commitment 6 – People are Healthier) and are critical for securing improved healthy life expectancy for residents.

5. Working with colleagues, the Public Health Contract and Performance Team manages the performance of providers to ensure the Authority and the residents of Nottinghamshire are receiving good outcomes, quality services and value for money.

6. Contract management is undertaken in a variety of ways including regular contract review meetings, quality assurance visits to the service and ongoing communication.

[1] These mandatory services include: local implementation of the National Child Measurement Programme, assessment and conduct of health checks, open access sexual health and contraception services

7. This report provides the Committee with an overview of performance for Public Health directly commissioned services and services funded either in whole or in part by PH grant, in July to September 2018 against key performance indicators related to Public Health priorities, outcomes and actions within:

    i) the Public Health Service Plan 2017-2018;
    ii) the Health and Wellbeing Strategy for Nottinghamshire 2017-21; and
    iii) the Authority's Commitments 2017-21.

8. A summary of the key performance measures is set out on the first page of **Appendix A**. Where performance is at 80% or greater of the target or meets the standard, it is rated green.

9. Appendix A also provides a description of each of the services and examples of the return on investment achievable from commissioning public health services.

NHS Health Checks (GPs)

10. The NHS Health Check Programme aims to help prevent heart disease, diabetes, stroke, kidney disease and certain types of preventable dementia by offering a check once every five years to everyone between the ages of 40 and 74 who has not already been diagnosed with one of these conditions.

11. Quarter 2 of 2018/19 shows reasonable performance, with 8,228 people being invited to attend a health check, above the quarterly target of 8,218. During the same period 4,946 health checks were undertaken, indicating an uptake of 60.1%, which compares favourably against the national average of 42.6% (Q1 2018/19).

12. Over the last four quarters, there had been a slight but noticeable drop in the number of people offered a health check, which was traced to a minor fault in the set-up of the new IT system that identifies the eligible population. This had been programmed to re-invite high risk patients ('high risk' is defined as having a likelihood of 20% or more of suffering a cardiovascular disease (CVD) event within the next ten years) who had not responded to their first invitation and two follow-ups after a period of one year. These had been prioritised over first time invitations for all other patients within the main five year cohort, both low and high risk. It is *first-time* invitations that are reported to Committee and to Public Health England for performance management purposes.

13. This has since been rectified, as evidenced by the strong Quarter 2 performance. Nonetheless, practices are still encouraged to target high risk patients when they send out first-time invitations and follow-ups. Once confirmed as high risk by the health check, these patients immediately exit the programme and are treated by their GP to prevent more serious outcomes. Patients with a lesser risk are also offered advice and sometimes treatment, as well as sign-posting to appropriate lifestyle services.

14. In addition to encouraging practices to increase the number of checks that they complete, considerable focus has been given by Public Health to supporting practices to undertake fully compliant health checks (i.e. that they complete all of the required assessments correctly). Overall compliance has improved consistently as a result of this intervention.

Focusing on the quality of the checks undertaken rather than just the quantity is essential in ensuring that patients receive the correct CVD risk score and associated guidance.

15. In addition to health checks undertaken in GP surgeries, Public Health commissions a small outreach service provided by a local community pharmacy which delivers NHS Health Checks in county workplaces. This service enables working people to access NHS Health Checks more conveniently and also seeks to target specific groups within the workforce at higher risk of CVD. During Quarter 2, six sessions were delivered to 59 people, a quarter (25%) of whom were found to have high blood pressure or cholesterol and nearly half (42%) were offered advice on lifestyle interventions.

Integrated Sexual Health Services (ISHS) (Nottingham University Hospitals (NUH), Sherwood Forest Hospital Foundation Trust (SFHFT) and Doncaster and Bassetlaw Hospitals (DBH)

16. The ISHS provides a testing and treatment service for sexually transmitted infections (STIs) and contraception. There are 3 sexual health providers and they continue to perform well in quarter 2 with a slight improvement in the number of filled appointments compared with quarter 2 last year from 12,234 to 12,322.

60% of new users accepting HIV test

17. SFHT and DBH are now working to the new definition for this quality standard which is in line with the Public Health Outcomes Framework (PHOF) definition. This means there has been a significant improvement in performance. NUH has seen a fall in the number of new service users accepting an HIV test and this may be due to IT updates to their reporting system. This will be discussed in full at the Quarter 2 contract review meeting. The Authority is waiting for Public Health England (PHE) analysts to independently review the data. It appears that different IT systems at the various provider organisations and coding issues have caused figures to be artificially low in Nottinghamshire. Until PHE complete this piece of work there can be no speculation about what the percentages will be, but it is expected they will be considerably higher.

75% of 15-24 year olds accepting a chlamydia test.

18. Chlamydia is one of the most common STIs and although often symptomless it can cause long-term health problems including infertility if left untreated.

19. SFHT has exceeded the quality standard of 75% of 15-25 year olds in contact with the service accepting a chlamydia test in quarter 2. NUH and DBH remain below target, however as part of the overall aim to improve chlamydia testing rates for this age group, work is ongoing between the Authority and all providers to improve performance against this metric. It is expected that all providers will achieve the standard in the next six months.

20. The most recent PHOF data for Quarter 2 2018 shows a continuing upward trend for Nottinghamshire with a positive detection rate of 1,989 which is higher than the East Midlands and England rate for the quarter. High detection rates and diagnoses is a sign of a good service as it means more people are getting treated and able to manage their condition.

21. The use of the on-line testing service for chlamydia continues to increase. Online chalmydia testing provides an accessible and confidential way for young people to get tested for a relatively common but potentially serious sexually transmitted disease which often shows no symptoms in the early stages. This means that positive cases can be treated, preventing onwards transmission and reducing the likelihood of chlamydia infection for sexually active young people in Nottinghamshire.

Young People's Sexual Health Service- C Card (In-house)

22. The C-card scheme is a free and confidential advice and condom service for young people living in Nottinghamshire. The provider has been given a difficult stretch target to meet which may need to be reviewed.The service is performing well overall, with a 40.4% increase in new service users registering for the scheme between Q1 and Q2. Historically, achieving an increase has been a challenge and an action plan has been developed for 2018/19 which aims to continue the increase in new registrations and number of active sites across the scheme.

Alcohol and Drug Misuse Services (Change Grow Live)

23. Change, Grow, Live (CGL) is the substance misuse treatment and recovery service in Nottinghamshire.

24. Successful completions from the whole service as defined by the contract have been consistently good and have been exceeded by the provider as evidenced in the performance figures.

25. CGL works proactively across the county to ensure residents get free from their substance misuse. Successful completion data from CGL for non-opiates such as cannabis, amphetamines, steroids, cocaine and crack cocaine and Novel Psychoactive Substances (or what were formerly known as 'legal highs'), show that for quarter 2, there is a completion rate of 39.5% which is both above the CGL national average of 38.4% and the Public Health England (PHE) national average of 39.04%. Successful completions for non-opiates are on an upward trajectory which is positive for residents.

26. Furthermore, overall completion rates for opiate users of heroin or codeine from CGL are above the PHE national average of 6.41% and the CGL national average of 6.13% with an average of 7.3%.

27. Successful completions for alcohol are also on an upward trajectory with a 39.42% completion rate, which is in line with the PHE national average.

28. These results demonstrate the effectiveness of the treatment and recovery system in Nottinghamshire, especially as the Nottinghamshire measurements are harder to achieve than the national framework. The aim in Nottinghamshire is to ensure all service users with any substance misuse issues are helped to recovery and not just those who require a clinical intervention (generally opiate users).

29. CGL works extensively with service users in Nottinghamshire to ensure recovery is part of their treatment pathway from entry into the service. CGL offers a quality peer support for those who are finishing with their treatment and wish to support other service users along with their recovery.

Young People's Substance Misuse Service (Nottinghamshire Healthcare Foundation Trust)

30. The dramatic decline in referrals into the service in quarter 2 is due to the provider serving notice on this contract and a number of staff leaving the service. From the beginning of the third quarter, this service has been taken over by CGL, the main substance misuse provider. It is always difficult for any new provider to run with a new service albeit expectations are high that targets will be met by the end of the financial year.

Smoking Cessation (Solutions 4 Health)

31. The service in Nottinghamshire (SmokefreeLifeNotts) was recently restructured to deliver a new model for smoking cessation. The new model offers a more flexible, individualised approach with increased access to telephone and online support as well as the more traditional groups and one to one sessions.

32. SmokefreeLifeNotts staff are now on the wards in King's Mill Hospital, offering support at the bedside to patients who smoke, either with quitting or temporary abstinence during their hospital stay. "Stop Before the Op" support is also offered to outpatients waiting for elective surgery. This will complement the ongoing work that continues to take place with pregnant women at King's Mill Hospital and the wellbeing coordinators.

33. SmokefreeLifeNotts staff are also now on the wards at Nottingham University Hospitals (NUH) to enable them to adopt the same ward based approach to support County patients who attend the hospital as inpatients and outpatients, in line with the prevention approach outlined by the Health Minister in November.

34. Due to the cyclical nature of smoking cessation (more people quit at New Year, following Stoptober and Stop Smoking Day in March), referrals and therefore quitters are expected to rise in line with these key campaigns.

35. It is positive to note that, albeit small, there is an improvement in the numbers of successful quitters. It is expected with all the changes made by the service and extra input from public health that this upward trajectory is set to continue.

Illicit Tobacco Services (In-house)

36. The Council's officers continue to take effective enforcement action against individuals and businesses that sell and distribute illicit tobacco. During Quarter 2 of 2018 officers conducted a total of 23 inspections at premises in the county, resulting in 7 seizures of illicit tobacco. Total seizures amounted to a retail value of £28,590 (£25,370 of cigarettes and £3,220 of tobacco). The work is intelligence led and targeted in order to work in the most efficient and

effective way. The employment of a Police Officer as part of the team is integral to its success in achieving prosecutions. A number of investigations are ongoing.

Assist (In-house)

37. The ASSIST peer led smoking prevention programme continues to be run in targeted schools across Nottinghamshire and the impact on young people across the county continues to be very positive. ASSIST is improving young people's health whilst providing valuable life skills. ASSIST's activity based training improves leadership, communication skills, resilience, self-esteem, confidence, highlights empathy and shows the value of taking a non-judgemental approach to peer-led conversations. The whole school benefits from increased conversations around smoking and health.

38. A further five schools have been recruited to the programme during 2018/19 quarter 2 and it has been agreed that the programme will continue to run until March 2019

Obesity Prevention and Weight Management (Everyone Health)

39. The Obesity Prevention and Weight Management service supports children, and adults through a variety of targeted community prevention healthy eating and physical activity initiatives and weight management support. The service is performing above target for adults supported in weight management and on track for children. Performance for the number of pregnant women supported is below target.

40. The Provider has identified that low uptake of maternity weight management services is due to a combination of lower than expected demand from pregnant women, low number and untimely referrals from NHS maternity services, and the need for a service offer more tailored to service user preferences. The Authority has worked with the Provider and NHS leads to develop a service improvement plan for maternal weight management. These service and system changes have resulted in improvements in the uptake of the maternal weight management offer in comparison to the same period a year ago, but this is still below the planned level of service uptake.

41. Regular contact with the midwifery leads addressing the issues relating to referrals which are different for each midwifery service keeps this agenda in the spotlight. The new pathway is being implemented and Everyone Health has adopted revised marketing materials.

42. The service is now able to refer individuals to 12 other weight management offers through sub-contracting arrangements, where appropriate to the service user's need. This has increased the number of adults accessing weight management services and the service is currently above target. It also offers service users more choice of weight management support.

43. The service is on track with its prevention sessions, projects in schools, and with vulnerable adults.

44. As a result of a re-negotiation of the contract at the beginning of 2018/19, the Service is establishing additional new prevention projects covering both physical activity and nutrition

based support at district and borough level in community, workplace and schools settings. The projects are proceeding as scheduled.

Domestic Abuse Services (Notts Women's Aid and Womens Aid Integrated Services)

45. The Domestic Abuse service provides information, advice, safety planning and support (including support through the courts) to women, men, teenagers, children and young people. Services are facing increasingly complex and difficult cases but continue to to be on track to meet all indicative targets set by commissioners (the Authority and the Office of the Police and Crime Commissioner). Quality Assurance visits further evidence that the services provided are robust, well received by service users and provide good value for money.

46. The numbers of adults, children and young people show an increase compared with the same period last year.

47. There are a number of children on Child Protection Plans who live in a household with domestic abuse and to this end the providers work closely with Children's Services and have workers based with the Family Service.

Seasonal Mortality (Nottingham Energy Partnership)

48. This service protects and improves the health of residents in Nottinghamshire County, by facilitating insulation and heating improvements and preventative adaptations in private sector homes, providing energy efficiency advice and reducing fuel poverty. The service targets the most deprived private sector households, with a specific emphasis on support to residents over 60 and a smaller provision for families with children under 5 and pregnant women. The service is on track to achieve 2018/19 targets.

49. In Quarter 2, the service has reached the target of 68 people who received comprehensive energy efficiency advice and/or were given help and advice to switch energy supplier or get on the cheapest tariff. The service also trained 42 (against a target of 47, 89% achievement) individuals to deliver Energy Efficiency Brief Interventions to improve awareness of the links between cold-homes, fuel poverty and ill health and to generate appropriate referrals to the service.

Social Exclusion (The Friary)

50. The Friary provides a "one-stop" approach on three mornings a week from a single location in West Bridgford to individuals in crisis situations, including homeless people. It delivers one to one assessment of need, specialist advice and practical support regarding housing, benefits, debts and health needs (including signposting to other services that operate within the Friary e.g. GP clinic, substance misuse services) The service offered support to 374 individuals in Quarter 2 with the service giving specialist advice to 2,528 people and providing 1,240 health care support and interventions. This shows a slight increase in numbers presenting, compared to Quarter 1.

Public Health Services for Children and Young People aged 0-19 (Nottinghamshire Healthcare Trust)

51. The service has entered its second year of delivery and the Healthy Families Programme is now embedding across the County as a fully integrated universal service for children, young people and their families. The Authority has set ambitious targets for the provider and whilst some of these targets have yet to be met, the service overall is performing well with Nottinghamshire data for mandated reviews comparable with, or better than the England average.

52. Staffing and recruitment challenges experienced by the service due to retirement, maternity leave, and sick leave are resolving. The Trust is working pro-actively to recruit and retain the workforce and a rolling programme of recruitment for permanent staff has been launched. This increase in workforce capacity is being reflected in improved performance against the key performance indicators.

53. A quality assurance visit focussing on safeguarding was conducted by the Authority during Q2. Whilst this identified good safeguarding procedures within the 0-19 service, it also highlighted the need to work more closely with colleagues in primary and secondary care in order to improve communication pathways. This will be monitored as part of ongoing contract management processes

Oral Health Promotion Services (Nottinghamshire Healthcare Trust)

54. Nottinghamshire's specialist Oral Health Promotion Team works to improve oral health within local communities and among vulnerable groups by delivering training for the health, social care and education workforce, a supervised tooth-brushing programme in targeted primary schools (with linked nurseries) and health promotion activities such as the provision of tooth-brushing packs to one year olds.

55. During Q2, oral health promotion training among frontline staff was delivered to 62 staff working in child-related services and 71 in adult-related services (Q2 target of 50 each). The supervised toothbrushing programme was active in 19 primary schools (against a target of 20) and parents of 2,135 children received oral health advice and resources at their child's one year health review (97% of the Q2 one year old child cohort). This represents good performance by the service, which continues to work with energy to develop new ways of promoting oral health widely among the population.

56. The service has also recently reached the finals of the Oral Health Awards 2018 in the 'Best Community Initiative' category for its innovative educational resource, Teeth Tools for Schools. This resource contains lesson plans, information and whole school approaches to motivate local primary schools to embrace oral health and make it integral to the school day. In 2017/18, 94% of primary schools in the county actively utilised this resource (which can be viewed at www.nottinghamoralhealth.com), successfully sharing key oral health messages with local children.

Single Person Supported Accommodation (Framework)

57. The service provides intensive support in short term hostel accommodation (up to 18 weeks) and less intensive support in Move On and Housing First Accommodation (typically for six months, and up to a maximum of 12 months) aimed at enabling the service user to achieve a range of outcomes including self-care, living skills, managing money, motivation and taking responsibility, social networks and relationships, managing tenancy and accommodation, reducing offending and meaningful use of time.

58. The Single Person Supported Accommodation contract was re-tendered in Q2 with Framework Housing Assocation being awarded the contract for contract commencement on the 22nd of September 2018. The service will continue to provide the opportunity for the assessment of support needs, followed by intensive and targeted housing related support to enable an individual to move towards independent living. Going forward the service will support people to meet their health and social care needs alongside targeted housing related support.

59. Following the procurement of this service, service mobilisation was undertaken in Quarter 2 with new targets which have not all been met albeit it is anticipated the percentage of service users leaving hostel accommodation in a planned way will increase and meet targets in the next six months.

Community Infection Prevention and Control (CCGs)

60. This service provides advice and assistance to prevent the spread of infectious and avoidable diseases. The team has provided initiatives in care homes, GP practices and the acute hospital trusts including hand hygiene training, viral swabbing, advice and assistance. The service continues to meet all of the Authority's key performance indicators.

Academic Resilience (Each Amazing Breath-EAB and Young Minds-YM)

61. Academic resilience providers develop and deliver an evidence-based programme that improves emotional health, wellbeing and resilience of children and young people in 30 Nottinghamshire schools. It is a whole school approach, meaning that school leaders, staff, children and young people are all involved. It includes approaches such as training the trainer and pupils and students as coaches, mentors or teachers. The programmes are sustainable and will enable schools to have the understanding, knowledge, skills and resources to continue independent delivery of the programme thus building resilience for new cohorts of children and young people after the direct contract activity ends. There are currently two provider organisations commissioned to deliver programmes within Nottinghamshire: 'Each Amazing Breath' and 'Young Minds'.

62. Developed by Each Amazing Breath (EAB), 'Take Five' is a Whole School Resilience Building Programme based on breathing, grounding, and awareness that helps children to develop their capacity to handle life's challenges with awareness and confidence, building skills of self-regulation, and managing anger. EAB is currently commissioned by the Authority to deliver the programme in 15 schools across Bassetlaw, Newark and Sherwood, Mansfield and Ashfield.

63. In Broxtowe, Gedling and Rushcliffe, the Authority has commissioned Young Minds to deliver a school based academic resilience programme which uses evidence based approaches to

help schools close the attainment gap. Schools are supported to develop their own practical, integrated whole-school approach to identifying and supporting vulnerable pupils to enable them to achieve their emotional and academic potential.

64. Young Minds supports 15 schools in the three boroughs, including one school for children with special educational needs and disability, Derrymount. During Q1 and Q2 100% of school staff who have taken part in academic resilience training report that they now have an increased understanding of mental health and resilience.

Other Options Considered

65. None

Reason/s for Recommendation/s

66. To ensure performance of Public Health services is scrutinised by the Authority

Statutory and Policy Implications

67. 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

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

Public Sector Equality Duty implications

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

Safeguarding of Children and Adults at Risk Implications

70. Safeguarding is a standing item on contract review meeting agendas and providers are expected to report any areas of concern allowing the Authority to ensure children and adults at risk are safe.

Implications for Service Users

71. The management and quality monitoring of contracts are mechanisms by which commissioners secure assurance about the safety and quality of services using the public health grant for service users.

RECOMMENDATION

1) For Committee to scrutinise the performance of services commissioned using the public health grant

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
Nathalie Birkett
Group Manager Contracts and Performance
nathalie.birkett@nottscc.gov.uk
01159772890

Constitutional Comments [CEH 08.11.2018]

72. The recommendation falls within the delegation to Adult Social Care and Public Health Committee under its terms of reference.

Financial Comments [DG 07.11.2018]

73. The financial implications are contained within paragraph 68 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.

- 'None'

Electoral Division(s) and Member(s) Affected

- 'All'

Nottinghamshire County Public Health Services Performance Report

Number	Quality standard
YTD 80% or higher of expected	Standard met or exceeded
YTD less than 80% of expected	Standard not met

Quarter 2 2018/19

Service Name	Indicator or Quality Standard	2017/18 final figures for comparison	2017/18 Q2	Annual plan 2018/19	Plan to Date	Q1	Q2	Actual YTD
NHS Health Checks	No. of eligible patients who have been offered health checks	28,540	9,160	32,874	16,437	5,941	8,228	14,169
	No. of patients offered who have received health checks	19,065	4,956	21,697	10,849	5,049	4,946	9,995
Integrated Sexual Health Services	**Total number of filled appointments**							
	Sherwood Forest Hospital NHS Trust	23,381	5,906	23,543	11,772	5,791	5,945	11,736
	Nottingham University Hospital NHS Trust	16,217	4,352	15,387	7,694	3,890	4,094	7,984
	Doncaster and Bassetlaw Hospitals NHS Trust	8,130	1,976	9,486	4,743	2,102	2,283	4,385
	Total	**47,728**	**12,234**	**48,416**	**24,208**	**11,783**	**12,322**	24,105
	Quality Standard 60 % of new service users accepting a HIV test							
	Sherwood Forest Hospital NHS Trust	39%	31%	>60%	>60%	76%	78%	77%
	Nottingham University Hospital NHS Trust	66%	68%	>60%	>60%	53%	51%	52%
	Doncaster and Bassetlaw Hospitals NHS Trust	53%	55%	>60%	>60%	58%	62%	60%
	Quality Standard At least 75% of 16-24 year olds in contact with the service accepting a chlamydia test							
	Sherwood Forest Hospital NHS Trust	66%	67%	>75%	>75%	83%	81%	86%
	Nottingham University Hospital NHS Trust	70%	71%	>75%	>75%	71%	69%	70%
	Doncaster and Bassetlaw Hospitals NHS Trust	66%	69%	>75%	>75%	63%	80%	70%
	Quality Standard 30% of women aged 15-24 receiving contraception accepting LARC							
	Sherwood Forest Hospital NHS Trust	47%	48%	>30%	>30%	44%	48%	46%
	Nottingham University Hospital NHS Trust	38%	41%	>30%	>30%	40%	38%	39%
	Doncaster and Bassetlaw Hospitals NHS Trust	49%	48%	>30%	>30%	49%	50%	50%
Young Peoples Sexual Health Service - C Card	Number of individuals aged 13-25 registered onto the scheme	1,297	318	1,600	800	235	330	565
	Number of individual young people aged 13-25 who return to use the scheme (at least once)	2,197	488	2,000	1,000	400	333	733
Alcohol and Drug Misuse Services	Number of successful exits (i.e. planned)	904	237	-	162	263	248	511
	Number of unplanned exits	751	286	-	-	135	159	294
	Number of service users in the service (last day of quarter) Including transferred in	Rolling	11,788	10,394	5,771	6,582	2,277	8,859
Young People's Substance Misuse Service	Total referrals of young people requiring brief intervention or treatment	292	65	300	150	37	14	51
	Quality standard 80% Planned exit from treatment	98%	100%	80%	80%	94%	75%	89%
Smoking Cessation	Number of people setting a quit date	3729	882	-	-	519		-
	% actually quit - Russell standard	60%	55%	>40%	>40%	75%		-
	Pregnant Smokers who successfully quit	74	16	500	250	23	Total of 502 as at 5/11 more data yet to be added Q2 submission due 3/12	-
	Under 18 Smokers who successfully quit	42	2	200	100	1		-
	Routine and Manual Workers successfully quit	648	124	1,500	750	144		-
	All other smokers who successfully quit	1,468	347	2,800	1,400	219		-
	Total Successfully Quit	**2,232**	**489**	**5,000**	**2,500**	**387**	**502**	889
Illicit Tobacco Services	Number of inspections	124	49	75	38	41	23	64
	Number of Seizures	45	11	37	19	9	7	16
Obesity Prevention and Weight Management (OPWM)	Number of adults supported	1,058	302	260	130	175	176	351
	Number of children supported	87	23	108	54	24	27	51
	Maternity	43	4	104	52	16	15	31
	Adults triaged to other 12 week weight management	New KPI 2018/19	New KPI 2018/19	1,778	889	424	588	1,012
	Number of tier 1 prevention projects	New KPI 2018/19	New KPI 2018/19	65	33	35	17	52
	Number of tier 1 prevention sessions	New KPI 2018/19	New KPI 2018/19	376	188	194	148	342
Domestic Abuse Services	No of adults supported	1,881	461	2,088	1,044	536	468	1,004
	No of children, young people & teenagers supported	510	109	622	311	156	132	288
Seasonal Mortality	Number of people from the target groups given comprehensive energy efficiency advice and/or given help and advice to switch energy supplier or get on the cheapest tariff	391	63	259	130	160	68	228
	Number of individuals trained to deliver Brief Interventions i.e. number of people attending the training courses	319	110	187	94	51	42	93
Social Exclusion	Number of one-to-one specialist advice interviews undertaken	8,197	2,057	7,128	3,564	2,227	2,528	4,755
	Number of health care support and interventions undertaken	5,219	1,338	5,445	2,723	1,197	1,240	2,437
Public Health Services for Children and Young People aged 0-19	Percentage of New Birth Visits (NBVs) completed within 14 days	85%	85%	95%	95%	88%	89%	89%
	Percentage of 6-8 week reviews completed	87%	86%	95%	95%	86%	85%	85%
	Percentage of 12 month development reviews completed by the time the child turned 15 months	86%	85%	95%	95%	89%	91%	90%
	Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	78%	80%	95%	95%	95%	99%	97%
Oral Health Promotion Services	Number of frontline staff (CHILD RELATED) trained to deliver oral health brief advice	236	59	200	100	51	62	113
	Number of frontline staff (ADULT RELATED) trained to deliver oral health brief advice	257	61	200	100	60	71	131
Homelessness	Hostel Accommodation Number exited in a planned way	New service	New Service	-	-	31	34	65
	Hostel Accommodation % exited in a planned way	New service	New Service	>80%	>80%	70%	69%	70%
	Move on Accommodation Number exited in a planned way	New service	New Service	-	-	36	29	65
	Move on Accommodation % exited in a planned way	New service	New Service	>80%	>80%	100%	97%	100%
Resilience Building in Schools	North: Number of children undertaking a daily resilience building activity at school	2679	Target for duration of service - max 36 months	2500	2500	53	232	2964
	North: Number of prioritised schools signed up to the service	14	Target for duration of service - max 36 months	14	14	14	14	14
	South: Proportion of staff trained report increase in understanding of mental health and resilience	100%	Target for duration of service - max 36 months	80%	80%	100%	100%	100%
	South: Number of children engaged in insights gathering for audits and action plan implementation	148	Target for duration of service - max 36 months	90	90	19	0	109

Nottinghamshire County Public Health Services Performance Report - Service description

PH Outcomes Framework Indicator	Indicator description	Service Name	Service description
2.22	Take up of the NHS Health Check programme - by those eligible	**NHS Health Checks**	The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk. http://www.nhs.uk/Conditions/nhs-health-check/Pages/What-happens-at-an-NHS-Health-Check-new.aspx
2.12	Excess weight in adults		
2.13ii	Proportion of physically active and inactive adults		
4.04ii	Under 75 Cardiovascular disease related death		
4.05ii	Under 75 Cancer related death		
2.04	Under 18 conceptions	**Integrated Sexual Health Services**	Good sexual health is an important part of physical, mental and social well-being. Over the past decade, there has been a steady rise in new diagnoses of STIs in England. Diagnoses of gonorrhoea, syphilis, genital warts and genital herpes have increased considerably, most notably in males. A proportion of this rise is due to improved access to STI testing and routine use of more sensitive diagnostic tests. However this has also been driven by ongoing unsafe sexual behaviour, with increased transmission occurring in certain population groups, including MSM.5 Of the 446,253 new STI diagnoses made in England in 2013, the most commonly diagnosed were: • Chlamydia (47%), • Genital warts (17%). • Genital herpes (7%), • Gonorrhoea (7%). Between 2012 and 2013 there was an increase nationally of 15% in diagnoses of gonorrhoea and 9% in infectious syphilis. The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in MSM. www.fsrh.org www.bashh.org. The ISHS will support delivery to achieve the three main sexual health related Public Health Outcome Framework (PHOF) measures to improve sexual health in mid-Nottinghamshire: • A reduction in under 18 conceptions • Achieve a diagnostic rate of 2,300 per 100,000 for Chlamydia screening (15-24 year olds) • A reduction in people presenting with HIV at a late stage of infection. In addition, the service will deliver against the following overarching outcomes to improve sexual health: • Clear, accessible and up-to-date information about services providing contraceptive and sexual health for the whole population, including information targeted at those at highest risk of sexual ill health • Reduced sexual health inequalities amongst young people and young adults; for example, Black and Minority Ethnic (BME) groups and MSM through improved access to services and prevention interventions • Be responsive to potential gaps in provision especially in the areas of highest need and sexual ill health • Reduced rates of acute STIs through increased diagnosis and effective management and treatment of STIs and through targeting those groups most at risk • A high level of coverage for chlamydia testing, ensuring that services are accessible, are provided across a range of venues and exceed the national chlamydia diagnosis target of 2.3 per 1,000 • An increase in the number of people accessing HIV screening, particularly from those groups most at risk • A reduction in the proportion of people diagnosed with HIV at a late stage of HIV infection through increased education and screening to encourage earlier presentation and reduce the stigma of HIV • Increased access and uptake of effective methods of contraception, specifically Long Acting Reversible Contraception (LARC), for all age groups • Increased access and uptake of condoms; specifically targeted at young people (those aged 25 and under) and MSM • Increased identification of risk taking behaviour and risk reduction interventions to improve future sexual health outcomes across mid-Nottinghamshire • A reduction in unintended pregnancies in all ages • Increased quality standards across Nottinghamshire and Bassetlaw.
3.02	Chlamydia Detection Rate (15-24 year olds)		
3.04	HIV Late Diagnosis		
2.04	Under 18 conceptions	**Young Peoples Sexual Health Service - C Card**	Good sexual and reproductive health is important to physical and mental wellbeing, and is a cornerstone of public health. Young people who are exploring and establishing sexual relationships must be supported to take responsibility for their sexual and reproductive health. The C Card scheme aims to reduce teenage pregnancy and sexually transmitted infections amongst young people in Nottinghamshire by allowing young people to access free confidential sexual health advice and condoms.
1.05	16-18 year olds not in education employment or training	**Alcohol and Drug Misuse Services**	Drug use can have a wide range of short- and long-term, direct and indirect effects. These effects often depend on the specific drug or drugs used. Longer-term effects can include heart or lung disease, cancer, mental illness, HIV/AIDS, hepatitis, and others. Long-term drug use can also lead to addiction. Drug addiction is a brain disorder. Not everyone who uses drugs will become addicted, but for some, drug use can change how certain brain circuits work. These brain changes interfere with how people experience normal pleasures in life such as food and sex, their ability to control their stress level, their decision-making, their ability to learn and remember, etc. These changes make it much more difficult for someone to stop taking the drug even when it's having negative effects on their life and they want to quit. Drug use can also affect babies born to women who use drugs while pregnant. Broader negative outcomes may be seen in education level, employment, housing, relationships, and criminal justice involvement. Persistent alcohol misuse increases your risk of serious health conditions, including: •heart disease •stroke •liver disease •liver cancer and bowel cancer •mouth cancer •pancreatitis As well as causing serious health problems, long-term alcohol misuse can lead to social problems, such as unemployment, divorce, domestic abuse and homelessness The service aim is to reduce illicit and other harmful substance misuse and increase the numbers recovering from dependence.
1.13	Re-offending levels		
1.15	Homelessness		
2.18	Admission episodes for alcohol-related conditions		
2.15	Drug and alcohol treatment completion and drug misuse deaths	**Young People's Substance Misuse Service**	Young people's drug use is a distinct problem. The majority of young people do not use drugs and most of those that do, are not dependent. But drug or alcohol misuse can have a major impact on young people's education, their health, their families and their long-term chances in life. Each year around 24,000 young people access specialist support for substance misuse, 90% because of cannabis or alcohol. It is important that young people's services are configured and resourced to respond to these particular needs and to offer the right support as early as possible. The model used to illustrate the different levels of children and young people's needs in Nottinghamshire is referred to as the Nottinghamshire Continuum of Children and Young People's Needs which recognises that children, young people and their families will have different levels of needs, and that a family's needs may change over time. The agreed multi-agency thresholds are set out across four levels of need

2.03	Smoking status at time of delivery (maternity)	**Tobacco Control and Smoking Cessation**	Smoking is the primary cause of preventable illness and death. Every year smoking causes around 96,000 deaths in the UK. The prevalence of smoking across Nottinghamshire is equal to the English average at 18.4%. We are seeking to continue the downward trend in prevalence through this newly commissioned model. Our local framework for tackling tobacco use sets out a range of interventions that we will be implementing in order to achieve this aspiration, one key element that will contribute to and support these aspirations will be our local tobacco control service(s). To reflect the model 3 themes will be used to provide context; • Stopping smoking • Preventing the uptake of smoking • Reducing harm from tobacco use
2.09	Smoking prevalence - 15 year olds		
2.14	Smoking prevalence - adults (over 18's)		
2.14	Smoking prevalence - adults (over 18's)	**Illicit Tobacco Services**	Nationally, Tobacco smuggling costs over £2 billion in lost revenue each year. It undermines legitimate business and is dominated by internationally organised criminal groups often involved in other crimes such as drug smuggling and people trafficking. Trading Standards resource works to reduce illicit tobacco supply and demand within the county
1.16	Utilisation of outdoor space for exercise/health reasons	**Obesity Prevention and Wight Management (OPWM)**	Being overweight or obese can bring physical, social, emotional and psychosocial problems, which can lead to the onset of preventable long term illness, stigma, discrimination, increased risk of hospitalisation and reduced life expectancy. Someone who is severely obese is three times more likely to need social care than someone who is a healthy weight, so the need for quality weight management services does not only impact individuals, but also affects public funds and the wider community. The aim of this contract is to reduce the prevalence of overweight and obesity so that more adults, children, young people and families achieve and maintain a healthy weight therefore preventing or reducing the incidence of obesity related illnesses.
2.06	Child excess weight in 4-5 and 10-11 year olds		
2.11	Diet		
2.12	Excess weight in adults		
2.13	Proportion of physically active and inactive adults		
1.11	Domestic abuse	**Domestic Abuse Services**	This service aims to reduce the impact of DVA in Nottinghamshire through the provision of appropriate services and support for women, men and children who are experiencing domestic abuse or whose lives have been adversely affected by domestic abuse.
4.15	Excess winter deaths	**Seasonal Mortality**	In 2011, the Marmot Review Team released 'The Health Impacts of Cold Homes and Fuel Poverty' report16. The report reviews the evidence for the long-term negative health impacts of living in cold homes and concludes: "many different population groups are affected by fuel poverty and cold housing, with various levels of health impacts relating to different groups." Vulnerable children and the elderly are most at risk of developing circulatory, respiratory and mental health conditions as a consequence of cold, damp homes. The Health Housing Contract will maintain and improve the health of citizens in Nottingham City and Nottinghamshire, by facilitating insulation, heating improvements and preventative adaptations and giving advice to help reduce fuel poverty in the homes of citizens over 60 and to a lesser extent (up to 10% of the total), families with children under 5 and pregnant women
1.18	Social isolation	**Social Exclusion**	Nottinghamshire Homelessness Health Needs Assessment, July 2013 – this identified higher levels of need among non-statutory homeless people in relation to lifestyle health risks: hepatitis and flu vaccination, smoking, diet, substance misuse (including alcohol), TB screening, sexual health checks. Multiple physical health problems were common; especially musculoskeletal, respiratory and oral health. Mental health problems were common; especially stress, depression, sleeping difficulties and anxiety. The aim is to protect and support the health and well being of vulnerable adults using the person centred approach. Specifically this will be addressed via specialist one to one assessment and advice sessions as a means of accessing appropriate emergency practical support and co-located services. This will follow as far as possible an "under the same roof" and "one-stop" model.
1.01	Children in low income families	**Public Health Services for Children and Young People aged 0-19**	The foundations for virtually every aspect of human development - physical, intellectual and emotional, are established in early childhood. In 2009, the Department of Health set out an evidence-based programme of best practice, the Healthy Child Programme, with the ambition of making everywhere as good as the best by developing improvements in health and wellbeing for children and young people. The Healthy Child Programme provides a framework to support collaborative work and more integrated delivery. The Programme (0-19) aims to: • help parents develop and sustain a strong bond with children, • encourage care that keeps children healthy and safe, • protect children from serious disease, through screening and immunisation, • reduce childhood obesity by promoting healthy eating and physical activity, • identify health issues early, so support can be provided in a timely manner, • make sure children are prepared for and supported in all child care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five'
1.02	School readiness		
2.02	Breastfeeding		
2.03	Under 18 conceptions		
2.05	Child development at 2-2½ years		
2.06	Child excess weight in 4-5 and 10-11 year olds		
4.02	Proportion of five year old children free from dental decay	**Oral Health Promotion Services**	In Nottinghamshire, oral health is an important Public Health policy area due to the diverse nature of the county and its associated health inequalities. The impact of poor oral health is felt within all seven districts with significant variation. To deliver an evidence-based oral health promotion service for identified individuals, communities and vulnerable groups in Nottinghamshire, to maintain and improve their oral health. The service is based on the recommendations from 'Local authorities improving oral health: commissioning better oral health for children and young people' and NICE guidelines.
2.05	Child development at 2-2½ years	**Children's Centres**	Children's Centres play a key role in early intervention and are a vital source of support for young children and their families.... They offer a range of activities, family services and advice to promote school readiness, improve family outcomes and reduce health inequalities in child development
1.15	Statutory homelessness	**Supporting People: Homelessness Support**	The aims of this service are: - To address homelessness, support people back to independence and prevent repeat homelessness - To reduce the adverse effects of homelessness on individual and population health and wellbeing - To improve the health and wellbeing of homeless service users - To promote social inclusion
4.09	Excess under 75 mortality rate in adults with serious mental illness	**Mental Health**	The Co-production Mental Wellbeing service provides a countywide service that aims to improve the health and wellbeing of adults and supports them in recovery. The service is for those people experiencing mental health problems
1.15	Statutory homelessness	**Reduction in statutory homelessness**	The Moving Forward Service aims to: Prevent homelessness and promote independence, reduce social exclusion and isolation, improve the general health of people with mental health problems, prevent hospital admissions and support timely discharge, support carers of people with mental health problems and develop efficient ways of working
1.01	Children in low income families	**Resilience Building in Schools**	The providers Each Amazing Breath (EAB) CIC, 'Take 5 at School Programme' in the north and west of the County and Young Minds (YM), 'Academic Resilience Approach' in the South of the County, develop and deliver an evidence-based resilience programme in schools that will improve the emotional health, wellbeing and resilience of children and young people in 30 Nottinghamshire schools. It is a whole school approach, this means school leaders, staff, children and young people which may include approaches such as training the trainer and pupils and students as coaches, mentors or teachers. The programmes are sustainable and will enable schools to have the understanding, the knowledge, skills and resources to continue independent delivery of the programme via a whole schools approach and to have maximum impact for children and young people after the direct contract activity ends
1.03	Pupil absence (from School)		
1.05	16-18 year olds Not in Employment, Education Training		
2.23	Self-reported wellbeing		

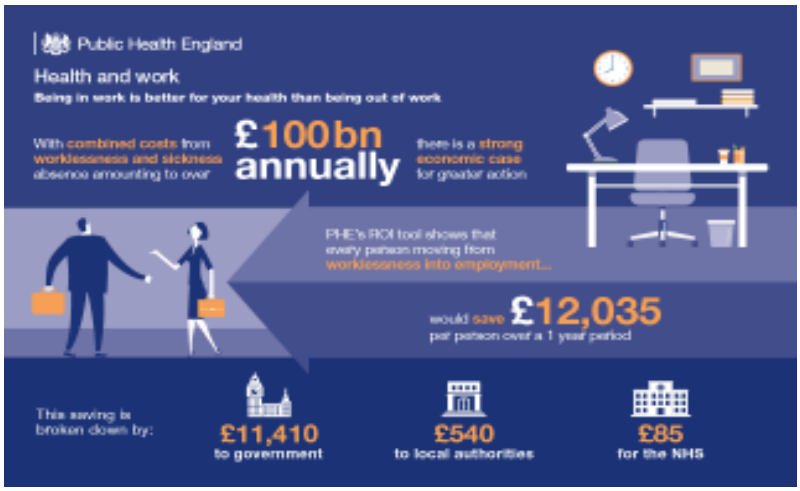
		Q1			Q2			Total		
		Denominator	Numerator	%	Denominator	Numerator	%	Denominator	Numerator	Average %
Integrated Sexual Health Services	**Quality Standard 60 % of new service users accepting a HIV test**									
	Sherwood Forest Hospital NHS Trust	1087	826	76%	1026	799	78%	2112.84	1625	77%
	Nottingham University Hospital NHS Trust	1219	641	53%	1257	638	51%	2476	1279	52%
	Doncaster and Bassetlaw Hospitals NHS Trust	707	410	58%	684	425	62%	1391	835	60%
	Quality Standard At least 75% of 16-24 year olds in contact with the service accepting a chlamydia test									
	Sherwood Forest Hospital NHS Trust	576	479	83%	591	479	81%	1167	958	82%
	Nottingham University Hospital NHS Trust	465	329	71%	476	329	69%	941	658	70%
	Doncaster and Bassetlaw Hospitals NHS Trust	354	223	63%	290	231	80%	644	454	70%
	Quality Standard 30% of women aged 15-24 receiving contraception accepting LARC									
	Sherwood Forest Hospital NHS Trust	1016	447	44%	983	471	48%	1998.91	918	46%
	Nottingham University Hospital NHS Trust	288	116	40%	276	105	38%	564	221	39%
	Doncaster and Bassetlaw Hospitals NHS Trust	582	285	49%	624	314	50%	1206	599	50%
Young People's Substance Misuse Service	Quality standard 80% Planned exit from treatment	50	47	94%	20	15	75%	70	62	89%
Public Health Services for Children and Young People aged 0-19	Percentage of New Birth Visits (NBVs) completed within 14 days	1853	1638	88%	1990	1771	89%	3843	3409	89%
	Percentage of 6-8 week reviews completed	1834	1577	86%	1954	1657	85%	3788	3234	85%
	Percentage of 12 month development reviews completed by the time the child turned 15 months	1990	1766	89%	2197	1991	91%	4187	3757	90%
	Percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)	1880	1788	95%	1704	1693	99%	3584	3481	97%
Homeleessness	Hostel Accommodation % exited in a planned way	44	31	70%	49	34	69%	94	65	69%
	Move on Accommodation % exited in a planned way	36	36	100%	30	29	97%	66	65	99%

Making the economic case for prevention

Posted by: John Newton and Brian Ferguson, Posted on: 6 September 2017

It is widely acknowledged that poor lifestyle behaviors as well as wider determinants of health place a significant burden on public finances now and in the future, and the evidence shows that a large number of prevention programmes represent value for money. Therefore there is a strong economic case for greater action.

For example, our work shows that moving a person from unemployment into employment would save £12,035 per person over a one-year period.

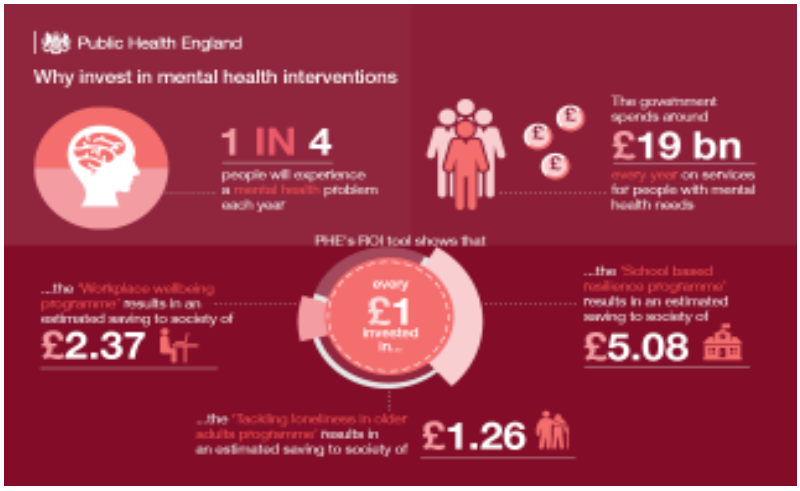


Another example we can use to make the economic case is analysis of a 'targeted supervised tooth brushing programme'. This initiative provides a return of £3.06 for every £1 invested after 5 years and £3.66 after 10 years. On this occasion we are taking into account NHS savings, increased earnings for the local economy and improved productivity.

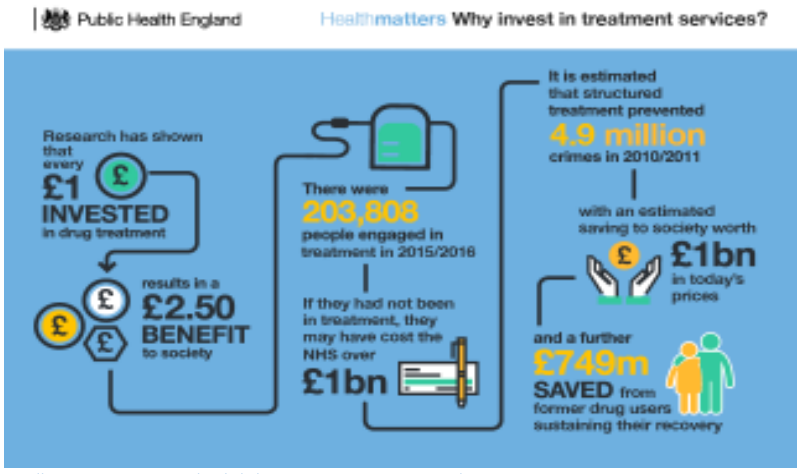
There is also excellent evidence to support investment in tobacco control services. Over a lifetime, for every £1 spent the return will be £11.20 when impacts to the local economy, wider healthcare sector and QALYs are considered. When omitting the health effects (measured by QALYs), there is still a saving of £1.90 for every £1 spent.

Every £1 spent on drug treatment services saves society around £2.50 in reduced NHS and social care costs and reduced crime in the short-term (85% due to reductions in offending).

And as we recently flagged as part of a suite of mental health resources, initiatives which prevent mental health problems can yield a good return on investment. We looked at interventions such as school-based resilience programmes, workplace stress programmes and support for people in debt.

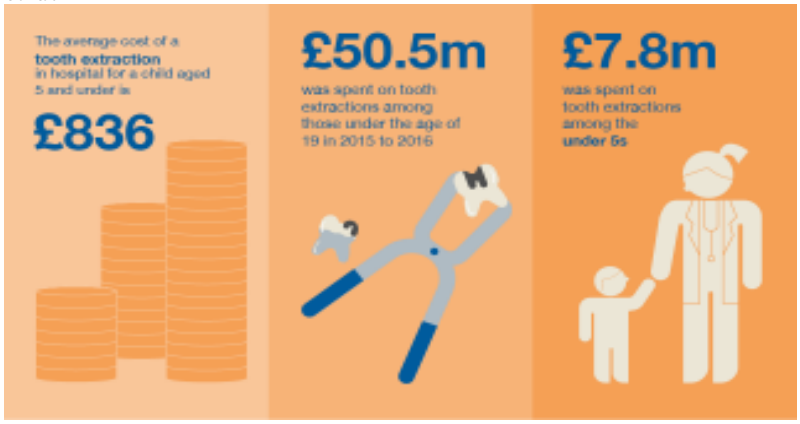


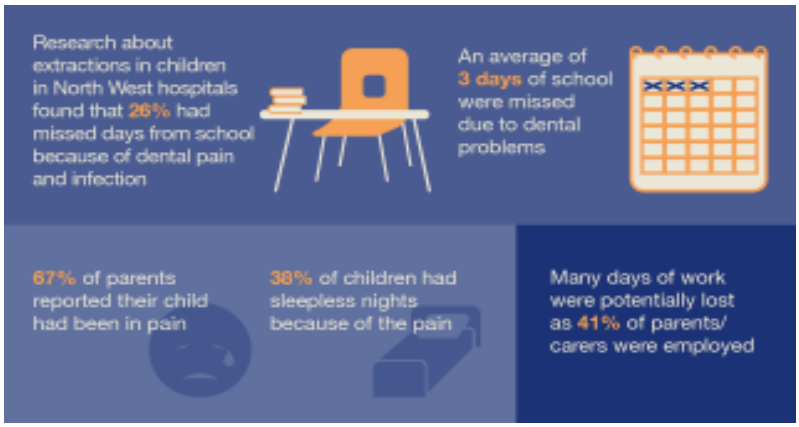
Drug treatment not only saves lives, it provides value for money to local areas:



https://publichealthmatters.blog.gov.uk/2017/09/06/making-the-economic-case-for-prevention/

Oral Health





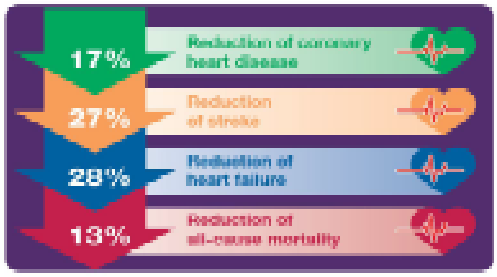
Social Value refers to wider financial and non-financial impacts of programmes, organisations and interventions, including the wellbeing of individuals and communities, social capital and the environment.
From a business perspective it may be summarised as the net social and environmental benefits (and value) generated by an organisation to society through its corporate and community activities reported either as financial or non-financial (or both) performance.

Useful links:

https://www.nice.org.uk/media/default/About/what-we-do/NICE-guidance/NICE-guidelines/Public-health-guidelines/Additional-publications/Cost-impact-proof-of-concept.pdf

It is estimated that up to 80% of premature deaths from CVD can be prevented through better public health. All current blood pressure guidelines agree that support for behaviour change to address modifiable risk factors (smoking, alcohol, inactivity, obesity and poor diet) should be the first step in preventing high blood pressure

There is robust evidence that taking action to lower blood pressure can reduce the risk it poses to health. A major systematic review found that in the populations studied, every 10mmHg reduction in blood pressure resulted in the following reductions.



https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/672554/Tackling_high_blood_pressure_an_update.pdf

Prevention is better than cure: our vision to help you live well for longer, Published 5th November 2018:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 6

REPORT OF DIRECTOR OF PUBLIC HEALTH

USE OF PUBLIC HEALTH GENERAL RESERVES

Purpose of the Report

1. To seek approval to proposed additional uses of Public Health general reserves and to the establishment of two temporary posts within the Public Health division associated with two of the proposed additional uses.

Information

2. Since transferring into the local authority in 2013, Public Health has been fully funded through a ring-fenced Public Health grant, provided annually as an allocation from the Department of Health. In past years, the Public Health grant allocation has been underspent, for reasons including:
    - underperformance on some payment by results (PBR) contracts
    - slippage on other contracts with reprofiling of activity in future years
    - extra efficiencies being generated through integrated commissioning approaches
    - rigorous contract management focused on achieving value for money
    - savings on the staffing budget due to recruitment drag
    - requirement to retain a level of reserves as contingency for risk (see para 5 below)

3. Unspent Public Health grant is placed in a separate, ring-fenced Public Health (PH) General reserve. The conditions of the grant allow that if at the end of the financial year there is any underspend this can be carried over, as part of a public health reserve, into the next financial year. In utilising those funds the next year, the grant conditions will still need to be complied with. More information on the Conditions is given in paragraphs 13-17 in this report.

4. The PH General reserve has also been used to hold small amounts of external funding on behalf of other organisations, such as NHS Pioneer funding awarded to a consortium of local Councils for a health and housing project.

5. Because the Public Health division has access to the PH General reserve, the division makes its own arrangements to address risk. It is not expected to draw on the Council's other reserves in case of unexpected expenditure. Therefore, it has been important for the division to hold some level of reserves. Such reserves are tracked and expected to accrue to ensure Public Health retains a satisfactory reserve for sudden expense such as local health protection emergencies.

6. As well as the PH General reserve, Public Health also holds some additional, separate Section 256 reserves. Section 256 of the National Health Act 2006 allows Primary Care Trusts (or successor bodies) to enter into arrangements with local authorities to carry out activities with health benefits. Section 256 funds received by the Council and currently held by Public Health are for activities to combat substance misuse, and support for Children and Young People's mental health (Future in Mind programme). Plans are in place to spend all of the S256 reserves on the relevant activities.

Summary of Public Health Reserves 2018/19

7. Public Health General reserves were last scrutinised by Committee in December 2017.

8. The Public Health reserves fluctuate for a number of reasons, as follows:
   a. Slippage on contracts has to be held in PH reserves in order for it to be transferred to the next financial year. This does not represent underspend, but rather rescheduling of approved activity.
   b. Receipt of additional income from other organisations, for specific activities or purposes, which again is held in reserves until the time for it to be used.
   c. Underperformance on Payment By Results (PBR) Contracts which can lead to underspend on contracts, if it is not possible to reprofile the activity and recover performance.

9. Appendix 1 of this report lists all the current commitments against reserves. These are a mixture of slippage from previous years (contracted spend), items to be funded by resources received by the Council for that specific purpose, and items previously approved for funding from PH reserves by Committee. The current commitments total £4.894M. All of the approved uses of reserves are compatible with the conditions of Public Health grant and contribute to Commitment 6 in the Council Plan: People are healthier. Other impacts of the approved uses of reserves are identified in the Appendix.

10. The table below summarises the current Public Health general reserves position. Although there are £5.077M of currently uncommitted reserves, £1M of these are required as provision for future risk, leaving £4.077M for potential allocation at the present time.

Table 1 Summary of Public Health General Reserves 1 November 2018

	£M
PH Reserves balance	9.971
Committed uses of PH reserves as of 1 November 2018	4.894
Provision required for risk	1.000
Total potential PH reserves available for allocation as of 1 November 2018	4.077

Proposals for use of the remaining Public Health reserves

11. A list of proposed items for use of some of the unallocated reserves is contained in Appendix 2. These proposed items total £3.698M. Appendix 2 includes information on:
   - The level of funds requested for each proposal
   - The rationale for each proposal
   - Anticipated impacts of the intervention including links to Public Health outcomes

- Risks / consequences of not allocating the Public Health reserves funding

12. Two of the new proposals for use of reserves will include appointment of temporary staff within the Public Health division. The related proposals are at number 1(Increase capacity within the Public Health division to support the wellbeing agenda in the workplace) – 1 FTE Public Health Support Officer at Band B, and number 9 (Better data for prevention and population health need) – 0.5 FTE Public Health Intelligence Analyst, in Appendix 2.

Compliance with conditions of Public Health Grant

13. The ring-fenced allocation of Public Health grant is subject to national conditions specified by the Department of Health. These conditions apply to all local authorities in receipt of Public Health grant.

14. As the reserves were originally received in the form of Public Health grant, the conditions still apply to the use of the grant, even though these resources were provided as Public Health grant in previous years. The grant conditions reference this specifically as follows: "If there are funds left over at the end of the financial year they can be carried over into the next financial year. Funds carried over should be accounted for in public health reserve. All the conditions that apply to the use of the grant will continue to apply to any funds carried over. However, where there are large underspends the Department reserves the right to reduce allocations in future years."

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

16. Although a Council may use its Public Health grant for other functions of the local authority, the Conditions state that "the authority must be of opinion that those functions have a significant effect on public health or have a significant effect on, or in connection with, the exercise of the functions described – "the public health functions as specified in Section 73B(2) of the National Health Service Act 2006" - and the authority must be satisfied that, having regard to the contribution from the public health grant, the total expenditure to be met from the fund and the public health benefit to be derived from the use of the fund, the arrangements provide value for money."

17. The Department of Health and Social Care provides a list of categories for reporting local authority public health spend. In the 2018/19 list, the Public Health prescribed functions appear first (sexual health (STI testing & treatment; contraception), NHS health checks, local authority role in health protection, public health advice to NHS Commissioners, National Child Measurement Programme, prescribed children's 0-5 services) followed by other non-prescribed public health activities such as obesity / physical activity, substance misuse, smoking and tobacco, children's 5-19 public health services, health at work, and public mental health. The last category in the list is Miscellaneous, which may be used to record other

expenditure on other Public Health services, which CIPFA previously defined as "Any spend from the public health grant used to tackle the wider and social determinants of health and health inequalities not already recorded in any other category".

18. The proposals for additional uses of the Public Health reserves set out in Appendix 2 are all compliant with the conditions of grant outlined above.

Other Options Considered

19. Option to use Public Health reserves for other budgetary purposes in the local authority - The Council is required to use the Public Health grant in line with the conditions, must sign annual statements of assurance to this effect and must complete government returns reporting expenditure against the grant within specified categories. Therefore, it is not possible to place unspent Public Health grant into the Council's main reserves nor to use it to offset budget pressures in other areas of the Council that do not contribute to Public Health outcomes.

20. Option to hold Public Health reserves against future Public Health expenditure beyond March 2021 - The Public Health grant ring fence is currently set to end in March 2020. The grant conditions state that unspent grant may be carried forward as a reserve for use in the next financial year so the current assumption is that unspent grant from 2019/20 would be able to be used for Public Health in 2020/21. No information has yet been provided by the Department of Health on what will happen to funds remaining in reserves after this time. If the Public Health reserves are not spent by this time, there is a risk that the funds may have to be returned to the Department of Health; therefore making decisions to utilise the funds before March 2021 will maximise funding available to the authority.

Reason for Recommendation

21. The proposed uses of Public Health reserves in Appendix 2 are compliant with the Public Health grant conditions and will maximise the use of funding whilst it is available to the authority.

Statutory and Policy Implications

22. 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 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

23. The Public Health reserves built up from unused Public Health grant allocations in previous years and are held separately so that they can be used in accordance with the conditions of the Public Health grant. Table 1 at paragraph 10 above summarises the current financial position on the Public Health general reserves. If all the proposed additional uses of Public Health reserves are approved, totalling £3.698M, this would leave £1.378M in PH reserves. About £1M of this is needed as provision for future risk, primarily to ensure that existing contractual commitments can be met in the context of known future reduction to Public Health grant in 2019/20 and likely additional reduction thereafter. £378K of reserves remain available

for commitment. Additional proposals for use of the remaining reserves are currently being worked on and will be brought back to Committee as soon as possible.

Human Resources Implications

24. Two of the new proposals for use of reserves will include appointment of temporary staff within the Public Health division. The affected proposals are at number 1(Increase capacity within the Public Health division to support the wellbeing agenda in the workplace) and number 9 (Better data for prevention and population health need) in Appendix 2. These additional posts are the same as existing roles which have already been evaluated.

25. Where proposals outside the Public Health division will involve the appointment of new staff, it will be the responsibility of the employing part of the Council to ensure that appropriate authorisation is sought as required to establish temporary posts.

RECOMMENDATIONS

1) That Members approve additional uses of Public Health reserves from the list in Appendix 2 of the report, including approval to implement agreed proposals and commence related procurement

2) That the following fixed-term posts be established:
   a) Fixed term 1 FTE Public Health Support officer at Band B, for a period of 2 years from the date of appointment
   b) Fixed term 0.5 FTE Public Health Intelligence Analyst at Band B, for a period of 12 months from the date of appointment

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
Kay Massingham, Public Health Executive Officer, tel 0115 993 2565, email kay.massingham@nottscc.gov.uk

Constitutional Comments (KK 09.11.2018)

26. The proposals in this report are within the remit of the Adult Social Care and Public Health Committee.

Financial Comments (DG 08/11/18)

27. The financial implications are contained within paragraph 23 of this report.

Human Resources Comments (SJJ 12/11/2018)

28. The proposed temporary posts are positions that currently exist in the structure and do not require evaluation to determine a grade. The posts will be recruited to using the County Council's recruitment procedures. Trade Union collegues have received a copy of the report.

Background Papers and Published Documents

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

- Report to Adult Social Care and Public Health Committee, 11 December 2017, Use of Public Health General Reserves to March 2019
- Department of Health and Social Care, Local Authority Circular : public health ring fenced grant 2018/19, 21 December 2017
- Business Cases relating to the individual proposals for use of reserves contained in Appendix 2

Electoral Division(s) and Member(s) Affected

- All

Appendix 1: Existing commitments within Public Health General Reserves

Topic	2018/19 £	2019/20 £	Brief description of activity	Impacts
Small Steps	350,000		Support service for children and young people with concerning behaviours (indicative of Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder) in Nottinghamshire.	• Prevention in the escalation of concerning behaviours; families are better equipped, with the appropriate knowledge and skills to manage concerning behaviours in the home setting; children are better able to learn and achieve if their concerning behaviours are effectively managed • Improved early interventioncan reduce demand for statutory assessments of special educational need (EHCPs) • Longer term, children can have their needs met within mainstream settings through better understanding, management and communication of their behaviours from a young age and early on in their educational journey, reducing demand for specialist educational support and placements • Referrals for specialist health services, such as community paediatrics, are reduced.
Future in Mind Health and Justice	80,000		Resource received from CCGs to support Future In Mind activities related to mental health of young people.	Improved mental health and wellbeing of children and young people.
Kooth Online Counselling service	150,000		Universal, open access service providing advice, guidance and counselling for young people with mild emotional and mental health concerns, to improve wellbeing and reduce escalation and need for higher cost, specialised services. See Annex 2 for additional request for further support from reserves.	Children and young people accessing the service receive appropriate, timely and evidence based support to meet a diverse range of issues that impact on their mental health, wellbeing and quality of life.

Children's Health Website	20,000		Expansion of existing health web site aimed at teenagers (Health for Teens) to provide advice for younger children and families/parents/carers (Health for Kids). Clinically assured interactive content, striking design, games, localised information and signposting, divided between sections on staying healthy, illness, feelings, help yourself and getting help.	Engagement with more families including those who may not engage with traditional services. Increased knowledge of available health and other services and when to use them. Reduced barriers to accessing services leading to earlier intervention and better outcomes. Early identification of need or prevention in relation to weight management, physical activity, smoking, emotional health and other PH priorities
Children's 0-19 PH Service	100,990	1,259,506	The 0-19 service includes delivery of Healthy Child Programme 0-19 (statutory duty of LAs), delivery of mandated reviews and delivery of National Childhood Measurement Programme (NCMP - statutory duty of LAs). These reserves represent slippage from previous years, which will be needed to meet activity profiles in future years.	Services contribute to Council Plan Commitment 1 and 2 and to all priorities of the 2016-2018 Children, Young People and Families Plan Contribution to PH outcomes (PHOF indicators): • Maternal smoking status at time of delivery • Breastfeeding initiation and maintenance • School readiness • Proportion of five year old children free from dental decay • Children aged 4-5, children aged 10-11 classified as overweight or obese • Smoking prevalence at age 15

Family Nurse Partnership Service extension	10,898		Intensive preventive home visiting programme for vulnerable, first-time young parents. Please see annex 2 for a further request for additional reserves for this activity.	Contributions to PH outcomes include: • Reduced under 18 conception rate per 1,000 population • Lower % all live births at term with low birth weight • Improved breastfeeding initiation and prevalence at 6-8 weeks after birth • Reduced maternal smoking at time of delivery • Improved school readiness in vulnerable groups • Fewer16 to 18 year olds not in education, employment or training • Reduced incidence of domestic abuse • Fewer hospital admissions caused by unintentional and deliberate injuries in children and young people under 25.
Schools Health Hub	136,000	136,927	Staffed Schools Health Hub (SHH), working with CFS as part of the Tackling Emerging Threats to Children team. Please see Annex 2 for proposal to extend scheme.	Contributions to PH outcomes: • reduced pupil absence • fewer first time entrants to the youth justice system • reduced smoking prevalence at age 15 • reduced conception rate in under 18s. Contributes to priorities of the 2016-2018 CYPF Plan and Commitment 1, 2 and 3 of Council Plan.
ASSIST smoking prevention in schools	150,000	80,600	Smoking prevention in schools service, delivered under licence by NCC Youth Service, using a model of peer support within target schools. Please see Annex 2 for proposal to extend scheme for a further year.	Contributions to PH outcomes: 2.09 Smoking prevalence at age 15 2.14 reduce smoking prevalence among adults and young people
Tobacco control acute trust smoking cessation activity	153,364	63,240	Smoking cessation support in acute trusts to implement new NICE guidance on smoking cessation. Supports 18 months of activity within mental health units and hospitals. See Annex 2 for request to extend activity.	Contributes to PHOF outcomes:2.14 reduce smoking prevalence among adults and young people

Tobacco control : police partnership work	33,000		Additional resource to tackle trade in illegal tobacco, in partnership with other activity in Trading Standards. Contribution to police time to deal with arrests and prosecutions. The work grew out of the illicit tobacco collaboration with Trading Standards, as cases became more complex and were increasingly linked to organised crime.	Contributions to PHOF outcomes: 2.09 Smoking prevalence at age 15 2.14 reduce smoking prevalence among adults and young people Links to Nottingham and Nottinghamshire Declaration on Tobacco Control supported by the Health and Wellbeing Board and partners.
Kaleidoscope Mental Health First Aid Training	16,666	33,334	Mental health first aid awareness raising and training delivery for emergency services and front line staff.	Improve mental health outcomes such as; • Increased prevalence of self-reported wellbeing • Reduce the number of suicide deaths • Reduce the rate of self-harm A & E attendances Impacts include; • Promoting good mental health • Preventing future mental health and co-existing physical health problems • Target and develop pathways for those with existing mental health problems to access health improvement interventions.
Health and Housing Coordinator	53,963		Joint initiative with district Councils to promote health in housing. Funding comprises remainder of NHS Poneer Fund award plus previously approved PH reserves to extend the project until March 2019. Coordinator post filled by secondment.	Relevant PHOF outcomes 4.15 Excess winter deaths, all ages and 85 years+ 1.17 Fuel poverty, low income, high cost
Seasonal Death Reduction Initiative	17,500	3,894	Work with partners approved through HWB; provides advice on keeping warm and support with making grant applications throughout the County, targeted on vulnerable older people, people with long-term health conditions and families with children under 5 who are in fuel poverty.	Relevant PHOF outcomes 4.15 Excess winter deaths, all ages and 85 years+ 1.17 Fuel poverty, low income, high cost

Community Infection Prevention and Control Service	157,139	210,044	Additional advice and guidance to care homes, nursing homes and other organisations to help them prevent and control infections. Delivered via Section 75 agreement with CCGs.	Improved health and wellbeing and quality of life of the general population and more specifically reducing risk of harm to people who are more vulnerable to infection due to pre-existing health conditions. Fewer people experience long term disability. Better quality of life, fewer infections and associated deaths. Lower burden on adult social care as a result reduction in avoidable hospital admissions and need for social care at discharge.
Anti Microbial Resistance Campaign	20,000		Antimicrobial resistance arises when the micro-organisms that cause infection survive exposure to a medicine that would normally kill them or stop their growth. This allocation was for a public -facing awareness-raising campaign regarding use of antibiotics.	Reduced antibiotic consumption and a focus on antimicrobial stewardship. Contribute to national goal for commissioning for quality and innovation (CQUIN) 2016/17
Chlamydia Control activities	22,333	36,000	Provision of additional Chlamydia testing service in response to outreach work to address need in the population. Allocation includes some contracted slippage plus additional previously approved resource to meet demand.	Address failing DRI (Detection Rate Indicator) to support achievement of the PHOF 3.02 Chlamydia Diagnosis Rate (Aged 15 to 24) • Facilitates access from different client groups that may not access a test via current outlets (young males) • Manage demand via online access route
Avoidable injury campaign	40,000	60,000	Home safety equipment provision and education scheme to improve home safety in families with young children. Avoidable injuries at home result in 450,000 emergency department (ED) attendances, 40,000 hospital admissions and 60 deaths per year in under-5s.	Potential 29% reduction in hospital admissions in under-5s. Cost savings - 10% reduction in injuries per 100,000 population saving over £47,000 in hospital admissions and ED attendances locally each year. Reduced short and longer term (disability, scarring, psychological harm) consequences of injuries. Improved home safety for local families. Reduced inequalities in safety equipment possession and use. Increased parental knowledge, confidence and skills in maintaining safer homes.

Falls pilot project	75,000	75,000	ASCH developed a pilot project seeking to reduce falls in older people, for which funding was due to cease in March 2018. Public Health reserves were used to fund an extension to the pilot project until March 2020. The falls prevention project has focussed primarily upon creating and promoting resources specifically for prevention and early intervention services, using communications to promote the benefits of physical activity and home safety in reducing the falls risk; providing training for front line staff to identify people at risk of a fall and offering advice on supporting them and signposting to appropriate guidance; and collaborative working: building the strength of preventative approaches within the falls pathway and the links between primary and secondary prevention.	Contribution to Public Health outcomes: 2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons) 4.14i - Hip fractures in people aged 65 and over (Persons) 2.13ii - Percentage of physically inactive adults - current method Impacts on Adult Social Care Outcomes Framework: Permanent admissions to residential and nursing care homes per 100,000 aged 65+ NICE Guidance states that evidence based tailored exercise programmes to reduce falls can reduce falls by between 35 to 54 per cent.
Friary Drop In extension	17,884		Provision of support service to homeless people. Additional resource provided for one year to give organisation time to identify alternative funding sources.	Contributes to PH outcomes: Statutory homelessness, self reported wellbeing.
Domestic Violence contract cost pressure: Young People's Violence Advisors YPVAs	44,000		To meet additional costs associated with children and young people (4-18 years) going through the Family Civil Courts.Represented an unmet need/emerging need not originally considered when the contract was developed and agreed.	Children can be re-traumatised as part of the family court process and perpetrators can use these proceedings to continue their controlling behaviour. YPVAs support, safeguard and work with the child to avoid further DVA, improve emotional wellbeing, school attendance and future life chances.
BHP Rebasing	523,000	523,000	Transfer of Public Health funding attributable to the Bassetlaw CCG.	Funds attributable to Bassetlaw Health Partnership.
Temporary Commissioning Resource	94,807	145,801	Fixed term staff to support recommissioning of Public Health services by 1 April 2020. Approved by ASC&PH Committee February 2018.	New commissioned services will contribute to Public Health outcomes linked to smoking, physical activity, obesity, alcohol.
Total	**2,266,544**	**2,627,346**	**4,893,890**	

Appendix 2: New proposals for use of Public Health General Reserves

Ref	Topic	2018/19 £	2019/20 £	2020/21 £	Brief description / Rationale	Impacts including links to PHOF outcomes	Risks of not allocating reserves funding
1	Increase capacity within the Public Health division to support the wellbeing agenda in the workplace		49,000	49,000	Employment of a two-year fixed-term full-time Public Health Support Officer to support the wellbeing agenda (including wellbeing@work (W@W), Making Every Contact Count, and the Tobacco Declaration). There are over 50 organisations already signed to the W@W programme in Nottinghamshire. By expanding staff capacity this number could be increased. The scheme has recently been refreshed and is due for relaunch in February 2019, making this an optimum time to put more resource into supporting the programme. The expansion of the W@W programme underpins the Council Plan "Your Nottinghamshire Your Future" and its ambitions; supports the delivery of the Place and the Adult Social Care and Health departmental strategies, and contributes to the priorities of the Nottinghamshire Health and Wellbeing Strategy	An additional 50 organisations would be worked with to realise the following benefits: • demonstrate exemplary practice by leading on the area of promoting positive health and well-being of employees • reduced sickness absence • reduced presenteeism (attending work when not fit or able to work productively) • reduced turnover of staff • reduced recruitment costs • happier, more motivated workforce. Wider benefits of workforce health schemes include: • Provide a return on investment – employee wellness programmes return between £2 and £10 for every £1 spent • workplaces with "very satisfied" employees had higher labour productivity, higher quality of output, and higher overall performance PHOF indicators: Sickness absence rate, plus various health improvement indicators.	Limited resources affecting take up of the wellbeing@work scheme. Lost opportunity to link with wider initiatives such as Making Every Contact Count and the Tobacco Declaration.
2	NCC Flu Vaccination campaign	10,450	66,880	86,661	ASC&PH Committee previously approved a policy to increase uptake of seasonal flu vaccination for all frontline care staff who are directly employed by the Council or are working in services commissioned by the Council. Vaccinating staff is primarily undertaken to protect vulnerable service users from seasonal influenza through transmission from their carers, but also helps to ensure business continuity by reducing sickness absence amongst staff. The proposal is for Public Health to contribute to the flu vaccination programme until 2020/21, with targets for uptake at 50% in 2018/19, 60% in 2019/20 and 75% in 2020/21.	transmission of seasonal influenza from their carers, resulting in fewer flu-related hospital admissions for service users and reduced levels of excess winter deaths. Local primary and secondary health care services will be under less pressure as a consequence. Other benefits for organisations include lower sickness absence among frontline staff with positive impacts on business continuity. PHOF indicators: 1.09 Working days lost due to sickness absence 4.07 Under-75 mortality rate from respiratory disease considered preventable 4.13 Health related quality of life for older people 4.15 Excess winter deaths	Effectiveness of vaccination in preventing transmission depends on uptake. Previously uptake was only 20-30% of front line staff, which meant that many service users remained exposed. A communications and information campaign is therefore included in the proposal, to raise the profile of the issue and encourage take up. Financial risk: if Public Health reserves are not used, to meet the targets already agreed by Committee, resource to fund vaccinations will need to come from budgets elsewhere in the Council.

3	Kooth Online Counselling service		75,000	150,000	Universal, open access service providing advice, guidance and counselling for young people with mild emotional and mental health concerns, to improve wellbeing and reduce escalation and need for higher cost, specialised services. Reserves funding would be used to extend the service up to March 2021. This area is a high priority, both locally and nationally. Public Health England 'The Mental Health of Children and Young People in England' (December 2016): identifies: "The emotional health and wellbeing of children is just as important as their physical health and wellbeing. Over the past few years there has been a growing recognition of the need to make dramatic improvements to mental health services for children and young people (CYP)."	This service is key to providing early intervention for young people of Nottinghamshire. Children and young people accessing the service receive appropriate, timely and evidence based support to meet a diverse range of issues that impact on their mental health, wellbeing and quality of life. In 2017/18, 1797 unique young people accessed Kooth, of which 87% returned to the site. 852 online counselling sessions were delivered and 7411 messages were sent. 97% of young people would recommend the service to friends. Demand has continued to rise with 1399 unique young people accessing Kooth in the first six months of 2018/19. The support and strategies promoted by the service enhance and improve day-to-day living, link young people with others as appropriate and refer to specialised services if higher level need is apparent.	Not providing the funds could lead to closure of the service, reducing the opportunity to improve children and young people's mental health and address gaps in young people's mental health provision in other parts of the system.
4	Family Nurse Partnership Service extension	416,761	426,716		FNP is a licenced, evidence-based, intensive nurse-led prevention and early intervention programme for vulnerable first time young parents and their children, delivered by specially trained Family Nurses. Countywide, FNP supports up to 375 first time teenage mothers and their babies, providing weekly or fortnightly visits up until the child's second birthday. There is a strong evidence-base for the effectiveness of the FNP programme compared with other programmes. In 2015 it was agreed to increase capacity in the FNP with funding from the Supporting Families Programme. This provided 175 extra places to the programme locally increasing coverage to 25% of the eligible population, in line with the national coverage. Given current cost pressures within the CFS Department, it is proposed to allocate additional funding from PH reserves to meet the costs of the expanded service in 2018/19 and 2019/20.	Impact: This service is targeted on first time teenage parents and delivers positive outcomes for a vulnerable client group, supporting up to 375 first time teenage mothers and their babies. Coverage will continue at 25% of the eligible population in line with national coverage. Continues to ensure that vulnerable first time teenage mothers and their children receive an evidence based intervention that will improve short and long term health and wellbeing and economic outcomes, whilst supporting Children's Services Department to manage cost pressures. Contributions to PH outcomes include: • Reduced under 18 conception rate per 1,000 population • Lower % all live births at term with low birth weight • Improved breastfeeding initiation and prevalence at 6-8 weeks after birth • Reduced maternal smoking at time of delivery • Improved school readiness in vulnerable groups • Fewer16 to 18 year olds not in education, employment or training • Reduced incidence of domestic abuse • Fewer hospital admissions caused by unintentional and deliberate injuries in children and young people	Impact on CFCS and achievement of priorities of Children, Young People and Families Plan 2016-18 for Nottinghamshire. Service risk: reduction in service to a vulnerable group of service users (vulnerable, first time young parents). Potential for increased costs elsewhere in the system if the preventive service is reduced or removed. Partner risk: impact on the provider that provides the service. Staff are currently employed to deliver the service as part of the Healthy Families Contract. Potential impact on CFS budgets.

5	Small Steps Extension		372,000		Extension of Small Steps support service for children and young people with concerning behaviours (indicative of Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder) in Nottinghamshire. Additional PH reserves funding would enable the service to continue to March 2020. Estimates for potential beneficiaries in Nottinghamshire based on national prevalance rates: between 3,200 and 5,400 children aged 5-18 are living with ADHD, with 1,600 experiencing symptoms severe enough to require medication; between 1,000 and 1,600 children aged 5-18 living with ASD	The service received 52 referrals in the first month of its operation (August 2018). Impacts: • Prevention in the escalation of concerning behaviours; families are better equipped, with the appropriate knowledge and skills to manage concerning behaviours in the home setting; children are better able to learn and achieve if their concerning behaviours are effectively managed • Improved early interventioncan reduce demand for statutory assessments of special educational need (EHCPs) • Longer term, children can have their needs met within mainstream settings through better understanding, management and communication of their behaviours, reducing demand for specialist educational support and placements • Referrals for specialist health services, such as community paediatrics, are reduced. Estimated reduction in referrals for specialist Community Paediatric provision, both first appointments and follow-up appointments, of a minimum of 10%.	Service risks: Not providing the funds could lead to withdrawal of the service with lost opportunity to improve support for children and young people with concerning behaviours and their families. Opportunity costs: additional demand for statutory assessments of special educational need and referrals to specialist health services could have cost implications elsewhere.
6	Schools Health Hub / Tackling Emerging Threats to Children team		50,000	186,000	The main aim of the Schools Health Hub is support schools to improve health and wellbeing, and educational outcomes, resulting in safe, healthy, happy, resilient children and young people who are able to achieve their potential. There are three SHH Co-ordinators within the team and each team member leads on specific health and well-being priority area as well as being linked to a geographical locality. This proposal seeks approval for the extension of Public Health funding to support the continuation of the Schools Health Hub service within the TETC team, for children and young people across Nottinghamshire in primary, secondary and special schools setting. The proposal also seeks to further fund the full time post of 'Child Sexual Exploitation Co-ordinator' placed within the TETC team.	Contributions to PH outcomes: • reduced pupil absence • fewer first time entrants to the youth justice system • reduced smoking prevalence at age 15 • reduced conception rate in under 18s. The wider Tackling Emerging Threats offer to schools and other stakeholders includes CSE, anti-bullying and Prevent work with young people. Contributes to priorities of the 2016-2018 CYPF Plan and Commitment 1, 2 and 3 of Council Plan.	Service risks: Reduction in health and wellbeing advice and information available to staff and young people in schools. Loss of contribution towards improved OFSTED rating for Nottinghamshire schools in areas of greatest need Reduction in Tackling Emerging Threats offer affecting anti-bullying, CSE and Prevent work. Partner risks: loss of service to and impacts on schools using the service. Operational risks: staff redundancies, additional costs to CFS.

7	Extension of ASSIST smoking prevention in schools			150,000	Smoking is an addiction largely taken up in childhood and adolescence. The ASSIST programme is the only evidence based programme which is proven to reduce uptake of smoking amongst 12-13 year olds across all socio-economic groups and genders. The programme operates in 13-15 targeted schools in Nottinghamshire per academic year. It is delivered under licence by the Youth Service, using a time limited allocation of funding from Public Health reserves previously approved by the former Public Health Committee. Feedback from participating schools consistently demonstrates positive impact in building resilience, self-esteem and confidence in pupils; activity-based training improves leadership, communication skills, highlights empathy and shows value of taking non-judgemental approach to peer-led conversations. Resources remaining from the original allocation of funding are sufficient to continue the ASSIST programme until March 2020. The proposal is to allocate a further £150,000 to enable the programme to continue until March 2021.	Benefits include: • more pupils in Nottinghamshire will benefit from the programme (15 schools are targeted according to adult smoking prevalence rates to address health inequalities) • schools will run the programme again to benefit a new cohort of pupils • schools will benefit from increased conversations around smoking and health • fewer young people will take up smoking. Delivering the programme across the County could reduce smoking prevalence in 15-year-olds from 7.4% to approximately 5.7% - i.e. approximately 150 fewer young people may start smoking each and every year PHOF indicators: • reduced smoking prevalence at age 15 In the longer term, contributes to: • reduced smoking prevalence in adults • reduced mortality rate from causes considered preventable • reduced under 75 mortality rate from cardiovascular diseases, cancers and respiratory diseases considered preventable • inequality in life expectancy and an increase in	Service risk: Smoking prevention programmes cease in schools with future impact on smoking uptake among young people. Wider benefits of the programme, such as positive impacts on self-esteem, resilience and confidence, may be lost. Operational risks: NCC Youth Service would be impacted by removal of funding for the service, which is delivered by youth workers in schools.
8	Chlamydia control activities		30,000	30,000	Chlamydia is the most commonly diagnosed sexually transmitted infection (STI) in the UK. If not treated, it can cause serious reproductive consequences such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal infertility. In 2017, Nottinghamshire had the lowest proportion of chlamydia testing among 15-24 year olds in the East Midlands. To address this, using previous funding from PH reserves, an online testing offer was developed to facilitate access by different client groups that may not access a test via current outlets. Since the service has been available, local performance on the Detection Rate Indicator (DRI) has improved. Additional resources will enable the online service to continue for two further years.	The benefits of screening for service users include: • a higher detection rate in young people (most at risk of infection) • improved access to service from client groups that may not access a test via other outlets (young males) • effective detection and treatment contributing to the control of Chlamydia • positive outcomes for individuals, who benefit from a reduction in serious reproductive consequences of an untreated, asymptomatic infection (PID, ectopic pregnancy, and tubal infertility). Increasing access to online testing will contribute to improving the DRI (Detection Rate Indicator) to support achievement of the PHOF 3.02 Chlamydia Diagnosis Rate (Aged 15 to 24). The Department of Health Public Health Outcomes Framework recommends that local areas aim to achieve a chlamydia detection rate among 15 to 24 year olds of at least 2,300 per 100,000 population. Nottinghamshire's current DRI for quarter 2 2018 is 1987.2.	If not approved, it would be necessary to cap the number of tests available and this would a) Impact on ability to improve testing and detection rates b) Adversely affect confidence in the service, if tests were not available on demand.

9	Better data for prevention and population health need		24,000		Invest to save proposal to examine potential for data sharing and collaboration between Public Health intelligence analysts and health and care organisations. The General Practice Repository for Clinical Care (GPRCC) is a collation of clinical and care data to support more effective care pathways and processes for Nottinghamshire patients, developed as part of the Connected Notts project. GPRCC includes data flows from GPs, Hospitals, Community providers, mental health services and older people's social care. Further expansion of data collection is planned for local authority commissioned services, ambulance service and 111 data. This proposal concerns the opportunity of secondary use of data to support the assessment of population health and care needs; strategic planning of health and social care systems and assessments of efficiency, effectiveness or equity of parts of the care system. Staff time will be assigned to work on this topic with backfill recruited to maintain capacity within the Public Health intelligence function.	Will assist in future fulfilment of PH mandatory functions associated with intelligence and information - e.g advice to CCGs, production of Joint Strategic Needs Assessment, information of service commissioning, production of DPH Annual Report.	Existing capacity in the PH intelligence team is limited. Developing secondary use GPRCC datasets would detract from other work within Public Health, including work on health needs assessments, the procurement of an Integrated Wellbeing Service and work to support the Prevention workstream of the ICS. The analysts currently deal with approximately 20 needs assessments per year and 430 requests for work. Current staffing levels are insufficient to enable time to release staff time to focus on GPRCC. Lost opportunity to explore newly emerging data sharing mechanisms.
10	ICS Support		120,000		Includes: Support for use of JSNA: Joint Strategic Needs Assessment (JSNA) and PopulationHealth Management (PHM) products for Integrated Care System (ICS), Integrated Care Partnerships (ICP) and localities (Locality Integrated Care Partnerships). Mental health leadership: Dedicated capacity and expertise is needed to provide leadership on the prevention elements of the ICS Mental Health Workstream, to ensure effective delivery on its ambitions and outcomes.	The impact of the JSNA support is to enable the ICS to build on an understanding of population health needs in a defined geographic area (notably the ICS, ICP or LICP footprints). The proposal will provide the much needed capacity and capability to help the ICS define, assess, improve and measure population health and understand how best to deliver impacts on health, to both optimise health gains alongside ensuring efficiency and quality. There is the potential for impact across all three outcome frameworks – NHS, ASC and PH. The impact of providing additional leadership will be to provide additional capacity for the ICS to realise its ambitions, particularly affecting prevention.	Ineffective and disjointed working betweenthe JSNA and PHM approaches of the ICS partners. Insufficient leadership capacity within the ICS.
11	Emergency Preparedness		40,000		Upper tier local authorities have a statutory duty to take steps to protect the health of people from all hazards and to prevent those threats emerging in the first place. Directors of Public Health (DsPH) have a responsibility for "the exercise by the authority of any of its functions that relate to planning for, and responding to, emergencies involving a risk to Public Health (PH)". Emergencies can include incidences of serious communicable disease infection, Healthcare associated infections where there may be an actual or perceived risk to the general public, outbreaks or epidemics which threaten the health of the local population e.g. pandemic influenza; events involving the microbial contamination of food, water or the environment; chemical biological, radiation hazards; widescale hazards arising from, for example, extreme weather events. The proposal is to fund scheduled emergency planning work and thereby improve preparedness for certain emergencies and deliver one-off support to the corporate financial position	Increased resilience in regard to response to emergencies.	Financial risk: funds to support the activity would need to be identified from other budgets.

12	Systematic approach to alcohol Identification and Brief Advice (IBA)		75,000	75,000	In Nottinghamshire in excess of 131,000 adults drink at levels that pose a risk to their health. More than 21,000 are dependant on alcohol. There are high levels of admissions to hospital for alcohol related conditions and injuries. System wide implementation of Alcohol Identification and Brief Advice (IBA) is a simple and brief intervention that aims to motivate at-risk drinkers to reduce their consumption and so their risk of harm. It is estimated that for every 8 people who receive alcohol IBA in key settings including primary care, one will reduce their consumption to lower risk levels. On a population level this offers significant opportunity for change. In order to deliver alcohol IBA at scale across the county a dedicated team tasked with specifically delivering alcohol IBA training to the wider workforce is required. The proposal is to vary the contract with existing specialist SM service providers to deliver alcohol IBA training due to their specialist knowledge, ability to deal with onwards referrals the highest risk (dependant) drinkers. Professionals trained will be able to conduct an audit of screening to assess alcohol consumption, alcohol related behaviours and alcohol related problems; offer evidenced based brief advice and information and promote appropriate interventions and services dependant on screening outcomes.	Training will be provided for 1,386 professionals; 198 training sessions per year with the expectation that a minimum of seven professionals attend per session. Target groups of professionals will be within agencies such as family services, district council housing teams and homelessness team, pharmacies, fire service (wellbeing team), hostels and care homes. Contributions to PHOF outcomes: Reduction in % of adults drinking over 14 units of alcohol a week / binge drinking Reducing admissions and readmissions for alcohol related conditions Reduction in admissions for alcohol related unintentional injuries Reduction in benefit claimants due to alcoholism (/mental health) Years of life lost due to alcohol-related conditions Alcohol related road and traffic accidents	Currently there is no systematic approach to alcohol training and awareness in the County. Substance misuse training (including alcohol awareness) is a component of the SM service (CGL) Public Health contract. However, there is insufficient capacity to deliver the required intervention at a scale that enables the wider workforce to systematically adopt alcohol IBA in order to see changes in behaviour that impact on the population (reduction in levels of risky drinking) and any impact on the wider system such as hospital admissions or alcohol related crime.
13	REACH: Routine Enquiry about Adversity in Childhood Implementation and Evaluation		123,100	72,000	There is significant research evidence regarding Adverse Childhood Experiences (ACEs) and their impact on health. An innovative programme, The Routine Enquiry about Adversity in Childhood (REACh) model aims to ask people directly about adverse experiences to enable professionals to plan more focused interventions. The REACh model has been implemented as a pathfinder in a range of multi-agency settings. Four independent academic evaluations have demonstrated its effectiveness. It is proposed to implement REACh over two years across key services working with vulnerable families, adults and young people in Nottinghamshire, and to evaluate the programme independently. An economic analysis would form part of the evaluation. Providing time limited funding would enable testing and provide evidence to inform a business case for future wider implementation. The proposal will address one of the recommendations in last year's DPH Annual Report, to develop trauma-informed practice amongst professionals.	650 professionals would be trained in the REACh approach. Potential benefits include a reduction in the demand for services and improvement in engagement – e.g services for families, children and young people; children's social care; services for young offenders; schools colleges and alternative education providers; police & community safety teams; CYP and adults substance misuse services; CAMHs ; homelessness teams; domestic violence services. • A desire to engage in services (for example, parents wish to modify or change their behaviour) • Benefits for service users include improved health, social outcomes. • Wider benefits may include a reduction in crime as a result of improved engagement in services. Nottinghamshire County Council would be a trailblazer for the development of trauma-informed services.	Lost opportunity to develop approach to routinely addressing childhood adversity which could bring benefits in reduced demand and/or improved engagement with services elsewhere.

14	Physical Activity insight work		34,000	34,000	In Nottinghamshire 33.6% of adults do not do the recommended 150 mins of moderate physical activity per week to benefit their health and 23.2% of adults are inactive (PHE 2018). Inactivity ranges from the least inactive in Rushcliffe (17.8%) to the most inactive in Mansfield (27.7%) which is significantly higher than the English average. Developing insight into which groups are more likely to be inactive, and the reasons for this is an approach recommended by Sport England. Pilot activity was previously undertaken in Bellamy in Mansfield. Funding is now sought to extend the Physical inactivity insight work across the County. Quantitative & qualitative insight work & an action research approach will be undertaken with communities. This work will identify and provide a replicable framework and approach to get to know and understand local communities; building strong relationships as part of the process, mapping assets, identifying opportunities and areas of concern. The total funding sought is £10K per 6 Districts (not including Mansfield, which already received funding) plus £8k towards external evaluation.	• Enable a change in organisational behaviours and approaches to working with underserved communities and delivering services • Influence the traditional sports and leisure sector to think and work differently with a public health orientated needs led approach • Enable true effective partnerships and co-creation of solutions • Inform commissioners and funders to understand what is needed if this work is to be effective, sustainable, impact fully and have longevity. • Influence change in PHOF, Physical Inactive Adults and Physically Active Adults, PHE, Active Lives, Sport England • Percentage of Physically active Adults - Notts (66.4%) similar to England (66.0%). Mans (58.9%) significantly lower. • Percentage of Physically inactive adults - Notts (23.2%) similar to England (22.2). Mans (27.7%) & Ash (26.6%) significantly higher	If this work was not delivered then there would be no further insight led work on physical activity for the other areas of the County, and learning from the pilot in Mansfield would not be transferred in a co-ordinated way for other localities.
15	Age Friendly Notts		92,500	92,500	Estimates of the numbers of older people living alone in Nottinghamshire show that there is expected to be a rise from around 53,000 in 2011 to 74,000 by 2025, an increase of 40%. The Age Friendly Nottinghamshire pilot, in Beeston and Mansfield, was developed to test a response to loneliness in the older population with time limited funding. 320 individuals benefited from the initiative. The proposal is to use Public Health reserves to develop this model and extend it to other communities within the County. The community development approach works to establish networks and structures within a locality so that the provision is sustainable.	communities. With two years additional funding, it is planned to extend the work to another five communities in Nottinghamshire. • Measured interventions and activities to tackle loneliness and isolation, preventing the reliance on public services, and ultimately saving money; • Improving healthier life expectancy – reducing exposure to risk factors for ill health • Strong and connected communities • Helping people to help themselves • Inter-connected residents and agencies to ensure public service activity is co-ordinated and supported locally; • Integrated knowledge sharing across partners to cascade the right information clearly and consistently; Contribution to Public Health outcomes: Self reported wellbeing	Without the PH resources, the pilot activities will cease and there can be no extension to other areas of the County.
16	Food Environment		70,000		The percentage of adults who have excess weight in Nottinghamshire is significantly higher than the England average. Support the work of the Healthy and Sustainable Places Coordination Group in delivery of specific place-based actions or initiatives across Nottinghamshire, to contribute to one or more of six identified food environment objectives, which cover the promotion of healthy food, tackling food poverty and diet-related ill health, building community food knowledge, promoting a diverse food economy, transforming catering and food procurement and reducing waste in the food system.	Enable and support residents to reduce their risk of obesity and diet related diseases such as diabetes, high blood pressure, cardiovascular disease and certain cancers	Lost opportunity to develop place based actions to contribute to food environment objectives.

17	Schools Catering		90,000	90,000	There are increasing levels of obesity in children and young people attending both Primary and Secondary schools.The percentage of children in England who are obese, doubles between Reception age (age 4-5 years) and Year 6 (age 10-11 years). The percentage of Year 6 children who have excess weight in Nottinghamshire (30.6%) is lower than the England average (34.2%). Again this masks variation in the county with levels of overweight and obesity being highest in Ashfield (34.8%) and lowest in Rushcliffe (21.5%). School meals contributes around one-third of energy and micronutrient intake on school days, and have been shown to play a role in the development of healthy eating habits, academic achievement, improved behaviour and a reduction in picky eating behaviours at school . Numerous studies have also shown that, on average, school lunches are of a superior nutritional quality to the food provided as a packed lunch in UK primary schools, with fewer than 1% of packed lunches meeting the nutrient-based framework that underlies current food based standards for school food. The proposal is to provide additional resources for promotion and awareness raising activities by the School Meals service.	Improve the diet of school aged children through the direct impact of increased uptake of school meals that meet the nutritional standards for school meals. Contribute to development of healthy eating habits among children and young people, with potential to contribute to improved academic achievement, improved behaviour and reduction in picky eating behaviours in schools. Through coordination with other food and wider health initiatives in schools and the local communities through the Health and Wellbeing Board's Food Environment plans; this project has the opportunity to contribute to PHOF indicators relating to child obesity and adult overweight.	NCC school meals are constrained by lack of resources to be able to promote the Free School Meal policy to parents and families, develop frontline colleagues in terms of their knowledge and skill base and build relationships between school, customer (student), suppliers and school meals service. There is an opportunity to build on the 40,000 school meals currently provided across some 260 outlets and improve sustainability of the service.
18	Co-ordinated personal travel planning with residents and at workplaces		25,000	165,000	Analysis of the existing information on obesity and inactivity identifies that there is a greater prevalence of inactivity and obesity/overweight in Ashfield, Bassetlaw and Mansfield districts. Air quality monitoring data identifies that there are transport related air quality issues on County Council managed roads in Ashfield, Gedling and Rushcliffe. Personal travel planning can help to address these issues. Personal travel planning has recently been, or is programmed to be, delivered in Mansfield, Daybrook and West Bridgford and therefore it is proposed that travel planning funded as part of this project would be targeted at addressing the identified health issues in Ashfield and Bassetlaw.	success criteria are: • two rounds of residential PTP with 9,000 households • workplace PTP with 2,000 employees at up to 20 businesses • Changes in travel behaviour amongst participants to help deliver Public Health outcomes, specifically (the percentage increases below are the percentage increases of all trips to work made by participants e.g. where 2% of the total trips to work are currently made by cyclists, the target would be to increase this to 5% the total trips to work by particpants): o 3% increase in cycle journeys to work o 6% increase in walking journeys to work o 4% increase in public transport journeys to work o 4% increase in car share journeys to work o 17% reduction in car journeys (as driver) to work. Public Health outcomes contributions: 2.12 Excess weight in adults 2.13 Proportion of physically active and inactive adults 2.23 Self-reported well-being 3.01 Fraction of mortality attributable to particulate air pollution	The travel planning activities will not take place without the funding.

19	ROW promotion		60,000		The Public Rights of Way (PROW) network offers a vital resource in promoting health and wellbeing for Nottinghamshire residents and visitors. Public rights of way provide a means for people to walk, cycle and horse ride that is free of charge and can improve physical, mental and social wellbeing. The project will provide promotional activity and publicity for the ROW network, working with partners, volunteers, PROW user groups such as Nottinghamshire Local Access Forum, the Ramblers Association, Walking to Health Groups, and public health stakeholders such as local GP Practices and the commissioned Obesity Prevention and Weight Management Services. Successes will be measured by the number of people using the public rights of way and wider countryside network, increased levels of physical activity and a reduction in those reliant upon healthcare.	Increase the number of members of public enjoying the walking and cycling network; improving health and mental well-being and reducing costs to the local and national economy by reducing reliance on the health provision. Encouraging children and families to appreciate the wider environment in today's technological society. Contributes to PHOF outcomes related to increasing levels of physical activity and improvements in air quality.	Limited resources for promotion and publicity lead to reduced use of the PROW network.
20	Smoking Cessation advisors in acute trusts		114,750	153,000	Tobacco use remains one of the most significant public health challenges. Currently 97,883 (15.1%) of adults smoke across Nottinghamshire. This figure masks local variation across the county as high smoking levels are concentrated in the more deprived areas. Smoking causes more deaths each year than any other preventable cause. It is costly to both individuals and the economy and is the greatest single cause of health inequalities placing a huge burden on national and local finances. In the last eighteen months, PH reserves provided support for smoking cessation activity in acute trusts - hospitals and mental health units - to implement new NICE guidance on smoking cessation and create an environment which actively encourages patients, staff and visitors to stop smoking and remain smoke free or temporarily abstain from tobacco use during their time in hospital. Activities include improving knowledge and competency of smoking cessation in the workforce, providing advice and developing training, developing processes and interventions to keep the Acute Trust premises (including grounds, vehicles and other settings) are smoke free, working in partnership with with Smokefreelife Nottinghamshire (SFLN) to reach the wider networks of staff and patients by identifying new opportunities to provide suitable stop smoking support.	Nottinghamshire county residents have a smoking prevalence of 15.1%, representing 97,883 adults, resulting in 1341 early deaths as a result of smoking. The costs of this to the local NHS are £41.1million of which £12million is due to 7766 hospital admissions for smoking related diseases. This proposal will support the following PHOF outcomes such as a reduction in: • smoking prevalence in adults (PHOF 2.14) • mortality rate from causes considered preventable (PHOF 4.03) • under 75 mortality rate from cardiovascular diseases considered preventable (PHOF 4.04) • under 75 mortality rate from cancer considered preventable (PHOF 4.05) • under 75 mortality rate from respiratory disease considered preventable (PHOF 4.07) • inequality in life expectancy (PHOF 0.2) and an increase in healthy life expectancy (PHOF 0.1) This intervention is also aligned with the objectives of the Nottinghamshire County Council Health and Wellbeing Strategy.	Potential stalling of reduction in prevalence of smoking and increasing inequalities due to tobacco.
	Total	**427,211**	**1,937,946**	**1,333,161**	**3,698,318**		

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 7

REPORT OF DIRECTORS OF PUBLIC HEALTH AND ADULT SOCIAL CARE TRANSFORMATION

PROGRESS REPORT ON THE NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM (ICS) WORKSTREAM: 'PREVENTION, PERSON AND COMMUNITY CENTRED APPROACHES'

Purpose of the Report

1. This report sets out the work on the Nottingham and Nottinghamshire Integrated Care System (ICS) workstream 'Prevention, person and community centred approaches' as requested by Committee.

2. It provides an opportunity for the Committee to consider any further actions arising from the issues contained within the report.

Information

3. The ambition of the Nottinghamshire ICS is to improve Healthy Life Expectancy by 3 years and reduce inequalities in life expectancy by 2020/21. This overarching aim reflects the gap between the aspirations of people in Nottinghamshire to enjoy good health and live independently in their later years and current reality: many people – and especially those in disadvantaged communities – currently spend more years living in poor health than is necessary, equitable or sustainable for communities and local services.

4. NHS Five Year Forward View (FYFV) identified this gap as a "rising burden of ill-health". It is driven by factors relating to the social and economic circumstances in which we grow, live, and work and accumulates from the earliest moments in life. Therefore, improving population health must mobilise action on these factors from a range of partners; address the whole lifecourse; build on existing community assets; empower individuals to exercise increased control over their own health and wellbeing; and maximise opportunities for independence.

5. With this in mind, the Integrated Care System (ICS) has established a priority work area to promote wellbeing, prevention and independence. There are three key ambitions:

   a) To promote people's wellbeing and prevent illness to enable people to live healthy and independent lives with the support of their local community. By 2021 we want to see people

in Nottingham and Nottinghamshire enjoying an additional three years of life that is spent in good health ('healthy life expectancy').

b) To change the way that people are supported so they feel able to exercise increasing levels of responsibility and control over their own health, with the support of local services as and when needed. Where local services are needed, people are offered choice and control about the support they receive and supported to live independent lives, as far as possible.

c) To tackle the differences in health and wellbeing across our population by targeting our support to those areas where ill health is at its worst.

6. The Strategy **(attached as appendix 1)** was developed by a working group over a short period of time with a range of local partners, including the community and voluntary sector and engagement with residents with lived experiences of services. Overall, the engagement with key stakeholders was positive, with constructive feedback for improvement of the Strategy. The Strategy is supported by a workplan, which sets out the required work in more detail.

7. The strategy intends to reduce the complexity, inconsistency and duplication of approaches and look for ways to deliver all of the above through a simplified, place-based approach that maximises informal solutions.

8. The Strategy was endorsed by the ICS Board in September 2018 and approved by the Health and Wellbeing Board on 7th November 2018.

Features of the strategy

9. The prevention elements of the strategy are based on strong evidence about the main risk factors accounting for the disability and loss of life years in Nottinghamshire and about how these risk factors are distributed across the population. There is also good evidence about what works for addressing these risk factors including interventions at the level of individual, community and wider society.

10. Securing the ambition of increasing Healthy Life Expectancy (HLE) by three years requires changes throughout the local system and that prevention is regarded as everybody's business. For this reason, the strategy seeks to ensure that prevention is a thread which runs through all ICS workstreams. Furthermore, since the dominant influences on population health arise from the environments in which we grow, live and work, the strategy also references the dependency with partner plans, including local Health and Wellbeing Strategies and the need for collaboration with Health and Wellbeing Boards.

11. Where people need support, the focus will be on approaches which are place-based, person-centred and are delivered in local communities in partnership with the public, community and voluntary and private sectors.

12. As part of enabling people to exercise increased control, a personal health budget will be offered to people who require long term support for complex needs.

Action plans

13. Building on the wide range of work already underway across the County and City, there are five key programmes of work.

Programme 1 & 2: Primary & Secondary Prevention

14. The ICS Leadership Board has approved a focus on alcohol related harm as the short term prevention priority for 2018/19. Therefore, alongside the key areas listed below in primary and secondary prevention, alcohol related harm will be a priority throughout plans.

15. Key areas are:
    - To model the behavioural and other changes required to deliver Healthy Life Expectancy targets. This will be supported by Population Health Management and the opportunity to target communities according to need.
    - Align priorities and outcomes with Health and Wellbeing Strategies, especially in relation to the population of approximately 400,000 people across the whole ICS population who do not have complex needs but would benefit from interventions at the level of the individual and in the wider environment to support behavioural change.
    - Establish prevention priorities for each of the ICS workstreams and partner organisations, including relevant plans and outcomes.
    - Agree workforce plans across ICS partners that link with staff health and wellbeing programmes and can be replicated in local stakeholders and agencies.
    - Alongside alcohol related harm, tobacco has been agreed as a priority.

16. Progress:
    - An action plan for alcohol related harm has been approved by the ICS Leadership Board. This will be progressed through the Nottinghamshire Alcohol Pathways Group.
    - Meetings with other ICS workstreams are being held to identify how they will integrate prevention in their workstream plans.
    - A draft prevention framework has been agreed, which will support planning and action plans.

Programme 3: Person-Centred Approaches

17. Key areas are:
    - To change the way that people are supported so they feel able to increasingly take responsibility for their own health and wellbeing, with the support of local services, as and when needed.
    - Where local services are needed, people are offered choice and control about the support they receive to meet their needs and live independent lives, as far as possible. This includes personal health budgets, where people have an individual budget for their health and/or social care needs

18. Progress:
    - Nottingham and Nottinghamshire are a national NHS England (NHSE) demonstrator site for the expansion of personalised care through increased numbers of personalised care and support plans and personal health budgets.
    - Nottingham and Nottinghamshire perform well on numbers of personal health budgets. At the end of 2017/18, the target was 1,071 and this was overachieved with 1,707 people on

a personal budget at year end. This year there is a target of 2,060 and current performance is projected to be ahead of the target for 2018/19.

- The target for support plans is 10,840 for 2018/19. To support the expansion of a personalised support plan for people with health and social care needs, an 'All About Me' one-page summary has been designed for a personalised care and support plan, care plan, or treatment plan. It summarises what matters to a person (what is important to them) and how to support them well, quickly and clearly communicating this information to every health and care professional the person encounters so they can provide truly personalised care. Anyone working with a person can help them complete an 'All About Me', and the aim is that everyone has one. This is being rolled out to the health and social care workforce. This supports people to have greater choice and control and is a foundation for then providing personal budgets if required.
- NHS England findings and local evaluations show:
    - Personal health budgets have, on average, reduced the direct care costs for NHS Continuing Healthcare packages by 17%. Savings arise because people are empowered to replace traditional care packages with assistive technology or a more cost-effect provision where appropriate

Programme 4: Community-Centred Approaches

19. Key areas are:
    - To work with partners to develop a community-based wellbeing offer, targeted at supporting people who lack the skills and confidence to meet their own wellbeing needs and focused on promoting independence and self-care skills.
    - To assess the range of community-based support already available across Nottinghamshire so we can build on good practice already being delivered, engaging closely with the third sector.
    - To roll out the use of Patient Activation Measures (patient activation assess the knowledge, skills and confidence a person has in managing their own health and care) community signposting, including social prescribing, and health coaching and structured education, identifying existing best practice and scaling up across the ICS.

20. Progress:
    - There is a target of 10,840 people receiving community based support by the end of March 2019. Work is underway to capture the range of community centred approaches that enables people to keep healthy, safe and independent in the community.
    - A Nottinghamshire wide Workshop was held on 12th September to engage stakeholders in developing a vision and to co-produce an agreed standard(s) for community centred approaches across the footprint. Following the workshop, there was a meeting of system leaders to agree a consistent model for community centred approaches across the ICS footprint.

Programme 5: Integrated Health and Social Care Pilot

21. Nottinghamshire is one of three national sites (including Gloucestershire and Lincolnshire) to pilot health and social care taking a pro-active and joined-up approach to support.

22. Key areas are:
    - Ensure people will have an improved experience for a simpler, more streamlined process for health and social care assessment and review, with health and wellbeing needs included in the process.
    - Work together as a system so that people will have a joined-up personalised care and support plan which covers health and wellbeing needs.

23. Progress
    - There will be a phased approach to the introduction of a joined-up assessment, person centred care and support plans and personal health budgets.
    - The pilot has begun in three integrated care teams and focus is mainly on older adults in the following locations:

        - Mid Nottinghamshire – North Mansfield and South Mansfield Local Integrated Care Teams (over 65s)
        - South Rushcliffe Care Delivery Group (over 65s)
        - Nottingham City, Radford and Hyson Green Care Delivery Group (over 50s).

    - It is intended the learning from the pilot will be used to inform a future roll out during 2019-20. This will extend the benefits of the pilot to other cohorts of people and to all areas within the Nottingham and Nottinghamshire ICS footprint. In Bassetlaw, discussions are taking place about how the learning from the pilots can inform local developments on joined up assessments and support planning.

Measuring success

24. Outcome measures for prevention have been identified as follows:

Outcome measure	City				County **			
	Latest period	Latest value	2020/21 ambition	Trajectory to reach ambition	Latest period	Latest value	2020/21 ambition	Trajectory to reach ambition
Healthy life expectancy at birth -male (years)	**2014/16**	57.4	58.1	59.4	**2014-16**	61.7	65.4	64.2
Healthy life expectancy at birth - female (years)	**2014/16**	55.1	59.5	60.8	**2014-16**	62.4	65.7	64.6
Adult smoking prevalence	**2017**	19.4%	22.3%	21.5%	**2017**	15.1	15.2	-
Smoking at the Time of Delivery	**2017/18**	17.2%	13.8%	12.2%	**2016/17**	14.8	12.1	13.5
Admission Episodes for Alcohol Related Conditions (per 100,000 pop)	**2015/16**	999.7	888.9	773.2	**2015/16**	693.3	585.9	628.8

Alcohol consumption ***	-			-		
Percentage of adults (aged 18+) classified as overweight or obese *	**2016/17**	61.6%	Targets to be reviewed following changes in indicator methodology	**2016/17**	64.4	Ambitions to be reviewed following changes in indicator methodology
Childhood obesity†	†	†		†	†	
Percentage of physically active adults *	**2016/17**	65.3%		**2016/17**	66.4	
Percentage of physically inactive adults *	**2016/17**	23.3%		**2016/17**	23.2	
Proportion of the population meeting the recommended '5 a day' *	**2016/17**	52.6%		**2016/17**	58.7	
Low birth weight at full term	†	†		†	†	

Source: Public Health England (PHE) PHOF, LAPE fingertips profiles, URL: https://fingertips.phe.org.uk/

Key

Better than target

Worse than target

* Change in indicator methodology: ambitions to be reviewed

** County ambitions are set to indicate direction of travel for reasonable improvement rather than hard committed targets and may be subject to review

*** alcohol consumption: No directly related outcome measure has been agreed, however to consider future inclusion

† childhood obesity: No directly related outcome measure has been agreed, but again to consider for future inclusion

25. Evaluation of the person and community-centred approaches will form part of the overall evaluation of ICS activity and programmes. This will need to look at, amongst other things, the extent to which the growth of demand for statutory services is reducing, including unplanned acute care, A&E attendance, GP appointments and social care packages. The key targets to achieve by March 2019 are:
    - 10,840 receive personalised support plans
    - 2,060 receive personal health budgets
    - 10,840 people receive:
        - Patient Activation Measure (PAM) or an equivalent tool;
        - Referred for self-management support, health coaching and similar interventions; and
        - Referred for social prescribing, community groups, peer support and similar activities with a focus on community connectivity and self-help.

Other Options Considered

26. No other options were considered.

Reason for Recommendation

27. The report provides an opportunity for the Committee to consider any further actions arising from the issues contained within the report.

Statutory and Policy Implications

28. 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

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

Implications for Service Users

30. The implementation of the Strategy will provide a better experience of health and social care and deliver better outcomes for the residents of Nottinghamshire.

RECOMMENDATION

1) That the Committee considers any further actions arising from the issues contained within the report.

Jonathan Gribbin
Director of Public Health

For any enquiries about this report please contact:
Jane North, Transformation Director
Jane.north@nottscc.gov.uk

Constitutional Comments (LMcC 02.11.2018)

31. The Adult Social Care and Public Health Committee is the appropriate body to consider the contents of the report. Members will need to consider any actions they require in respect of the issues contained in the report.

Financial Comments (DG 05.11.2018)

32. The financial implications are contained within paragraph 29 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.

Joint Health and Well Being Strategy 2018-22

Electoral Division(s) and Member(s) Affected

- All

Strategic Plan

Prevention, Person and Community Centred Approaches

What Matters to you?

1st August 2018

Contents

1. Introduction

Prevention, person and community centred approaches needs to be at the heart of the Sustainability and Transformation Plan (STP) for Nottingham and Nottinghamshire. This is because we can improve the quality of care and health and wellbeing of local people and create a sustainable future for our local services through scaling up prevention and empowering local people.

It is generally accepted that most people want to live long and healthy lives. Indeed, life expectancy in the UK has doubled in the past 170 years, primarily through reductions in communicable diseases and treatment of long-term conditions. People are now living longer lives but with longer periods in poorer health. Much of this burden of ill health is preventable. As little as 10%[1] of our health is achieved through access to health care services; the rest is influenced by social factors such as good work, good education, healthy environment and strong and supportive communities. This strategy outlines our approach to both prevent ill health and promote good health as well as supporting individuals with existing conditions to live as independently as possible. This requires a rebalance of the relationship between people and public services towards prevention, community resilience and taking shared responsibility for keeping as healthy and well as possible. In addition, by doing so, people will live happier and healthier lives, whilst also reducing demand on services.

We know that supporting people to manage their own health conditions can reduce the need for hospital admission. Offering people rehabilitation and reablement after illness enables them to return to independent living and avoids the need for long-term care. Supportive social networks and resilient communities are good for people's health and wellbeing. Too often, however, the health and care system is better at reacting to crises and relies too much on hospitals and long-term care. This results in overstretched A&E departments, delayed discharges in hospital and people going into long-term care instead of going home. We need a different model. We will only see this improvement in health and wellbeing if we change our approach. This means that we need to focus in people and place rather than organisations. There is now solid evidence that prevention, person and community centred approaches reduce demand on our resource and deliver good outcomes.

2. Our Vision

Our vision is to maximise independence, good health and well-being throughout our lives. We want to empower local people to make healthier choices that support their own health and wellbeing. We want to ensure that people in our communities live long, healthy and independent lives.

This 'healthy' state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support.

[1] McGovern L, Miller G, Hughes-Cromwick P. Health Policy Brief: The relative contribution of multiple determinants to health outcomes. Health Affairs. 21 August 2014.

By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

Our vision is to develop a system which is focused on delivering improvements in the health, wellbeing and independence of our population, based on the '4 Pillars'[2] identified by the Kings Fund (Appendix One). This means making connections between the following areas:

- Wider determinants of health and well-being
- Our health behaviours and lifestyles
- Communities, health and well-being
- Integrated care and relationships with communities.

3. Our Aims

This strategy focuses on changing behaviours at the levels of the individual, community, workforce and the whole system in order to move away from a reactive, disease-focused and fragmented model of care towards one that is more proactive, holistic, preventative, and focused on improving population health.

This plan aims to support a sustainable future for our public services by reducing demand and costs for health and care services through prevention, community resilience and people taking shared responsibility for keeping healthy and well as possible. Where people require long term support for complex needs, we will offer a personal health budget to maximise choice and control. It recognises that whilst targeted approaches for people with specific long-term conditions can yield short-term results, we know that a greater return on investment will be achieved through primary prevention and addressing the wider determinants of health.

The overarching aim of the prevention, community and person centred approaches workstream is to ensure that prevention is everybody's business. This strategy is not a standalone document as prevention and self-care runs through all of our STP work streams and partner plans.

The intention is to reduce the complexity, inconsistency and duplication of approaches and look for ways to deliver all of the above through a simplified, place-based approach that maximises informal solutions. This will be supported by a commissioning plan that sets out our intentions.

Overall, this strategy is focused on changing behaviours at the level of the individual, community, workforce and whole system, supported by an action plan which will provide a clear, evidence-based and locally modelled system-wide programme to deliver the vision.

3.1 Individuals

- Ensure people's lives are made better because the services or interventions they receive, add benefit and focus on prevention and promoting self-care to enable them to be as independent as possible
- Embed a strength-based approach enabling people to live healthy and fulfilled lives, increasing life expectancy and reducing disease prevalence

[2] Kings Fund (2017) The four pillars of a population health system: making the connections

- Provide a proactive and universal offer of support to people with long term needs to build knowledge, skills and confidence through supported self-care and community-centred approaches
- Embed intensive approaches to empowering people with more complex needs to have greater choice and control over the care they receive
- Ensure anyone who receives a needs assessment under the Care Act 2014 from the local authority can be given a joint health and social care assessment and a joint health and care and support plan where needed

3.2 Communities

- Build community, service providers' and people's support networks so there is a stronger and more resilient community with a focus on prevention
- Work in partnership with local organisations to design and shape services, using people's support networks and working effectively to promote self-care and well-being
- Encourage a vibrant and active community and self-care sector, enabling small, neighbourhood and community groups to develop and grow and support diverse and inclusive groups to evolve to meet local needs and continuing to respond flexibly to changing circumstance and increased demand

3.3 Workforce

- Train and equip staff involved in the delivery of all people's care to identify self-care needs and take a flexible, holistic approach to people's needs with a strong prevention focus, encompassing person-centred approaches.

3.4 System

- Embed system wide leadership for prevention and improving population health through a shared understanding of the relationships between the social determinants of health, lifestyles and health behaviours and the role of communities in health behaviours and as partners
- Take a whole population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing and make informed choices and decisions when their needs change
- Use learning from the Integrated Personal Commissioning programme to develop a whole system approach to personalised care and support planning for anyone who receives a needs assessment under the Care Act 2014 from the local authority

4. Our Principles

- Develop a whole system approach to delivering our priorities
- Have a whole population, whole life approach
- Consider both universal and targeted interventions which address primary, secondary and tertiary prevention, based on evidence and cost-effectiveness
- Hold reduction of health inequalities to be a central driver

- Increase the influence of the person in decision making through a co-production approach
- Recognise the value of the workforce in delivering prevention, community and person centred approaches

5. Strategic Drivers for Change

5.1 National Drivers

The **Care Act (2014)** is a comprehensive piece of legislation that governs the provision of social care. It is founded on the new statutory principle of 'promoting wellbeing' and underpinned by the principle of 'personalisation'. Both of these principles apply to all people. The guidance sets out that '*The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life…. Underpinning all of these individual care and support functions ….is the need to ensure that doing so focuses on the needs and goals of the person concerned.'*

The Care Act works in partnership with the **Children and Families Act (2014)** which amends the Children Act 1989. In combination, the two acts enable councils to prepare children and young people for adulthood from the earliest possible stage, including their transition to adult services.

Within the **Health and Social Care Act (2012)** there is a duty to promote the involvement of people and carers in decisions which relate to their care and treatment. The duty requires CCGs to ensure they commission services which promote the involvement of patients, including self-care and self-management support to better manage health and prevent illness. The act aims to focus healthcare on the promotion of personalisation of care with people in control.

The **Equity & Excellence: Liberating the NHS (2010)** this outlines the core principle of 'No decisions about me without me', with the aim of giving everyone more say over their care and treatment with more opportunities to make informed choices to secure better care and outcomes.

The **Health and Social Care Act 2012** also set out local authority Public Health responsibilities, including a duty to take steps to improve public health, health protection and health improvement.

The Five Year Forward View (FYFV)[3] acknowledged that the future sustainability of the NHS hinges on addressing the rising burden of ill health being driven by demographic change, lifestyles, deprivation and other social and economic influences. It set out a central ambition for a radical upgrade in prevention and public health and promotes a shift in power and decision making. The FYFV identified three gaps:

- The health and wellbeing gap:

[3] NHS. Five Year Forward View. October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

    - We are living longer lives, but we are not living healthier lives. The overwhelming majority of ill health and premature death in this country is due to diseases that could be prevented.
- The care and quality gap:
    - We need to narrow the gap between the best and the worst whilst raising the quality bar for everyone.
- The finance and efficiency gap:
    - The NHS needs to achieve efficiency to meet the forecast rise in demand, driven by population growth, an increase in chronic conditions, technological change and an aging society.

5.2 Local Drivers

Nottinghamshire Health and Wellbeing Strategy

The Health and Wellbeing Strategy for Nottinghamshire includes four key ambitions:

- To give everyone a good start in life
- To have healthy and sustainable places
- To enable healthier decision making
- To work together to improve health and care services

The healthy and sustainable places ambition aims to tackle the wider issues which affect health and wellbeing like housing, our environment, the food we eat, skills and education, transport and our friends, families and local communities.

Happier, Healthier Lives: The Joint Nottingham Health and Wellbeing Strategy 2016 to 2020

The aim of the Nottingham City Health and Wellbeing Strategy is to increase healthy life expectancy and reduce inequalities between neighbourhoods. A key approach to achieving this is through fostering a culture where citizens are empowered to better look after themselves in order to prevent the onset of ill health for as long as possible or to confidently manage their ill health themselves. The healthy culture element of the plan is about making it easier for citizens to access information about services and information on how to stay healthy. The roll-out of learning from the self-care pilot is also an integral part of the strategy to ensure that citizens can have control over their health.

The Nottinghamshire JSNA[4] provides detail on the impact of local demographics - an aging population with an increasing number of complex long term conditions which has implications for individuals and will lead to increasing costs to wider system.

There is strong evidence from local and national programmes that preventive interventions make cost savings to the health and care systems[5]. The proposed prevention and self-care interventions have been modelled to contribute to the STP financial gap through both demand-related cost savings and future cost avoidance.

[4] https://www.nottinghamshireinsight.org.uk/research-areas/jsna/

The financial benefits will be realised through interventions delivered over short-, medium- and longer-term timescales, and the action plan reflects this.

Our Health and Wellbeing Gap

Some of the key factors that drive demand in health and social care and influence the prevalence of conditions and illnesses and the health and wellbeing outcomes for people in Nottinghamshire are:

- Aging population
- Deprivation
- Healthy life expectancy (see Appendix Two)
- Prevalence of multiple morbidities
- Significantly higher premature mortality (under 75 years) compared with England for all causes, cancer, circulatory disease and coronary heart disease[6]
- Health inequalities
- Lifestyle factors (diet, smoking, weight, alcohol, physical activity)
- Mental Health

A more detailed demographic profile is currently being developed for the STP population and will be published on Nottinghamshire Insight.

Our Care and Quality Gap

Our STP plan highlights areas where Nottinghamshire is a national outlier and where there is wide variation in quality of services or outcomes in organisations and communities within the STP area. The Prevention, Personalised and Community Centred Approaches workstream has identified a range of opportunities to support the delivery of the STP care and quality gaps, such as through Quality Outcomes Framework indicators for prevention and Commissioning for Quality and Innovation (CQUIN) indicators.

Our Finance and Efficiency Gap

The STP describes a finance and efficiency gap of £628 million across health and care systems in Nottingham and Nottinghamshire by 2020/21.
Properly implemented, there are a wide range of evidence-based interventions which extend healthy life expectancy and deliver financial efficiencies to the health and care systems. The proposed prevention and self-care interventions are being locally modelled in terms of their contribution to the STP financial gap through both demand related cost savings and future cost avoidance. The financial benefits will be realised through interventions delivered over short-, medium- and longer-term timescales and the action plan will reflect this. The planned interventions will also be modelled in terms of their contribution to improvements in health and wellbeing outcomes.

6. Achieving the Vision

We recognise that prevention, person and community centred approaches will need to be scaled up across the STP footprint. There are many examples of prevention, person and community centred approaches that are making an impact and contributing to key outcomes, but these are often on a small scale or geography through pilots or other short term initiatives.

[6] PHE. Premature mortality SMR 2011-2015. In Local Health Profiles
http://www.localhealth.org.uk/GC_preport.php?lang=en&s=154&view=map14&id_rep=r04

It is now essential that we work together to sustain and build on good practice to roll out across the STP footprint. We have identified several programmes to focus on in the next 18 months that would enable us to make progress at pace and at scale.
This approach and related pathways are depicted our local Prevention, Person-based and Community-based Approaches Model (Appendix Three).

Enabling and sustaining this change will need development work on a number of underpinning and enabling factors. There are some key enablers to scaling up prevention, person and community based approaches.

Culture:

Person and community-centred approaches are counter-cultural to a healthcare system which is still too focused on condition-specific diagnosis, treatment and cure. The challenge is for person- and community-centred approaches to be embraced systematically as complementary to, not in competition with, more medical models of care. We know that there is a leadership challenge in engaging system leaders at every level to support and endorse this approach. This engagement needs to go beyond giving permission to adopt the approach and instead create an expectation of a new way of working.

Work to progress: Organisational development and workforce will build into senior leaders' development programmes on prevention, person and community based approaches.

Capacity:

Generating the capacity to adopt a changed way of working is difficult as this involves implementing new systems, developing new working protocols and releasing staff for training whilst current services are short-staffed, under pressure and facing increased demand.

Work to progress: Organisational development and workforce will consider how long-term capacity can be developed. Appropriate training and support along with new protocols will be developed collaboratively with staff and people using services. We will address barriers to integration of VCSE partners so volunteers can be viewed as recognised assets who will support outcomes in health and social care and add to workforce capacity.

Capability:

Developing the right kind of capability involves widespread organisational and staff development, in general terms around the values and principles of community and asset-based approaches but also specifically around training in new models of working such as person-centred care and support planning, working with social prescribing models and personal budgets.

Work to progress: We will use 'Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support - a core skills education and training framework'[7] as a basis for training across the system. We will explore the role of the VCSE sector in bridging the gap between statutory organisations and communities/people, helping people access the information and support they need

[7] http://www.skillsforhealth.org.uk/news/latest-news/item/576-new-framework-to-promote-person-centred-approaches-in-healthcare

Enablers:

There are a whole range of system enablers which, if not addressed, have the potential to become blockers in practice to adopting person- and community-centred approaches.

These include information systems and governance; financial flows and contracts; and metrics and monitoring amongst others. We also know that success is dependent on having thriving private, public and third sectors, each independently successful but also working together in partnership and the need to support the development of a sustainable, responsive, diverse and resilient third sector economy.

Work to progress: We will ensure that there is a common understanding about what we mean by prevention, person and community centred approaches (see Appendix Four) across the system. We will work to ensure that integrated information and commissioning systems to developed as part of wider STP progress have are linked into the deliverables and metrics of this programme. We will encourage a vibrant and active community and self-care sector, which enables small neighbourhood and community groups to develop and grow and support diverse and inclusive groups to evolve to meet local needs and continue to respond flexibly to changing circumstance and increased demand.

Sustaining the Investment:

Much of this work is using resource from non-recurrent funds to progress person- and community-centred approaches; this will need to come from mainstream commissioning budgets on a long-term basis. Commissioners must be planning for this now with active involvement of providers. We will have a specific focus on commissioning for the future to develop new ways of releasing resource by having a more integrated and targeted approach.

Work to Progress: Develop an STP commissioning plan for prevention, community and person based approaches to deliver a simplified, place-based approach maximising on informal solutions.

7. Delivering the Vision

In looking to overcome these challenges and deliver our vision, we will:

- Promote prevention and person- and community-based approaches as a golden thread which should run through all STP work streams
- Ensure that senior leaders and staff from across the STP are engaged in all areas of work, developing champions to share the messages
- Develop a strong and consistent communication strategy which raises the profile of the prevention, person- and community-based approaches work
- In collaboration with the STP workforce leads, train and support the workforce to enable a shift in relationships with a focus on prevention, co-production and promoting self-care for all people
- Work to understand and rationalise commissioning and service delivery across the footprint where this supports achievement of these aims, looking at new models of commissioning to support this
- Ensure best use of resources across the system to ensure that in times of financial challenge duplication of effort and resource is minimised

- Ensure clear partnership arrangements between statutory and non-statutory services toward the common objectives recognising the pivotal role the VCSE organisations have at the heart of local communities and the ability that they have to organically grow through those communities
- Ensure all decisions made regarding commissioning or delivery across the system are influenced and informed by people with lived experience who have the knowledge, skills and confidence to engage with the system
- Build appropriate prevention into individual contact work

There are five key programmes of work for the prevention, person- and community-based approaches. The focus is for place-based, person-centred services delivered in local communities in partnership with the public, community and voluntary and private sectors. We will work with Greater Nottingham and Mid-Nottinghamshire in the delivery of the programme plan that has been developed (Appendix Five).

7.1 Programme 1: Primary Prevention

- A range of behaviour change approaches and interventions will be modelled in order to provide a quantified evidence base of outputs required to achieve the targets for improved healthy life expectancy.
- Approaches and interventions will be evidence-based and include primary and secondary prevention approaches which have an initial focus on delivering outcomes over a short-term timescale.
- We will consider prevention initiatives which will impact on outcomes in the medium to long term. Such approaches will have a greater emphasis on primary prevention and social determinants of health.
- We will model behavioural change and assumptions required to deliver healthy life expectancy targets. This modelling will consider options for universal and stratified targeted work relative to maximising cost-effective interventions linked between primary and secondary prevention at individual and community level.
- We will explore options for universal and stratified targeted work relative to maximising cost-effective interventions linked between primary and secondary prevention at both individual and community levels.
- We will identify, quantify and model benefits of specific prevention work in cancer, urgent care and planned care using MECC and supporting evidence-based aspects of care pathways.
- We recognise the need to develop other preventative work in strategies for overall wellbeing, children and young people, frailty, and mental health, and we will work with the relevant workstreams to identify next steps.
- We will ensure that the role of the Health and Wellbeing Boards is central to system-wide efforts on primary prevention, and this area of work should take its strategic advice from these established leadership processes.

7.2 Programme 2: Secondary Prevention

- We will make every contact we have with people count (MECC) in ensuring opportunities for prevention are maximised.

- We will support staff in all interactions with people to have brief conversations on how they might make positive improvements to their health or wellbeing in order to have a significant impact on the health of our population through supporting people and their families to live healthier lifestyles[8][9].

- We will focus initially on action on **smoking and alcohol i**n order to make a difference to NHS and social care demand and utilisation:
    - Smoking: Maintaining current improvements in smoking prevalence with a particular focus on groups and areas where prevalence remains high and demonstrates great inequality with population norms by using brief and targeted intervention approaches
    - Alcohol: Developing systematic work in healthcare settings across the STP footprint with a particular emphasis on individuals or communities with high NHS or social care utilisation using brief and targeted intervention approaches

- We will work systematically in healthcare settings across the STP footprint with a particular emphasis on individuals or communities with high NHS or social care utilisation using brief and targeted intervention approaches to promote improved outcomes.
- We will continue to support existing programmes around cardiovascular disease and stroke prevention. These (health checks and RightCare stroke prevention) are firmly embedded in healthcare work and must continue to be strongly supported by the STP.
- We will ensure future choices about focus in a strong evidence base and speed of effect of changes in behavioural factors (e.g. stronger evidence base developing for secondary prevention in obesity management with a longer term need to see a step change in exercise levels).
- We will regularly consider NICE and Public Health England guidance to assess if new or revised prevention work should be prioritised.
- We will ensure that other preventative work is developed in strategies for overall wellbeing, children and young people, frailty, and mental illness, and we will work with the relevant workstreams to identify next steps.

7.3 Programme 3: Person-Centred Approaches

- We will ensure a focus on promoting self-care without unnecessary services and intervention, developing access to a range of appropriate choices to support this.
- For those who need more assistance, we will provide personal budgets, personal health budgets or integrated budgets in order to ensure meaningful choice and control, resulting in social care appropriate to their needs.

- We will give people access to a range of services that enable them to make choices that will focus on self-care without unnecessary intervention. For those eligible for personal budgets, we will ensure that there is meaningful choice and control resulting in both health and social care that meets the person's needs.

[8] NICE. Behaviour change: individual approaches. 2014. https://www.nice.org.uk/guidance/ph49 [accessed June 2018]

[9] PHE, NHSE, HEE. Making Every Contact Count (MECC): a consensus statement. 2016. http://mecc.yas.nhs.uk/media/1014/making_every_contact_count_consensus_statement.pdf [accessed June 2018]

- We will develop a genuinely personalised approach to empower a real, sustainable outcome, using all of people's available resources. A different conversation should take place involving people and their support network; this should include a holistic, joined-up process to facilitate assessment and planning.

- We will ensure a person centred approach is used to empower all people using health and social care services in order for them to build their own knowledge, skills and confidence to self-care.

- We will support a culture where a different, person-centred conversation is the norm and people are recognised as equal partners. To do this, we will ensure our co-production group My Life Choices are involved at all stages of project planning, delivery and service development.

7.4 Programme 4: Community-Centred Approaches

- We will develop and share clear health and wellbeing goals and approaches across communities and community organisation assets.
- We will work with partners to develop simplified and consistent availability of community-based wellbeing support, targeted at supporting people who lack the skills and confidence to meet their own wellbeing needs and focused on promoting independence and self-care skills.
- We will map and fully assess the range of community-based support already available across Nottinghamshire so we can build on good practice already being delivered, engaging closely with the third sector.
- We will roll out the use of Patient Activation Measures, community signposting, including social prescribing, and health coaching and structured education, identifying existing best practice and scaling up across the STP.
- We will collaborate on a system-wide basis across agencies and workstreams, including prevention, housing, and social, primary and acute care to build on Community Connectivity models in operation across the county. Implementation will recognise the importance of ongoing engagement with the Voluntary, Community and Social Enterprise sector (VCSE).
- We will work together to develop more effective ways to recognise and direct people towards community-based skills and resources that support people from those communities to achieve wellbeing goals.

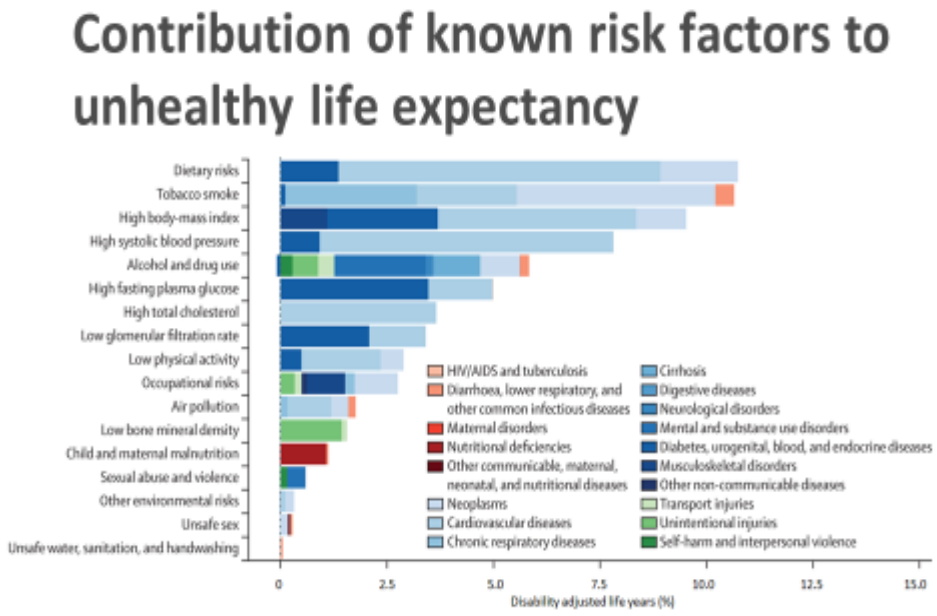
7.5 Programme 5: Integrated Health and Social Care Pilot

- We will ensure people will experience a simpler, more streamlined process for needs assessment and review, with health and wellbeing needs included in the process.
- We will work together as a system so that people will have a joined-up personalised care and support plan which covers health and wellbeing needs.
- We will develop systems so that, when needed, people can get an integrated personal budget (including health as well as social care funding).

8. How will we know we have been successful?

Evaluation of the prevention, person- and community-centred approaches will form part of the overall evaluation of STP activity and programmes. This will need to look at, amongst other things, the extent to which the growth of demand for statutory services is reducing, including unplanned acute care, A&E attendance, GP appointments and social care packages. In the longer term, we will also use population health measures to understand the extent to which this work is improving life expectancy and narrowing the health gap.

8.1 Prevention (tbc)



England 2013
Newton et al. (2015) The Lancet
DOI: 10.1016/S0140-6736(15)00195-6

8.1.1 Metrics (modelled with targets and trajectories but needs updating)

- Healthy life expectancy
- Life expectancy at birth
- Alcohol – alcohol-related admissions (narrow definition), alcohol consumption, premature mortality from ALD, IBA interventions
- Tobacco - smoking prevalence, smoking at delivery
- Physical activity – percentage of physically active and inactive adults
- Dietary risks – percentage of daily intake fruit and vegetables
- Obesity – excess weight in 4-5-year-olds, 11-12-year-olds and adults
- Breastfeeding at six to eight weeks
- Low birth weight at full term

8.2 Person and Community

Personal outcomes will need to be developed and feature in future STP population level outcomes frameworks as person- and community-centred approaches are central in preventing ill health, delaying deterioration of health and improving population health and wellbeing outcomes. Personal outcomes, based on "I" statements and building on work to date locally and nationally, should be developed to cover things like health and wellbeing, social connectedness, independence and resilience, dignity and respect, full involvement in decisions, and good quality and accessible information. A set of draft personal outcomes metrics should be developed and used to provide both a baseline and a measure of success.

The process and output measures suggested below would act as proxies for progress against longer-term outcomes in the short to medium term. These output measures are generic in that they highlight common characteristics and features shared by prevention, person and community centred approaches. They would not be specific to a particular model of delivery, nor would they set any targets for local delivery, but they will be an important tool to monitor and account for progress and are linked to the NHSE Nottinghamshire MOU (Appendix Six).

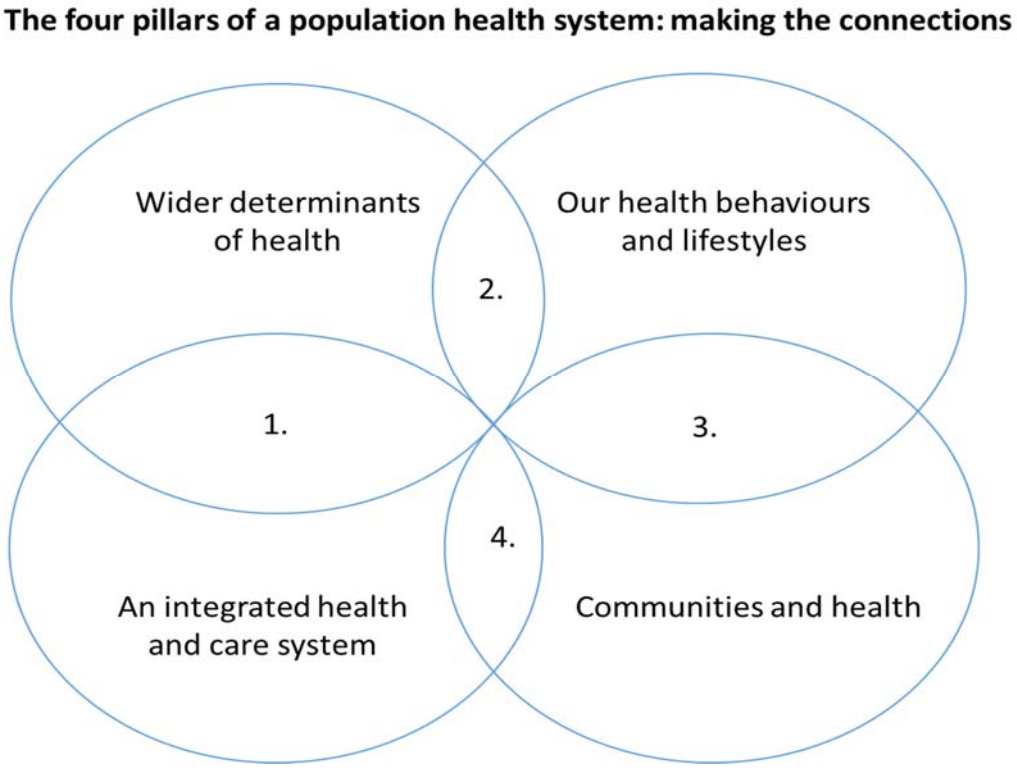
These will include:

- Increased number of personal health budgets or integrated budgets (PHBs/health and social care funded) to 2,060 by March 2019.
- At least 50 looked-after children and young people with identified mental health needs receiving a PHB/integrated personal budget
- Increased number of person-centred care and support plans to 10,840 across the STP by March 2019.
- Increased number of community signposting referrals or equivalent, e.g. self-referrals/people participating in asset-based approaches to10,840 across the STP by March 2019.
- Increased number of people on the Patient Activation Measure (PAM) or equivalent.
- Improving PAM scores.
- Proportion of community practitioners (all sectors) trained for and confident in person-centred conversations.
- Proportion of MDTs including VCSE and/or "care navigator" link workers.

Appendices

Appendix One: The Four Pillars of a Population Health System: Making the Connections (King's Fund, 2017)

The 'system' = connections between the pillars:



Our vision = making those connections

Connection 1 – wider determinants and integrated care

- The NHS narrows income inequalities and adds more net-VA in poorer communities
- Providers as anchor institutions

Connection 2 – wider determinants and health behaviours

- Behaviour is socially determined, including poverty and decision-making
- Clusters of health behaviours, population groups and future inequalities

Connection 3 – health behaviours and communities

- Social norms, social networks and roles in setting behaviours
- Communities as assets, seen as partners as well as (not instead of) needs

Connection 4 – integrated care and communities

- Community and social models of health and the relationship with integrated services
- Community as part of pathways of integrated care (including VCSE)

Appendix Two: Healthy Life Expectancy

Healthy life expectancy describes how long a person might be expected to live in 'good health' based on data from the Annual Population Survey. It is measured separately for both men and women. Both life expectancy and healthy life expectancy have increased nationally and locally over recent years; however, life expectancy continues to increase at a faster rate, meaning that the population is spending a greater proportion of its total life in poor health. This has implications for both individuals, due an increased proportion of life spent with illness and disability, and society, due to associated health and social care costs.

Women in Nottingham City can expect to spend XX years (or XX% of their life) in poor health. In Nottinghamshire County, the equivalent is XX years of poor health (XX% of life). Men in Nottingham City can expect to spend XX years (a quarter of their life) in poor health; in Nottinghamshire County men can expect XX years in poor health, or XX% of their average lifespan.

While increasing healthy life expectancy is the primary aim for the STP health and wellbeing gap, this should not be to the detriment of life expectancy in any population group: Increasing 'life to years' should not adversely affect added 'years to life'.

The rationale for the STP approach to improve HLE can be summarised by results from the World Health Organisation's work on the global burden of disease. The figure below illustrates how multiple risk factors interact with multiple disease outcomes for the STP population. It is clear that to achieve the largest possible gain in healthy life expectancy, consistent and concerted effort will be required to support healthy lifestyles, including smoking, alcohol consumption, diet, physical activity and healthy weight; halt the harmful effects of issues such as high blood pressure or cholesterol; and also modify the environment to prevent ill health (for example, by tackling air pollution or risks at work). This requires a comprehensive, systematic approach which incorporates addressing wider social factors that have a greater influence on health and wellbeing than good access to health and care services. Schemes to tackle risk factors in isolation, or focussing on diseases of one part of the body, will not maximise the potential increase in healthy life expectancy.

Inequalities in healthy life expectancy:

Across the STP footprint, HLE differs substantially; there is a XX year difference in HLE for men and XX years for women (lowest in areas of Nottingham City and highest in areas of Rushcliffe for both men and women). Within Nottingham City alone these differences are XX years for women and XX years for men. In order to tackle these inequalities, populations with the lowest healthy life expectancy will be targeted across the STP area, and progress to change inequalities will be measured.

Appendix Two: Health Life Expectancy

Risk factors and conditions amenable to change in the STP population

Risk factors related to conditions

		<<- higher contribution to total DALYs			Conditions					lower contribution to total DALYs ->>
	The impact that changing these risk factors ↓ ... will have on the disease burden caused by these conditions →	Circulatory diseases	Diabetes, reproductive, urinary	Cancers	Chronic chest diseases	Mental and substance use disorders	Unintentional injuries	Musculoskeletal disorders	Cirrhosis	Nutritional deficiencies
Risk factors (higher contribution to total DALYs ->)	Dietary risks	✓✓✓	✓✓	✓✓	-	-	-	-	-	-
	Tobacco smoke	✓✓	✓	✓✓✓	✓✓	-	-	-	-	-
	High body-mass index	✓✓✓	✓✓	✓	-	-	-	✓	-	-
	High systolic blood pressure	✓✓✓	✓	-	-	-	-	-	-	-
	Alcohol and drug use	-	-	✓	-	✓✓	✓	-	✓	-
	High fasting plasma glucose	✓✓	✓✓✓	-	-	-	-	-	-	-
	High total cholesterol	✓✓✓	-	-	-	-	-	-	-	-
	Low glomerular filtration rate (kidney function)	✓	✓✓	-	-	-	-	-	-	-
	Low physical activity	✓✓	✓	✓	-	-	-	-	-	-
	Occupational risks	-	-	✓	✓	-	✓	✓	-	-
	Air pollution	✓	-	✓	✓	-	-	-	-	-
	Low bone mineral density	-	-	-	-	-	✓✓	-	-	-
	Child and maternal malnutrition	-	-	-	-	-	-	-	-	✓

<<- lower contribution to total DALYs

Notes

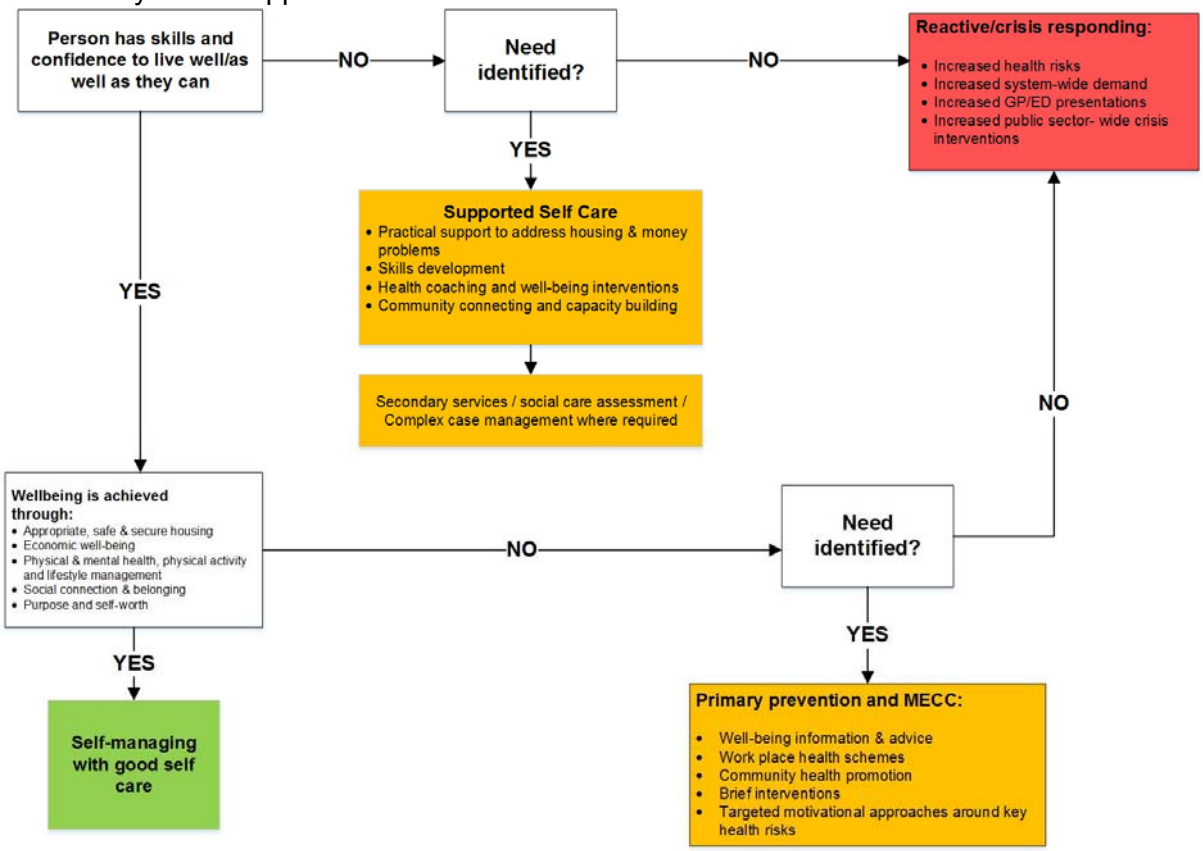
- Estimates for the STP population are derived from data for East Midlands deprivation quintiles, from the WHO Global Burden of Disease initiative
- This chart incoporates 95% of all disability adjusted life years (DALYs) amenable to intervention
- DALYS are a summary measure of years lived with disability and years of potential life lost. A reduction in DALYs is closely related to increases in healthy life expectancy (adding 'life to years' as well as 'years to life').

Key

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

Common factors driving preventable illness (GBD).

Appendix Three: Nottingham and Nottinghamshire Model for Prevention, Person-based and Community-based Approaches



Appendix Four: What do we mean by prevention, person and community centred approaches

Prevention

The term "prevention" or "preventative measures" can cover many different types of support, services, facilities or other resources. There is no one definition for what preventative activity is, and this can range from whole-population measures aimed at promoting health to more targeted, individual interventions aimed at improving behaviour, knowledge or skills for one person or a particular group. Prevention is often broken down into three general approaches, primary, secondary and tertiary prevention, with these three levels informing our approach:

1. **Primary prevention:**

   Primary prevention is aimed at people with no particular health or care needs. These are services aimed at keeping people well and independent by avoiding needs developing for health and social care.

   Primary prevention also extends to population-wide measures and social determinants of health, such as improving air and water quality, mass immunisation, and strengthening family and community ties to promote good mental health and reduce loneliness.

2. **Secondary prevention:**

   These are more targeted interventions aimed at individuals who have an increased risk of developing needs. Secondary intervention consists of screening for illnesses, particularly when risk factors are present, and early intervention measures to slow the progress of the disease while it is still in its early stages, i.e. pre-diabetes. It also includes provision of support to slow down or reduce any further deterioration. Some early support could stop a person's life tipping into crisis, such as a few hours of support to a family carer who is caring for their son with learning disabilities.

3. **Tertiary prevention:**

   These interventions are aimed at minimising the effect of disability or deterioration of people with established health conditions. It is particularly relevant for patients with complex needs and focuses on their recovery, rehabilitation and reablement after acute exacerbation of their chronic illness, i.e. self-management programmes or enablement for a person with mental health issues to regain skills and confidence to live independently.

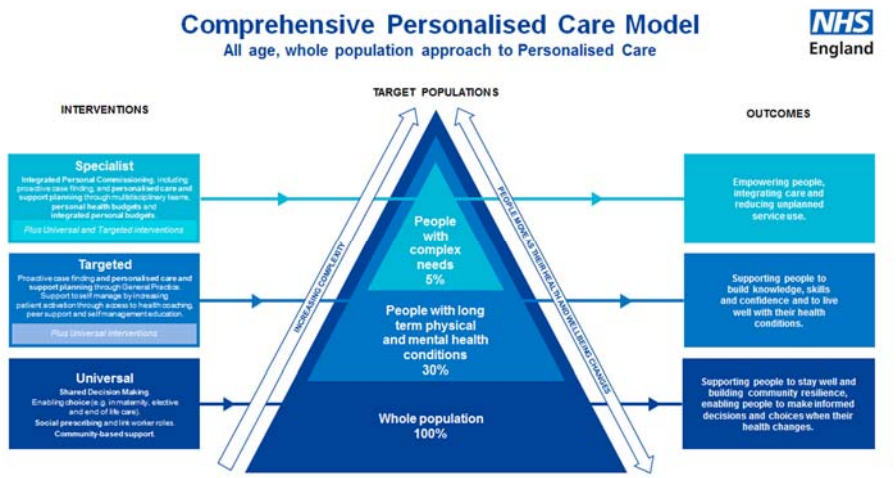
Community-Based Approaches

This is based on a whole population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing and make informed choices and decisions when their health and social care changes. A community-based approach provides a proactive and universal offer of support to people with long term physical and mental health conditions to build knowledge, skills and confidence through supported self-care and promoting needs. This is achieved by ensuring that people's preferences, needs and values guide health and social independence.

Self-care is the actions that we all take to look after individual health and wellbeing, in order to stay well and to manage long-term conditions. People who have the skills and confidence to self-care or who are more 'activated' have healthier lives, better outcomes, better experience of care and a lower impact on services. Linked to this, the assets or resources within our communities, such as the skills and knowledge, social networks and community organisations, are key building blocks for good health and wellbeing. It therefore follows that people and communities should be supported to self-care, and to do so it is necessary to build community resilience. One of the best ways to build community resilience is to start with a very practical understanding of what resources already exist and are strong within local communities, with a view to helping people to connect with them (referred to as 'social prescribing'). Other approaches such as shared decision making, health coaching and self-management education also help people with long term conditions to build self-management skills.

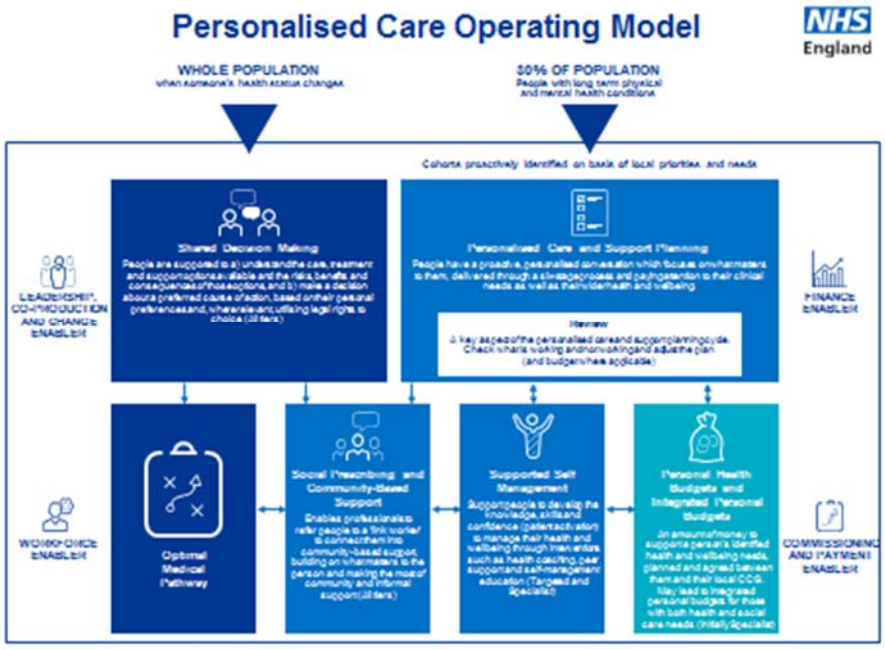
Person-Centred Approaches

A person-centred approach puts people, families and communities at the heart of health, care and wellbeing. It means people feeling able to speak about what is important to them and the workforce listening and developing an understanding of *what matters to people*. It means working in a system in which people and staff feel in control, valued, motivated and supported.



Person-centred approaches are a more personalised approach to commissioning, contracting and payment which enables people to access services that are more appropriate for their specific needs. It does this by:

- Designing a health and care system driven by people and communities
- Encouraging and motivating commissioners and providers to shift their approaches to focus on people and the outcomes most important to them
- Incentivising commissioners and providers, including VCSE organisations, to develop personalised care packages for people with the most complex needs
- Successful implementation of IPC and personal health budgets[10]



This approach is fundamental to social care and the changes the NHS is seeking to make over the next few years. The result is better health and wellbeing for individuals, better quality and experience of care that is integrated and tailored around what really matters to them, and more sustainable health and social care services.

[10] https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Personalised-commissioning-and-payment_S8.pdf

Being person-centred is about focusing care on the needs of the individual and empowering people to make informed choices about their health and social care decisions.

Appendix Five: Greater Nottingham and Mid Nottinghamshire Delivery Plan

STP Implementation Plan v 1.5 - one plan.

Appendix Six: Memorandum of Understanding for Personalised Care Demonstration Sites between NHS England, Local Government Association and Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Notts MOU.doc

Appendix Seven: Nottinghamshire STP Prevention, Person- and Community-Centred Approaches Workstream Strategic Overview and Key Areas for Development

Introduction

The Prevention, Self-care and Independence workstream is being re-designed to create a more unified and integrated work programme to increase efficiency and respond to an NHSE diagnostic suggesting closer working with personal health budget work. The new programme will also focus on place-based solutions to encourage local ownership tailored to differences in local needs.

The STP Leadership Board has confirmed that Healthy Life Expectancy remains a key performance metric for the STP and, as such, some of the early modelling used to establish this metric is being refreshed. This will bring aspects of primary and secondary prevention back into focus and strengthen delivery and oversight of system-wide actions. It will also allow us to weave prevention into the breadth of our work as well as identifying the additional actions needed in other workstreams to contribute to improving healthy life expectancy. Work on self-care and independence is well advanced with established NHSE targets but will also contribute to both reduced urgent care pressures as well as healthy life expectancy. Our work will also review the benefits to the system from reduced emergency and unplanned care as a consequence of a stronger focus on prevention, as clearly described in the Five Year Forward View.

Overarching outcome:

To improve Healthy Life Expectancy by three years from a baseline at 2015

Underpinning principles:

- A major challenge in prevention work is the training of clinical and care staff - especially around methods of engagement and empowerment and associated cultures. The Workforce group should be closely involved in this aspect of STP work.

- Prevention topics that arise in individual care conversations should be prioritised based on patient-led needs and may relate to prevention in the context of the care and self-care advice, e.g. reducing falls, reducing risk factors for vascular dementia, and mental wellbeing.

Main topic areas

1. Primary prevention

- Modelling of behavioural change and assumptions required to deliver Health Life Expectancy targets
- Consider options for universal and stratified targeted work relative to maximising cost effective interventions linked between primary and secondary prevention at individual and community level
- The role of the Health and Wellbeing Boards as central to system wide efforts on primary prevention and this area of work should take its strategic advice from these established Leadership processes

2. Person and Community Centred Approaches

Person:

- Person centred approaches to increase numbers of personalised support plans and development of personal health budgets
- Joined up assessment and support planning for individuals in contact with health and care services
- Build appropriate prevention into individual contact work

Community**:**

- Building Community Connectivity models, rolling out use of Patient Activation Models that include prevention, and rolling out community signposting including social prescribing
- Develop community needs-driven prevention work at local level including local GP delivery or provision groups and NHS provider prevention plans

3. Secondary Prevention

MECC:

- Short term: In order to make a difference to NHS and social care demand and utilisation, it is proposed that we will focus initially on action on **smoking and alcohol:**
    - Smoking: maintaining current improvements in smoking prevalence, with a particular focus on groups and areas where prevalence remains high and demonstrates great inequality with population norms. Use brief and targeted intervention approaches
    - Alcohol: systematic work in healthcare settings to be developed across STP footprint with a particular emphasis on individuals or communities with high NHS or social care utilisation using brief and targeted intervention approaches

Specific existing programmes:

- Cardiovascular Disease and Stroke Prevention; existing programmes (HealthChecks and Rightcare Stroke Prevention) are firmly embedded in healthcare work and must continue to be strongly supported by the STP

Other MECC topics and longer-term work:

- Base future choices on evidence base and speed of effect of changes in behavioural factors, e.g. stronger evidence base developing for secondary prevention in obesity management and longer term need to see a step change in exercise levels
- Regularly consider NICE (Public Health Guidance) and Public Health England guidance to assess if new or revised prevention work should be prioritised

4. Prevention into other workstreams

We will identify, quantify and model benefits of specific prevention work in cancer, urgent care and planned care using MECC and supporting evidence-based aspects of care pathways. Other preventative work needs developing in strategies for overall wellbeing, children and young people, frailty, and mental illness, and we will work with the relevant workstreams to identify next steps.

5. Support within our workstream

- Communications: There is a strong level of support for prevention in all that health and social care does and this should be harnessed to encourage greater focus and enthusiasm for what can be achieved.
- Finance: Alongside epidemiological and health gain metrics, the return on investment and cost-effectiveness data can and does make strong strategic sense, and we need finance support to effectively present such data in a whole system way.
- Leadership: We have taken some steps to strengthen this, but additional actions to work more closely with Health and Wellbeing Boards may be needed.

6. Support from other workstreams

We will work with all major workstreams in the STP to identify specific actions that support the prevention, person and community centred agenda, and we will work with them to quantify and prioritise that effort. Other cross-linking themes are also important contributors such as workforce and cultural change, IT, evaluation and co-production and engagement.

7. Summary and next steps

The workstream will develop an action plan to strengthen prevention work across the STP footprint and provide decision-makers with quantified options to help prioritise this work as part of the overall activity of the health and care system. This will include a refresh of the current PIDs and identify remaining gaps to help risk assessment and management. Some of these can be filled with sufficient resource whilst some, especially relating more closely to longer term educational or derivation related outcomes, require an intergenerational approach. As such our action plan requires short-, medium- and longer-term components.

Chris Packham

STP Senior Responsible Officer for Prevention

14.6.2018

V4

Appendix Eight: Glossary of Terms

Term	Definition	Reference for further information
Accountable Care System (ACS)	An Accountable Care System sees NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide more joined-up and better coordinated care. In return, they get far more control and freedom over the total operations of the health system in their area and work closely with local government and other partners to keep people healthier for longer and out of hospital.	https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained
Advanced Clinical Practice (ACP)	Advanced Clinical Practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterized by a high level of autonomy and complex decision-making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, management, leadership, education and research, with demonstration of core and area-specific clinical competence. Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes. Within Nottinghamshire there has been work to develop the degree with Nottingham University.	https://www.hee.nhs.uk/our-work/developing-our-workforce/advanced-clinical-practice/advanced-clinical-practice-definition
Approved Mental Health Professionals (AMHP)	The Approved Mental Health Professional is authorised by the local authority, and they practice on their behalf, even though they may be employed by a Trust or another local authority. The AHMP provides a broad range of tasks under the Mental Health Act.	https://www.lancashirecare.nhs.uk/Approved-Mental-Health-Professional

	What is important is that they are a counter balance to the medical model that can exist in mental health and bring a social or more holistic perspective. Their work involves the nearest relatives and carers, making sure service users are properly interviewed in an appropriate manner and ensuring they know what their rights are if they are detained under the Mental Health Act 1983. The Approved Mental Health Professional is also the applicant in the majority of Mental Health Act application.	
Asset-Based Approaches	An asset-based approach to care and support is about supporting health care professionals to identify an individual's strengths and building care planning around their assets rather than their problems (or deficits). This model is designed to support the citizen to take control of their lives.	http://www.health.org.uk/publication/head-hands-and-heart-asset-based-approaches-health-care
Assistive Technology (AT)	AT is assistive, adaptive, and rehabilitative devices for people with disabilities. Assistive technology therefore promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish or had great difficulty accomplishing by providing enhancements to or changing methods of interacting with the technology needed to accomplish such tasks.	
Better Care Fund (BCF)	The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join up health and care services so people can manage their own health and wellbeing and live independently in their communities for as long as possible.	https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
Centene	Centene is an international organisation, now established in the UK, which works directly with health and care systems. It has a track record of transforming health care systems internationally both in the USA and through partnerships in Europe. Centene is not a healthcare provider. It is currently providing advice on how an Accountable Care System could be established in Nottinghamshire.	https://www.centene.com/who-we-are/about-us.html
Clinical Commissioning Groups (CCG)	Clinical Commission Groups (CCGs) are responsible for designing, commissioning and quality monitoring local health services. Within Nottingham & Nottinghamshire STP there are six CCGs: Nottingham City, Nottingham West, Mansfield and Ashfield, Newark and Sherwood, Rushcliffe and Nottingham North and East.	

Commissioning for Quality and Innovation (CQUIN)	The Commissioning for Quality and Innovation (CQUINs) payments framework encourages health care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.	https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/
Community and Voluntary sector (CVS)	The community and voluntary sector (or third sector) is a group of voluntary organisations. The role of the CVS is vital when considering as asset based approach to care and heavily supports the self-care agenda, supporting individuals to help themselves. There are a number of services available to the public within the network of CVS that can offer individuals support and guidance on a number of issues.	http://www.nottinghamcvs.co.uk/
Community Education Provider Network (CEPN)	A CEPN brings together organisations who are involved with education and training in primary care. The CEPN delivers and co-ordinates education and training, promotes multi-professional training, supports local priorities and workforce needs, works collaboratively with health and social care, supports improvements in the quality of education, and utilises workforce data and provide continued professional development. The role of the CEPN is to help attract, recruit and retain staff in the region and help to develop a sustainable workforce.	https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf
Connected Nottinghamshire	Connected Nottinghamshire is a transformation programme working to improve the way health information is shared to enhance service quality across health and social care services, support changes in the way health and social care services will be delivered in the future so that more care takes place in people's homes, closer to where they live and in hospitals, and improve collaborative working between IT service providers working in health and social care organisations. Their work supports health and social care staff to work together to provide a more efficient and effective service.	http://www.connectednottinghamshire.nhs.uk/
East Midlands Ambulance Service (EMAS)	EMAS provides emergency 999 care and clinical assessment services for a population of 4.8 million people across the entire east midlands. EMAS operates over the a number of STP areas.	http://www.emas.nhs.uk/
General Practitioner Forward View – GPFV	The GP Forward View's aim is to provide support to GP practices, including increases in funding. There have been agreed funding streams and innovations to tackle the challenges that are facing the general practice workforce.	https://www.england.nhs.uk/gp/gpfv/

Greater Nottingham Transformation Partnership	The Greater Nottingham Transformation Partnership is made up of all the organisations responsible for health and care in the greater Nottingham area. This includes 4 clinical commissioning groups, Nottingham North and East CCG, Nottingham West CCG, Nottingham City CCG and Rushcliffe CCG. Greater Nottingham Transformation Partnership also includes Nottinghamshire County Council and Nottingham City Council as well as Nottingham University hospitals, Nottinghamshire Healthcare Trust, CityCare Partnership and Circle Nottingham. The Greater Nottingham Partnership Board also has representatives from NCVS and Healthwatch.	http://www.greaternottinghamtransformation.co.uk/
Health and Wellbeing Board	Health and wellbeing boards were established by local authorities to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards intend to increase democratic input into strategic decisions about health and wellbeing services, strengthen working relationships between health and social care, and encourage integrated commissioning of health care services. Within Nottinghamshire there are two health and wellbeing boards (Greater Nottingham Transformation Partnership and Mid Notts Transformation Board) which both report into the STP leadership board.	
Health Education England (HEE)	Health Education England (HEE) is a national leadership organisation for education, training and workforce development in the health sector.	https://hee.nhs.uk/
Health Literacy	Health literacy is the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.	http://www.who.int/healthpromotion/conferences/7gchp/track2/en/
Healthy life expectancy	Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury; it describes an improvement in the length of time that individuals are likely to live by keeping people healthier for longer.	http://www.who.int/healthinfo/statistics/indhale/en/

Healthy Living Pharmacies (HLP)	HLP is an organisational development framework underpinned by three enablers of: o Workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and wellbeing o Premises that are fit for purpose o Engagement with the local community, other health professionals (especially GPs), social care, public health professionals and local authorities The HLP concept provides a framework for commissioning public health services through three levels of increasing complexity and required expertise with pharmacies aspiring to go from one level to the next. o Level 1: Promotion – Promoting health, wellbeing and self-care (in July 2016, Level 1 changed from a commissioner-led process to a profession-led self-assessment process) o Level 2: Prevention – Providing services (commissioner-led) o Level 3: Protection – Providing treatment (commissioner-led)	http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/
Healthwatch	Healthwatch are a patient experience group who provide support and guidance to patients and highlight any inadequacies. Healthwatch state on their website: Healthwatch are a listening ear to people, especially the most vulnerable, to understand their experiences and what matters most to them, influencing those who have the power to change services so that they better meet people's needs now and into the future, empowering and informing people to get the most from their health and social care services and encouraging other organisations to do the same, and working with the Healthwatch network to champion service improvement and to empower local people.	http://www.healthwatch.co.uk/
Holistic Worker	The holistic worker model is an integrated approach to delivering care to individuals. Health and social care workers are trained in disciplines other than their own to provide joined up care to individuals and ultimately work to avoid hospital admission.	http://www.nhsemployers.org/case-studies-and-resources/2015/03/new-ways-of-working-in-nottingham-the-holistic-worker-model

House of Care	The House of Care is a framework which has been developed out of a need to manage the way that long term conditions are treated differently.	https://www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/house-of-care/
Improving Access to Psychological Therapies (IAPT)	The Improving Access to Psychological Therapies programme began in 2008. IAPT services provide evidence-based treatments for people with anxiety and depression. The priority areas for service development are to expand services so that at least 1.5 million adults access care each year by 2020/21, focus on individuals with long-term conditions, support people to find or stay in work and improve quality and people's experience of services.	https://www.england.nhs.uk/mental-health/adults/iapt/
Integrated Personal Commissioning (IPC)	Integrated personal commissioning is an approach to person-centred health and social care. It aims to: join up health and social care services so people with complex needs, carers and families can shape care that is effective and meaningful to them in their lives, offer councils and NHS commissioners and provider's technical support, regulation and financial flexibility to address the barriers they may experience as they change their systems, and partner with the voluntary sector to design effective approaches to change, support individuals and drive the cultural changes needed. The IPC programme builds on and brings together work on implementing personal budgets in the NHS and the Better Care Fund.	http://www.ipcprogramme.org.uk/about-the-programme/
Integrated budget	Integrated budgets are an amount of money to support a person's identified care and support and health and wellbeing needs, planned and agreed between the person and their social care and health team.	
Learning Beyond Registration (LBR)	Health Education East Midlands have entered into contracts with local training providers to provide training to professionals post-registration (excluding dentists and doctors) in order to improve the skills, knowledge and competency of the workforce.	http://lbr.eastmidlands.nhs.uk/
Local Information Online Nottingham (LION)	Nottingham LION has been developed by Nottingham City Council and Nottingham City CCG as an online directory of services and agencies within the Nottingham area.	https://www.asklion.co.uk/kb5/nottingham/directory/home.page

Local Workforce Action Boards- LWAB	Local workforce action boards have been set up across the areas of the sustainability and transformation plan and are working closely with health and social care providers and commissioners around the workforce elements of the STP.	https://hee.nhs.uk/sites/default/files/documents/TV_PaulineBrown_presentation.pdf
Local Medical Committee (LMC)	LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. They interact and work with – and through – the General Practitioners Committee as well as other branch of practice committees and local specialist medical committees in various ways, including conferences.	https://www.bma.org.uk/about-us/how-we-work/local-representation/local-medical-committees
Local Pharmaceutical Committee (LPC)	Local Pharmaceutical Committees (LPCs) represent all NHS pharmacy contractors in a defined locality. LPCs are recognized by local NHS Primary Care Organisations and are consulted on local matters affecting pharmacy contractors. Nottinghamshire LPC represents local pharmacies in Nottinghamshire, Nottingham City and Bassetlaw.	http://lpc-online.org.uk/
Make Every Contact Count (MECC)	Making Every Contact Count (MECC) is an approach to behavior change that utilizes day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations. The MECC approach has been developed by public health and has been rolled out to front line staff.	https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources
Make Every Contact Count (MECC) Plus	It is recognised that partner organisations such as local authorities may adopt a broader definition of the MECC approach, referred to as MECC plus. This may include conversations to help people think about wider determinants such as: • Debt management • Housing • Welfare rights advice	

Mid Nottinghamshire Alliance Transformation Board	Nottingham Better Together Partnership (Mid-Nottinghamshire Alliance Board) is made up of Mansfield and Ashfield CCG, Newark and Sherwood CCG, Sherwood Forest Hospitals, Circle Nottingham, East Midlands Ambulance Service, Nottinghamshire County Council and Nottinghamshire Healthcare Trust.	http://www.bettertogethermidnotts.org.uk/vanguard/
Multispecialty, community based provider – MCP	MCPs were introduced as a new type of integrated provider, combining the delivery of primary care and community-based health and care services. MCPs are part of the New Models of Care vanguard programme.	https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf
New Care Models – Vanguard	There are 5 types of vanguard, which are new models of care: • Integrated Primary and Acute Care Systems (PACS) – joining up GP, hospital, community and mental health services • Multispecialty Community Providers (MCP) – moving specialist care out of hospitals into the community • Enhanced Health in Care Homes (EHCH) – offering older people better, joined up health, care and rehabilitation services • Urgent and Emergency Care (UEC) – new approaches to improve the coordination of services and reduce pressure on A&E departments • Acute Care Collaborations (ACC) – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency. The New Models of care (Vanguards) are a key element to the delivery of the Five Year Forward View.	https://www.england.nhs.uk/2015/01/models-of-care/
NHS Five Year Forward View	This is a key strategic document for the NHS published in October 2014. It outlines the answers to: a) Why will the NHS need to change? b) What will the future look like? (use of new care models) c) How can we get there? Next Steps for the Five Year Forward View was published in March 2017.	https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
National Institute for Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care.	https://www.nice.org.uk/

Notts Help Yourself	The Notts Help Yourself website is aimed at supporting local people for find services or agencies that can support with finding help and advice. Notts Help Yourself was developed by Nottinghamshire County Council.	http://www.nottshelpyourself.org.uk/kb5/nottinghamshire/directory/home.page
Nottinghamshire County and Nottingham City Declaration on Tobacco Control	The Nottinghamshire County and Nottingham City Declaration on Tobacco Control is an extension of the original Local Government Declaration on Tobacco Control developed by Newcastle City Council as a response to the enormous and ongoing damage smoking causes to our communities. This locally developed, innovative document will enable organisations across the whole of the county and city to also sign up to the principles of the Local Authority Declaration and be supported to develop an action plan.	http://www.nottinghamshire.gov.uk/care/health-and-wellbeing/declaration-on-tobacco-control
Nottinghamshire Wellbeing @ Work programme	This is a local scheme that acts as an umbrella for a range of public health and wider health related priorities to be implemented across adult working age population and their wider families and peers. It encompasses a very effective community development model, whereby people in the workplace are trained to promote health and wellbeing in the workplace. The award scheme comprises five attainment levels across five themed areas with a tiered approach. The scheme brings together a large network of interested businesses and provides robust information on the importance of health and wellbeing, promoting local business as exemplary employers and improving their public image.	https://search3.openobjects.com/mediamanager/nottinghamshire/fsd/files/workplace_health_toolkit.pdf
Nurse Associates	The nursing associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. Following huge interest, some 2,000 people are now in training with providers across England. The new role is expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce with clear entry and career progression points. The new role will be regulated by the Nursing and Midwifery Council.	https://hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing

Person-Centred Approaches	The priorities of person-centered approaches are to tailor care planning to individuals. Skills for Health have produced a paper in relation to person-centered approaches which demonstrates the positive outcomes citizens have when they are supported with a person centered approach.	http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download
Personal budget	This is a budget that is funded by the local authority for individuals eligible for care and support under the Care Act.	
Personal health budget (PHB)	A PHB is an amount of money to support a person's identified health and wellbeing needs.	https://www.england.nhs.uk/personal-health-budgets/
Prevention	Prevention is the act of stopping something from happening or stopping someone from doing something. For the health and care system, this term refers to the general prevention of incidence and progression of ill health and wellbeing. The Care Act's triple definition of prevention: • Primary prevention is about minimising the risk of people developing needs. • Secondary prevention is about targeting people at high risk of developing needs and intervening early. • Tertiary prevention is about minimising deterioration and the loss of independence for people with established needs or preventing the reoccurrence of a health and social care crisis.	http://www.redcross.org.uk/About-us/Advocacy/Health-and-social-care/Prevention-in-action-resources-for-local-decision-makers
Priority Areas	Within the Sustainability and Transformation plan (STP), there are five areas where the biggest impact on improving services and improving the health and wellbeing of the population can be made. These areas are referred to as High Impact Areas (HIAs) throughout the STP.	
Promoting independence / maximising opportunities	This describes an approach where people are encouraged to do as much as they can for themselves whilst offering a good level of advice, information and access to support that can assist. Maximising opportunities for independence starts with people at risk of needing health or social care services through to people with complex health conditions or disabilities.	
Reablement	Reablement is interventions that are provided to individuals to help them to learn or relearn tasks to support them to regain their independence.	

Self-Care	Self-care is used to describe any human function that is under the control of the individual themselves. In healthcare, it is often used to describe people managing their long-term condition needs, but we are applying it in a broader context to wellbeing.	
Self-Care Forum	At the Department of Health on 10 May 2011, Paul Burstow, Minister of State for Care Services, met with 17 members of the Self Care Campaign. The occasion marked the inaugural meeting of the Self Care Forum, whose purpose is to further the reach of self-care and embed it into everyday life. The Minister invited the Self Care Forum to take over the organisation of Self Care Week, a yearly campaign that was started by the Department of Health in 2009. At the inaugural meeting, the Self Care Forum also agreed nine aims within its terms of reference, including to widely disseminate excellent examples of self-care activities.	http://www.selfcareforum.org/
Self-Management	Self-management is part of self-care. People with long-term conditions manage well when they understand and follow complex medical regimes and adopt necessary changes in lifestyle. This can often require support, whether in managing aspects of physical health, aspects of adapting everyday activities and roles, and/or dealing with the emotions arising from having a particular condition or number of conditions.	
Skills for Care	Skills for Care aims to support a better-led, skilled and well supported work force. Skills for Care support this by providing training for all individuals employed in the social care sector. Skills for Care were involved in the development of the Care Certificate.	http://www.skillsforcare.org.uk/Home.aspx
Social Care Institute for Excellence (SCIE)	Social Care Institute for excellence seeks to improve the lives of individuals who use care services by sharing information. This includes provision of training, consultancy and resources guides.	https://www.scie.org.uk/
Social Prescribing	Social prescribing, sometimes referred to as a community referral, is a means of enabling GPs, nurses and other primary care professionals to refer individuals to a range of non-clinical services. Social prescribing seeks to support individuals in a holistic way considering social, economic and environmental factors. There are many different models for social prescribing; most involve a link worker or navigator who works with people to access local sources of support.	https://www.kingsfund.org.uk/publications/social-prescribing

Sustainability Transformation Partnership	The Nottingham and Nottinghamshire Sustainability and Transformation Partnership is not a public body but a partnership of the six CCGs, two NHS Trusts and eight Local Authorities in Nottingham and Nottinghamshire who are now coming together to plan and deliver services across a wider geography and as an integrated health and care system. The footprint has a resident population of 1,001,600 citizens and has a total place-based spend across health and social care of £3.7 billion. A copy of the plan and supporting documents can be accessed on line at this address http://www.stpnotts.org.uk/	https://www.stpnotts.org.uk/media/116401/sustainabilitytransformationplansummaryguide.pdf http://www.smybndccgs.nhs.uk/application/files/9514/8041/4423/South_Yorkshire_and_Bassetlaw_STP_-_a_summary_.pdf
Three Tier Model	The three tier model has been developed to work with families, partners and communities to help more people to have healthy and fulfilling lives. The goal is for all service users to have a positive experience of care and support. Support will be tailored to individual's strengths, personal outcomes and the assets in the community. The model is based on three tiers: firstly, that individuals are supported to help themselves utilising resources readily available to all citizens including online resources, secondly, that there is a focused on short term care when needed, a reablement model that provides intensive support to support individuals to regain their independence, and thirdly, that there is help to live your life. This is self-directed based on citizens having choice and control.	
Workforce Temperature Check	In order to effectively respond to emerging workforce issues, it is vital that we have access to real time workforce intelligence. Numerous workforce data capture tools are utilised by STP partners, some of which capture mandatory data returns and data for internal reporting, but not all of which are readily available. There is no one system to systematically collect real time data that we can utilise to inform our plans. Conversations are currently taking place to determine the most effective approach for gaining system wide intelligence through a one off workforce survey. The survey will provide a 'temperature check' of key workforce risks and issues, including: o Business critical vacancies o Workforce skills gaps	

	o Recruitment and retention approaches and associated success rates o Temporary/flexible workforce and associated spend o Current workforce strategies o Known risks Analysis of this will help focus our limited resources and support the ongoing workforce modelling project. The LWAB are asked to support the roll out of this survey across STP organisations.	

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 8

REPORT OF THE SERVICE DIRECTOR, MID NOTTINGHAMHIRE

PROGRESS AND NEXT STEPS WITH THE TRANSFORMATION OF THE COUNCIL'S REABLEMENT SERVICE

Purpose of the Report

1. This report:

   a) provides an update on project work within the Adult Social Care and Health Department to transform the Council's Reablement Service (START) as part of the Improving Lives Programme.
   b) seeks approval of the additional savings targets to be delivered by this project.

Information

Background

2. The Council's Short Term Assessment and Reablement Service (START) provides a Reablement Service to people in their own homes. It works with adults to help them to regain and maximise their independence and confidence following a period of ill-health and often a stay in hospital. START is a regulated service which is registered with the Care Quality Commission (CQC), operating across three County Council teams (mid, south and north).

3. START is a therapy led service. This means that occupational therapists (OTs) will work with a person to identify the functional skills required to achieve the tasks and activities of daily living and then the reablement support team work with the person on these skills to enable them to regain their independence in the required task or activity.

4. The work of the Transforming Reablement project is building on an already successful Nottinghamshire START service. In 2017/18 1,576 people completed reablement with START, of which 73% went on to require no ongoing homecare package. START in Nottinghamshire also performs well against the key national performance indicator for the proportion of older people (aged 65 & over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. In 2018/19 92% of Nottinghamshire service users were still at home 91 days after discharge from hospital into START reablement, the same percentage as in 2017/18, exceeding the national target of 85%.

5. There have been a number of recent developments by the Council which have improved the capacity and efficiency of the Reablement Service and have been reported previously

to Committee, for example: the implementation of an electronic rostering system in 2017/18 which enables front line worker capacity to be used more flexibly and efficiently; and additional Reablement Support Workers, Occupational Therapists and other staff recruited towards the end of 2017/18 and early 2018/19 as a result of Improved Better Care Fund funding in order to support delivery of the Department's Adult Social Care Strategy.

Project update and targets

6. The purpose of the Transforming Reablement project is to build on success to date and further increase the capacity and effectiveness of START in order to support more adults with reablement potential to maximise their independence. This has several benefits because it improves the independence and quality of life for people, which in turn results in savings to the Council from reductions where appropriate in homecare packages. The majority of people that START works with are being discharged from hospital and the service therefore also helps to support hospital discharge. As capacity increases and the service is able to work with more people, the aim will also be to take more community referrals which will help to avoid unnecessary admissions to hospital.

7. Analysis work carried out for the Council in 2017 by Newton Europe, workshops with START colleagues across Nottinghamshire and consideration of best practice in other authorities, have all indicated that there is the potential to further transform the Reablement Service in order to support more adults to retain or regain as much independence as possible, in line with the Council's Adult Social Care and Health Strategy.

8. Based on the above information, it is estimated that as the project work is undertaken, START will be able to complete reablement with an additional 360 service users across 2018/19 and 2019/20 combined. This equates to a 23% increase over two years in the number of people reabled compared to 2017/18. As a result of more people completing reablement, it is anticipated to save the Council £2,067,233 (consisting of £1,199,131 in 2019/20 and £868,102 in 2020/21). In addition to these savings, the project will also deliver the already approved savings of £185,000 in 2018/19, as reported to the Committee on 8th January 2018.

Factors affecting the transformation of START

9. There are three key underpinning factors which will affect the Council's intended transformation of its START service, with each factor having an underlying assumption as set out below:

- <u>Demand:</u>
  That there is sufficient demand, as determined by consultants Newton, for significant additional numbers of service users to benefit from START reablement. There is, however, existing evidence of significant unmet demand for START from all three acute hospitals in the County. The figures for 2017/18 show that the older people (aged 65 years and over) who received reablement/rehabilitation services after discharge from hospital is currently significantly lower in Nottinghamshire than both the East Midlands and national average. In addition, due to the high demand from hospitals, START is rarely in a position to take referrals from other sources, meaning there is even greater potential demand for the service to work more preventatively with people in the future by also taking more community referrals.

- Home care:
  On average, 27% of people who complete their re-ablement goals do still require some ongoing homecare. The prompt availability of homecare at this point is vital to be able to release START staff to ensure the ongoing capacity to work with new people. In mitigation of this risk, there is significant work underway across the Department to increase homecare capacity. The new home care contracts are designed to enable this and additionally, local and national recruitment campaigns are being planned with a focus on frontline care providers.

- Outcomes:
  That the current good performance outcomes for service users (to live independently) are maintained or improved.

10. Of the above factors, it is important to note that even with the range of work that the Council is doing to support homecare providers to recruit and retain more staff, the delivery of sufficient homecare is heavily dependent on factors outside of the Council's control. The national difficulties recruiting and retaining frontline homecare staff are well known and linked to factors such as levels of pay and the general view that working in frontline social care services is not a desirable or valued career option, especially when compared to similar level roles in the NHS.

11. Overall, analysis indicates that there is significant scope for successfully improving available capacity of the START service. The Transforming Reablement project is six months into its delivery phase and the overall performance trend for the numbers of people completing reablement over 2018/19 in Nottinghamshire is positive. In addition, to support the scale of transformation required, a new temporary role of Group Manager for Reablement was approved by Committee in September 2018, with the post holder now in place from the end of October to March 2020 to help drive continued improvements.

ICT development to support the transformation of START

12. The Transforming Reablement project consists of a number of workstreams. Significant areas of project development are planned during 2018/19, followed by implementation as these are completed. A key workstream is the development of improved and enhanced ICT processes to increase the capacity of the service by supporting a more efficient flow of service users through START from point of referral to discharge. A very early estimate of ICT development costs is a maximum of £200,000. This would be a one-off project implementation cost. The ICT work will benefit the Council's Reablement Service on an ongoing basis. The indicative cost is based on the high level design requirements identified so far and work over the remainder of 2018/19 will determine the exact amount of investment required. The anticipated benefit of this ICT work is:

- a streamlined, faster and consistent referral process which will also provide a more accurate view of the demand for the service
- a reduction in the time spent by officers manually processing information which would enable officers to process more referrals and manage an increased caseload
- improved and faster access to information to provide a real time overview of the caseload and progress of service users.

Other Options Considered

13. It would be an option to continue with the already agreed reablement savings as approved by the Committee on 8th January 2018, without seeking further transformation within START. However, the analysis undertaken within the department, including with Newton Europe, identified the potential to further increase the capacity and effectiveness of START.

Reason/s for Recommendation/s

14. The Transforming Reablement project will further increase the capacity and effectiveness of START. This will enable the service to work with more people to improve their independence, thereby also reducing the cost of homecare packages.

Statutory and Policy Implications

15. 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

16. As set out in **paragraph 8**, the Transforming Reablement Project is anticipated to save the Council £2,067,233 (consisting of £1,199,131 in 2019/20 and £868,102 in 2020/21). Funding for project implementation costs set out in **paragraph 12** can be met from departmental reserves.

Human Resources Implications

17. The project posts have already been established as part of the Council's Improving Lives Programme.

Implications for Service Users

18. The Transforming Reablement project is designed to help START to deliver reablement to service users in a way that maximises their independence. Whilst this will mean that the overall spend on care packages should reduce, this is based on sound social work practices of promoting independence and wellbeing and supports the Department's Adult Social Care Strategy.

RECOMMENDATION

1) That Committee approves the performance targets and associated savings, as set out in **paragraph 8**, to be delivered by the project to transform the Council's Reablement Service as part of the Improving Lives Programme.

Sue Batty
Service Director, Mid Nottinghamshire

For any enquiries about this report please contact:

Rebecca Croxson
Strategic Development Manager, Adult Social Care & Health
T: 0115 977 2189
E: rebecca.croxson@nottscc.gov.uk

Constitutional Comments (LM 27/11/18)

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

Financial Comments (KS 28/11/18)

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

Background Papers and Published Documents

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

Adult Social Care and Health Consultation - Report to Adult Social Care and Public Health Committee on 9th October 2017

Adult Social Care & Health Consultation – report to Adult Social Care and Public Health Committee on 8th January 2018

Assessment and advice provided by external savings partner Newton to support savings programme – report to Adult Social Care and Public Health Committee on 12th March 2018

Revision to the Adult Social Care Charging Policy – report to Policy Committee on 28th March 2018

Adult Social Care and Health Changes to staffing establishment – report to Adult Social Care and Public Health Committee on 10th September 2018

Electoral Division(s) and Member(s) Affected

All.

ASCPH606 final

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 9

REPORT OF THE DEPUTY CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH

ADULT SOCIAL CARE AND HEALTH PERFORMANCE FOR QUARTER 2

Purpose of the Report

1. To provide the Committee with a summary of performance for Adult Social Care and Health for quarter 2 (1 April to 30 September 2018) and seek comments on any actions required.

Information

2. Some information relating to this report is not for publication by virtue of paragraph 3 of Schedule 12A of the Local Government Act 1972, this covers information relating to the financial or business affairs of any particular person (including the Council). Having regard to all the circumstances, on balance, the public interest in disclosing the information does not outweigh the reason for exemption because of the risk to the Council's commercial position disclosure is likely to pose. The exempt information is set out in the **Exempt Appendix**.

3. The Council's Planning and Performance Framework establishes the approach that the Council takes to planning and managing its performance to deliver effective and responsive services to service user and their carers.

4. The Council has agreed that the key measures of its performance will be defined through a number of core data sets which are detailed in its Council Plan and each of its Departmental Strategies.

5. Performance against these core data sets is reported to Committee every three months (quarterly) to support the performance management of the delivery of services.

6. This report provides a summary of the quarter 2 position for the Adult Social Care and Health Core Data Set performance measures that fall within the responsibility of the Adult Social Care and Public Health Committee. The full Core Data Set is attached as **Appendix A**. This report also includes an **Exempt Appendix** which contains details relating to Deprivation of Liberty Safeguards activity.

National Key Performance Indicators

Long term residential and nursing care (younger adults aged 18 – 64 years)

7. The Council monitors admissions per 100,000 population, as part of a national Adult Social Care Outcomes Framework (ASCOF) definition, which allows for comparison (benchmarking) with other councils. The Council has maintained the ambitious annual target of 12.4. As at the end of quarter 2, outturn against the target was 7.9.

8. During quarter 2 there were 38 new younger adults admissions. This equates to an average of six admissions per month during the first half of the year. The target for 2018/19 has been set at 60 and, in order to meet this, average admissions need to be no more than five per month.

9. Each new admission to long-term care continues to be scrutinised and an admission to long-term care is only made where there are no suitable alternative services or accommodation available to meet the person's needs.

10. Positively, the overall number of younger adults being supported by the Council in long-term residential or nursing care placements was under target at 632 on 30th September 2018. The annual target has been set at 635 and the number of younger adults supported has been under this target for the last three months.

Long term residential and nursing care (older adults aged 65 years and over)

11. Admissions for older adults are also monitored per 100,000 population.

12. Admissions into long-term care are being avoided where possible through scrutiny of all cases and the provision of alternatives within the community including Extra Care, telecare and short-term assessment beds for those older people leaving hospital.

13. The number of admissions for older adults was 357 against a year to date target of 474.

14. The number of older adults supported by the Council in long-term residential or nursing care placements was 2,284 on 30th September 2018, slightly over the annual target of 2,275. This figure has continued to reduce over the last 12 months however, following the trend of the last few years which has seen the overall number of older adults supported in long term care reduce.

Delayed Transfers of Care

15. A Delayed Transfer of Care (DToC) from an acute or non-acute hospital setting occurs when "a patient is ready to depart from such care and is still occupying a bed". Any patients falling within this definition are classified as a reportable delay and the information collected includes patients in all NHS settings.

16. As part of measuring DToC, the total number of days delayed per month per 100,000 population is monitored and this is a key national indicator. Nottinghamshire was ranked 6th best performing council nationally (out of 151) for delays attributed to social care in August 2018.

17. As part of the improved Better Care Fund, a rate of DToC bed days is now being monitored on a monthly basis. Delays attributed to social care are showing consistently good performance and continue to be better than target. Latest data available to the end of August show delays due to social care reduced positively to a rate of nil compared to a target of 0.7.

Older people at home 91 days after discharge from hospital into reablement type services

18. Reablement type services seek to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services. It captures the joint work of social services and health staff, as well as adult social care reablement. This is a two part indicator and monitors the effectiveness (part one) and the availability (part two) of the services delivered.

19. Included in this indicator are reablement type services such as:

- START – short term assessment and reablement service provided in a service user's own home, for example to help them regain their independence following a stay in hospital
- intermediate care – may be provided in a service user's own home or in a residential setting and can be used either as a short term intensive service to avoid a hospital admission, for example where a service user is suffering from a temporary illness, or can also be used to help a service user regain their independence following a stay in hospital
- assessment beds – assessment and reablement service delivered in a residential setting following a stay in hospital.

20. This indicator is produced on a rolling three-month snapshot basis. Results to date include people discharged from hospital into reablement services in March, April and May and checks if these people were still at home during the months to August. Reasons for people not being at home include being admitted to long term residential or nursing care or being re-admitted to hospital or having deceased.

21. At quarter 2 part one this indicator was above target at 82% against a target of 80%. In this period out of 381 older adults who received a reablement type service on discharge from hospital, 314 people were still at home 91 days after.

22. Part two of this indicator is also now being monitored and is expected to improve as more reablement type services have been commissioned (such as the Home First Response Service). This part of the indicator measures how many people were offered reablement type services over the number of hospital discharges (hospital discharges data provided by the NHS).

23. The latest figure is that 1.6% of people discharged from hospital are offered a reablement type service. The target for this indicator is 2.0% and it is anticipated that this will be achieved at year-end.

Adults with a Learning Disability in paid employment and settled accommodation

24. These measures are intended to improve the quality of life for adults with a Learning Disability, reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life and the nature of accommodation for people with a Learning Disability has a strong impact on their safety and overall quality of life.

25. At quarter 2 performance for service users in paid employment was 2.8% against a target of 3.3% for 2018/19.

26. The figure for service users in settled accommodation positively increased to 75% in quarter 2 against a target of 76% (maintained from 2017/18) which is in line with the national average.

Service users and carers receiving a Direct Payment

27. Research has indicated that personal budgets provided to service users impact positively on wellbeing, increasing choice and control, reducing cost implications and improving outcomes. Studies have shown that direct payments increase satisfaction with services.

28. The percentage of service users receiving a direct payment was 44% against a target of 46%. Performance for quarter 2 remains at around the same level as at the end of 2017/18. Benchmarking shows that the Council remains a high performer in this area, the latest national average being 18%. The Council currently supports 2,879 service users with a direct payment.

29. Carers are provided with a range of support, including respite and information, advice and support services. Some carers are assessed as eligible for Local Authority support, and are offered a direct payment to support their wellbeing, usually a small payment of £150 or £200. This equates to 100% of carers receiving a direct payment which has remained consistent in recent years.

Adults where the outcome of a safeguarding assessment is that the risk is reduced or removed

30. This is a measure of the effectiveness of the safeguarding process and could help to prevent repeat enquiries for individuals.

31. The percentage of completed safeguarding assessments where the risk was reduced or removed is just below target at 69% against a target of 70%. Quarter 2 results show an improvement on 2017/18 and Nottinghamshire is in line with the national average.

32. As part of Making Safeguarding Personal, staff are supporting people to manage existing risks where this is in line with people's 'desired outcomes'. Therefore, this indicator is expected to fluctuate as people are supported to take risks.

Local Key Performance Indicators

New assessments – average time to complete

33. The former internal measure of assessment timescales has been replaced to reflect changed working practices and processes in the Adult Social Care and Health Department. Previously, all new assessments (social work or occupational therapy) were measured to give an overall percentage completed within 28 days. This has been replaced with two measures which track the average number of days taken to complete care and support (social work) assessments and occupational therapy assessments.

34. The new measures, measuring care and support and occupational therapy assessments separately, allow for easier tracking of these separate types of assessments which have shown different performance rates.

35. For social work assessments the average time from the person contacting the Department to having a completed assessment, where required, was 27 days. For occupational therapy assessments the average time from contact to completion was 29 days.

36. Targets have not yet been set for these measures and performance is being monitored by the department's Senior Leadership Team.

Reviews of Long Term Services completed in year

37. It is important that people who receive support are reviewed in a timely manner. This maximises people's independence and ensures people only receive the services and support they need.

38. During quarter 2, 41% of service users received a review and this is higher than the equivalent period last year. Reviewing activity has increased in the first half of the year and 3,039 service users have been reviewed compared with 2,764 for the same time period last year.

Percentage of older adults admissions direct from hospital

39. This indicator measures the number of admissions to long term residential or nursing care direct from a hospital setting where the service user did not have access to any reablement type activity beforehand.

40. For 2018/19 the target has been maintained at a challenging 18% and the result to date is that the indicator is performing better than target at 16% which is extremely positive.

Safeguarding service user outcomes

41. The percentage of safeguarding service users asked what outcomes they wanted as a result of a safeguarding assessment was 79% for quarter 2, almost achieving the target of 80%.

42. 71% of people were then satisfied that their outcomes were fully achieved, which is slightly under the target of 80%. The strategic safeguarding team is developing a plan to improve performance on this indicator.

Percentage of completed Deprivation of Liberty Safeguards (DoLS) assessments

43. In the first half of the year 77% of referrals received have been completed. Performance on this indicator will continue to improve as the year progresses. Further information on DoLS activity is contained in the **Exempt Appendix**.

Other Options Considered

44. This report is provided as part of the Committee's constitutional requirement to consider performance of all areas within its terms of reference on a quarterly basis. The departmental strategy was agreed on 24 January 2018 and the format and frequency of performance reporting were agreed by Improvement and Change Sub-Committee on 12 March 2018. Due to the nature of the report no other options were considered appropriate.

Reason/s for Recommendation/s

45. This report is provided as part of the Committee's constitutional requirement to consider performance of areas within its terms of reference on a quarterly basis.

Statutory and Policy Implications

46. 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

47. There are no financial implications arising from the report.

RECOMMENDATION/S

1) That Committee considers whether there are any actions it requires in relation to the performance information for Adult Social Care and Health for the period 1st April to 30th September 2018.

Paul Mckay
Deputy Corporate Director, Adult Social Care and Health

For any enquiries about this report please contact:

Matthew Garrard
Performance, Intelligence & Policy Team Manager
T: 0115 9772892
E: matthew.garrard@nottscc.gov.uk

Constitutional Comments (LM 09/11/18)

48. The Adult Social Care and Public Health Committee is the appropriate body to consider the contents of the report. Members will need to consider any actions they require in respect of the issues contained in the report.

Financial Comments (CT 15/11/18)

49. The financial implications are contained within paragraph 47 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.

The Adult Social Care Outcomes Framework (ASCOF) Handbook of definitions can be found here: https://digital.nhs.uk/data-and-information/publications/ci-hub/social-care

Electoral Division(s) and Member(s) Affected

All.

ASCPH602 final

Nottinghamshire County Council

Core Data Set for Adult Social Care and Health
Adult Social Care and Health Performance Report Update: Quarter Two

National Key Performance Indicator	Nottinghamshire									Comparator Data
	Current Value		Best to be	Target	Reporting Period	Number of service users	Out of how many	Previous Value (Q1)	Previous Annual	National Average
Admissions of Younger Adults per 100,000 popn (ASCOF 2A)	**7.9**	-	Low	12.3	Jun 2018	38	479,962	5	17.4	13.3
Admissions of Older Adults per 100,000 popn (ASCOF 2A)	**217**	-	Low	576	Jun 2018	357	164,517	123	600	628
Number of Younger Adults supported in residential or nursing placements (Stat return)	**632**	+	Low	635	Jun 2018	632	N/A	640	644	n/a
Number of Older Adults supported in residential or nursing placements (Stat return)	**2284**	-	Low	2275	Jun 2018	2284	N/A	2,278	2307	n/a
Delayed Transfers of Care per day per 100,000 popn NHS (iBCF)	**5.9**	+	Low	5.5	May 2018	n/a	n/a	7.9	9.9	n/a
Delayed Transfers of Care per day per 100,000 popn Social Care (iBCF)	**0.0**	=	Low	0.7	May 2018	n/a	n/a	0.0	0.20	n/a
Delayed Transfers of Care per day per 100,000 popn Joint (iBCF)	**0.2**	+	Low	0.55	May 2018	n/a	n/a	0.5	0.70	n/a
Proportion of older people at home 91 days after discharge from hospital (effectiveness of the service) (ASCOF 2B)	**82.4%**	+	High	80%	May 2018	314	381	78.0%	78.8%	82.7%
Proportion of older people at home 91 days after discharge from hospital (availability of the service) (ASCOF 2B)	**1.6%**	+	high	2%	Jun-18	381	24443	1.3%	1.8%	2.9
Percentage of adults with Learning Disability in paid employment (ASCOF 1E)	**2.8%**	-	High	3.3%	Jun 2018	58	2,055	2.9%	2.8%	5.8%
Percentage of adults with Learning Disability in settled accommodation (ASCOF 1G)	**74.8%**	+	High	76%	Jun 2018	1,538	2,055	74.0%	73.1%	75.4%
Proportion of service users receiving a direct payment (ASCOF 1C part 2a)	**43.7%**	-	High	46%	Jun 2018	2,879	6,581	44%	44.2%	18.10%
Proportion of carers receiving a direct payment (ASCOF 1C part 2b)	**100%**	=	High	90%	Jun 2018	1,996	1996	100%	100%	67.40%
Proportion of adults where the outcome of a safeguarding assessment is that the risk is reduced or removed (Stat return)	**69.2%**	+	High	70%	Jun 2018	794	1147	68.0%	66.9%	67%

Local Key Performance Indicator	Nottinghamshire									Comparator Data
	Current Value		Best to be	Target	Reporting Period	Number of service users	Out of how many	Previous Value (Q1)	Previous Annual Performance	National Average
Average time taken to complete social care assessment (days)	**27**	-	Low	new	Jun 2018	1,595	N/A	25	n/a	n/a
Average time taken to complete occupational therapy assessment (days)	**29**	=	Low	new	Jun 2018	1,918	N/A	29	n/a	n/a
Percentage of reviews of Long Term Service Users completed in year	**41%**	+	High	80%	Jun 2018	3,039	7,046	23%	73.0%	n/a
Percentage of older adults admissions direct from hospital	**16%**	+	Low	18%	Jun 2018	58	357	19%	20.8%	n/a
Percentage of safeguarding service users who were asked what outcomes they wanted	**79.0%**	+	High	80%	Jun 2018	909	1147	76.8%	75.0%	n/a
Percentage of safeguarding service users (of above) who were satisfied that their outcomes were fully achieved	**71%**	+	High	80%	Jun 2018	579	817	51%	73.8%	nla
Percentage of DoLS assessments received and completed in year	**77%**	+	High	new	Jun 2018	n/a	n/a	67%	94.9%	n/a

The most recent data for national average is reported, where available. Where Nottinghamshire performance meets or exceeds the latest national performance information, this is highlighted by the emboldened boxes. Key: (p) = provisional data; (+) = better than previous value; ( ) = worse than previous value; (=) = same as previous value; (n/a) = not comparable to previous value

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 10

REPORT OF THE TRANSFORMATION DIRECTOR, ADULT SOCIAL CARE AND PUBLIC HEALTH

PROGRESS REPORT ON BUDGET, SAVINGS AND IMPROVING LIVES PORTFOLIO

Purpose of the Report

1. This report sets out how adult social care in Nottinghamshire is managing the budget at a time of unprecedented financial pressures, diminishing resources, demographic change and increasing demand pressures. This report is in response to a request by Committee at its meeting in October 2018 for an update on the budget.

2. It also provides a progress report to the Committee on the Improving Lives Portfolio, which is the programme of work delivering service transformation and budget savings for the Adult Social Care and Health department over the period 2018/19 to 2020/21.

Information

Budget

3. The Council continues to operate in a challenging financial landscape with funding to local authorities expected to undergo fundamental structural changes over the next few years. What was in the past the main government grant, the Revenue Support Grant (RSG), has drastically reduced over recent years and is expected to all but disappear by 2020/21. This has significantly reduced the funding the Council has to provide key services.

4. In recent years, to help mitigate the impact of the reduction in funding and balance the budget without departments having to make even higher savings, the Council has budgeted to use Reserves. There are four main types of reserve held by the County Council:

- The General Fund Balance is a non-earmarked reserve, consisting of the accumulated surpluses. A balance on the General Fund is maintained to cushion the impact of uneven cash flows and as a contingency to reduce the impact of unexpected events or emergencies
- Earmarked Reserves are held to meet specific planned expenditure, for example, that relating to PFI (Private Finance Initiative) schemes
- Schools Statutory Reserve represents monies held on behalf of schools under the Financial Management of Schools scheme
- Capital Grants have been received in advance but have not yet been applied.

5. As per the budget report to Full Council in February 2018, in 2018/19 the Council has budgeted to use £13.172m of Earmarked reserves and £1.529m of the General Fund in 2018/19. This will leave an expected balance in the General Fund of £29.1m at 31 March 2019.

6. On a national level, these unprecedented financial pressures and diminishing resources, coupled with demographic change and increasing demand from the health system, is recognised by all political parties. In response, the government has committed to issuing a Green Paper in the near future to address the longer term funding issues and in the interim has provided additional revenue to councils in a variety of forms. For example, the social care precept has enabled Nottinghamshire County Council to raise an additional £22.12m cumulatively in 2018/19. In addition, the government has provided additional temporary grant money to social care through the Improved Better Care Fund (£21.59m in 2018/19) and recently the winter pressures money (£3.527m 2018/19). These funding sources have conditions attached, but enable the Council to invest, albeit on a short term basis, in much needed services to meet the growing demand. This includes services to avoid people being delayed from hospital and to fund early intervention and promoting independence services to support the Adult Social Care Strategy. It has also helped Adult Social Care to balance budgets and avoid adult social care being the source of further reductions in the Council.

7. Each year the Council has had to find additional money to meet the growing need, complexity and cost of social care; this is referred to as budget pressures. In 2018/19, £11.287m was put into the budget to address demographic growth and inflationary cost pressures.

8. Against a backdrop of the diminishing government grant and lack of long term sustainable funding, these pressures are increasingly having to be met from temporary sources of funding and savings elsewhere. Temporary funding creates additional risks against delivering current statutory obligations on an ongoing basis. As the table below demonstrates, £27.177m (13.3%) of the original net budget for Adult Social Care in 2018/19 is currently also funded by temporary money. (This is in addition to the temporary funding supporting the overall Council budget, as referred to in **paragraph 4**).

Figure 1: Additional temporary monies against the Adult Social Care & Health budget:

	2018/19 (£m)
ASCH original net Budget	**£204.427**
Temporary sources of funding	
BCF Care	**£2.060**
IBCF	**£21.590**
Winter Pressures	**£3.527**
Total of temp funding	**£27.177**

9. In the Autumn Budget 2018, the Secretary of State for Health and Social Care announced £240m in additional national funding for adult social care during the winter period of 2018/19; for Nottinghamshire this means £3.527m. The funding has to meet criteria set by the Department of Health and Social Care in relation to reducing delayed transfers of care, reducing length of hospital stays, improving weekend discharge arrangements and

speeding up social care assessments and arrangements. Proposals for the allocation were reported to Adult Social Care and Public Health Committee on 12th November.

10. The Chancellor's budget statement on 29th October announced a further £240m for adult social care nationally in 2019/20 as well as £410m for adult and children's social care. There was also additional funding announced for Disabled Facilities Grants, which are overseen by councils with responsibility for housing. Further discussions will take place to discuss what this means for Nottinghamshire and how this funding should be allocated.

11. Whilst all additional temporary funding is welcome, it fails to address how social care funding will be made sustainable in the longer term. This will not happen until the next spending review expected in 2019 and the Green Paper has been delayed once again. The Chancellor also warned there will be 'difficult choices' on reforming social care longer term. Glen Garrod, president of the Association of Directors of Adult Social Services (ADASS) said 'this is still far short of the £2.35bn that ADASS identified would be needed for social care to stand still in 2019/20; councils have been struggling with funding shortfalls for years.'

12. A Local Government Information Unit (September 2018) identified some councils have announced that the scale of funding short falls and savings required mean that they are struggling to meet their statutory obligations and reducing their services to a core offer.

Progress on savings

13. Since 2011 to June 2018, the department has considered 253 savings ideas. Of these initial ideas, 31 ideas were not viable and via a staff suggestion scheme, 'Smart Ideas', a further 46 ideas have been taken forward fully or partially to improve the effectiveness and efficiency of services. 176 proposals have been developed for Members' consideration. 171 proposals have been accepted by Members. Five savings proposals have been rejected by Members.

14. Savings agreed with Members occurred over two distinct time frames: 2011–2014 and 2015–present. From 2011-2014 savings were concentrated on reducing costs such as reducing prices paid to providers, service and staffing reductions, demand management and increased income.

15. However, many of these savings could not be repeated, for example a reduction in social care workers or closure of schemes, such as the Welfare Relief Fund.

16. To support a more transformational approach from 2014 onwards the Adult Social Care Strategy was developed in 2014 (and refreshed in 2017) and helped focus activity on early resolution and promoting independence. This was achieved by embedding three key principles:

- promoting independence and wellbeing
- ensuring value for money
- promoting choice and control.

17. The Adult Social Care Strategy has provided a framework to:

- connect people with support and information they can access in their local communities and helping them make best use of their existing networks
- work with people in a timely way and support them to make their own decisions about short term support to promote their independence
- maximise potential for independence for service users through reviews.

18. From 2011 to 2017/18 Adult Social Care delivered savings of £95m which represents 93% of its target.

19. By 2017 it was becoming increasingly difficult to identify further savings opportunities within the context of £95 million already achieved. Newton, an external savings partner, completed a diagnostic with the department to identify any new savings opportunities, to make better use of resources and continue to meet the Council's statutory duties. The savings found by Newton had a significant overlap with the existing savings plans and overall no additional savings were found in the medium term. However, Newton's work did suggest some of the adult social care savings plans could go further with a different emphasis. Newton's advice helped shape the Improving Lives Portfolio which is the current transformation programme to deliver savings from 2018/19 to 2020/21.

20. The Adult Social Care Strategy has been successful in managing demand, with the number of service users with longer term packages now at 9,492, down by 362 people since 31st March 2017. In order to achieve this reduction, the use of short term interventions to help people to regain independence and reduce reliance on long term support has increased. In addition, whilst work to maximise opportunities for people to become more independent has been successful, it does mean that the remaining services user are those with more complex needs. This has resulted in service users often requiring larger packages of support to meet their needs. Hence, average package prices in some areas are increasing over the same time period.

21. Nationally, there is a debate about 'unmet need'. Age UK has identified the growing number of people in England who struggle without help to carry out essential everyday tasks or activities of daily living (ADLs). These include things like: getting out of bed, going to the toilet, washing and getting dressed. In England one in seven older people (aged 65 and over) now live with some level of unmet need and among this group over half do not receive any help at all. Research by Age UK estimates that 1.2 million adults aged 65+ have some kind of unmet care need and that this equates to roughly 10% of the over-65 population in the UK. If this calculation was applied to the population of Nottinghamshire, this would equate to 16,000 older adults who struggle with some everyday task or activity of daily living.

22. It should be noted, however, that the Age UK research uses a wider definition of unmet need than the eligibility criteria for social care under the Care Act 2014. Under the Care Act, eligibility is based on three conditions: 1) the adult has a physical or mental impairment 2) the adult is unable to carry out two or more outcomes 3) it has a significant impact on their wellbeing. Importantly, the eligibility criteria for the Care Act was raised from one to two outcomes by the Government at the time, because meeting just one outcome was unaffordable based on current levels of funding. In short, whilst the Council is meeting its legal requirement under the Care Act, there would be additional people who would qualify for support if the Age UK criteria was applied.

23. For people who do not meet the eligibility criteria, the Council has a responsibility to offer advice and information. The Council undertakes a snapshot customer survey to monitor the effectiveness of the advice and guidance provided. Of the 685 customers who were contacted during 2018, only 11 people reported the advice and guidance offered did not meet their needs. This was largely because the person's circumstances had changed. The survey will be repeated in 2019 to ensure the advice and information provided continues to meet people's needs.

Current savings position

24. In 2018/19, the department is projected to make savings of £14.679m. This includes an over-achievement of £6.110m. This over-achievement is largely from increased income and reviews of packages of support. The Programme Status Report, attached as **Appendix 1**, provides both a summary of cashable savings at a programme level as well as a status report. An Improving Lives Portfolio project exceptions and mitigating action summary (as at October 2018) can be found at **Appendix 2** and an Adult Social Care and Health Portfolio quarterly update as **Appendix 3.**

25. This brings the total projected savings for the department to £109.697m by the end of 2018/19. For 2019/20 to 2021/22 there is a further £13.606m of savings plans approved by Committee. A summary of new savings agreed by Committee since September 2018 is included below:

Project	Savings 2019/20 - 2021/22 (£m)
Minimum income guarantee	3.873
Extension of preparing for adulthood/ Transitions	0.100
Housing with Care	0.371
Total additional approved since September 2018	**4.344**

Current financial position

26. Notwithstanding all of the above, the Council still faced an identified budget gap of £54.2m in February 2018. (This is inclusive of the future savings plans approved by Committees).

27. During this financial year the Council has continued to face increasing demand in both Adults and Children's Services, which is causing the Council to overspend.

28. To address the rising pressures and forecast overspend, both Adults and Children's Services put in place a series of mitigating actions to control spend, reduce costs, increased senior management scrutiny and deliver an overachievement in savings. In Adults Services the overspend has largely been mitigated and the overspend had reduced to £0.12m as at period 6.

29. As a result of the forecast overspend this year and continued increases in demand the current projected budget gap has increased from February 2018 to £63.9m as shown in the revised Medium Term Financial Strategy. The current MTFS is shown in the table below:-

Revised Medium Term Financial Strategy

	2019/20 £m	2020/21 £m	2021/22 £m	Total £m
Year on Year Savings Requirement (Feb 2018)	28.7	12.7	12.8	**54.2**
Additional Pressures	10.0	4.4	-	**14.4**
Savings Shortfall	0.8	-	-	**0.8**
Committee Approved Efficiencies	(4.5)	(0.1)	(0.3)	**(4.9)**
Other Corporate Adjustments and Base Budget Adjustments	(0.6)	0.1	(0.1)	**(0.6)**
Revised Shortfall	**34.4**	**17.1**	**12.4**	**63.9**

30. Therefore, there is still an urgent need to find additional savings to meet the on-going budget gap of the Council of £63.9m. New savings proposals to meet the on-going budget gap are presented to Adult Social Care and Public Health Committee as soon as they are ready for consideration.

31. In summary, whilst significant savings have been achieved, this has involved making difficult decisions from 2011 onwards about services that the Council continue to invest in, reductions in the workforce and closures of services and raising income from service users. The Adult Social Care Strategy has supported the Council to achieve further savings through managing demand and promoting independence, whilst continuing to meet The Council's wide ranging statutory duties under the Care Act. No doubt in the future more difficult decisions will be needed to maintain a balanced budget in 2019-20 and 2020-21. Further savings proposals are being developed based on the principles of promoting independence and wellbeing, ensuring value for money and choice and control.

Other Options Considered

32. No other options on reporting have been considered as this is the method of reporting approved by Adult Social Care and Public Health Committee and Improvement and Change Sub-Committee.

Reason/s for Recommendation/s

33. To keep the progress of the Improving Lives Portfolio under review by Committee.

Statutory and Policy Implications

34. 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.

Data Protection and Information Governance

35. The data protection and information governance requirements for each of the savings projects is being considered on a case by case basis and Data Protection Impact Assessments will be completed wherever necessary.

Financial Implications

36. Progress, as at the reporting period ending October 2018, in achieving the 2018/19 to 2020/21 savings targets for each existing programme is detailed in **Appendix 1**.

Public Sector Equality Duty implications

37. The equality implications of the Adult Social Care & Health savings and efficiency projects have been considered during their development and, where required, Equality Impact Assessments undertaken.

Implications for Service Users

38. As above, the implications of the savings projects on service users have been considered during their development.

RECOMMENDATION/S

1) That Committee agrees to receive an update report in the next three to six months, and that this be included in the Committee work programme.

Jane North
Transformation Director
Adult Social Care and Public Health

For any enquiries about this report please contact:

Stacey Roe
Strategic Development Manager, Adult Social Care Transformation Team
T: 0115 9774544
E: stacey.roe@nottscc.gov.uk

Constitutional Comments (LM 29/11/18)

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

Financial Comments (KAS 23/11/18)

40. The financial implications are contained within paragraph 36 of the report.

Background Papers and Published Documents

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

- Assessment and advice provided by external savings partner, Newton, to support savings programme report to Adult Social Care and Public Health Committee on 12th March 2018
- Appendix Assessment and Advice Newton - to Adult Social Care and Public Health Committee on 12th March 2018
- Monitoring of savings in Adult Social Care report to Improvement and Change Sub-Committee on 25th June 2018
- Programmes, Projects and Savings – Quarter 1 - report to the Improvement and Change Sub-Committee on 4th September 2018
- Progress Report on Savings and Efficiencies - reports to Adult Social Care and Public Health Committee on 10th July 2017, 11th December 2017 and 16th April 2018
- Progress Report on Delivery of Programmes, Projects and Savings - report to the Improvement and Change Sub-Committee on 26th September 2017
- Financial Monitoring Report: Period 5 2017/2018 - report to Finance and Major Contracts Management Committee on 16th October 2017
- Proposals for allocation of additional national funding for adult social care – report to Adult Social Care and Public Health Committee on 12th November 2018
- Equality Impact Assessments.

Electoral Division(s) and Member(s) Affected

All.

ASCPH607 final

Improving Lives Portfolio - Programme Status Report October 2018
Exceptions and Remediated Exceptions only

Ref	Programme & Brief Overview	Programme Status (Last Month)	Programme Status (This Month)	Trend	Project Status	Savings Targets (£000)s					Savings at Risk / Slippage / Over delivery (£000)s					Savings delivered in an alternative way	Net at risk amount	Department/Finance/PMO Comments for CLT
						2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	2021/22 (£000)s	Total (£000)s	Previous Years (£000)s	2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	Total (£000)s			
	Improving Lives Portfolio	**On Target**	**On Target**	**Better**		**8,569**	**9,617**	**3,658**	**331**	**22,175**	-3,138	-6,110	-253		-9,501	22	-9,523	The overall portfolio status is on target. The Status remains On Target despite some programmes and projects being assessed as experiencing obstacles and at risk as there are a number of other projects expected to over achieve, including Targeted Reviews and Continuing Health Care and therefore in 18/19 and 19/20 we are forecasting to overachieve savings targets. This is a positive position, there are still a number of projects that are not currently achieving their activity measures, and mitigating action is planned to avoid impact on future years savings.
ASCH 180123	**Promoting Independence Interventions** **This programme of work will look at changes across 3 main areas detailed below:**	**On Target**	**On Target**	**Better**		**7,027**	**7,263**	**2,399**	**331**	**17,020**	-3,318	-6,254	-193		-9,765	22	-9,787	Overall the Promoting Independence Interventions Programme is on target and is reporting an over achievement for 18-19 of circa £6.3 million. Within the 65+ programme the Housing with Care project is experiencing obstacles. Work is ongoing to mitigate the situation and overall due to activity and delivery of other projects the 65+ Programme remains reporting as on target. The 18-64 programme is the only one of the three sub programmes reporting as not on target. This programme continues to report as experiencing obstacles however the trend since last month has improved, with two projects reporting increased levels of activity and therefore with lower savings totals at risk. The Cross cutting programme continues to over deliver due in large to the over delivery of targeted reviews and the increased collection of continuing health care funds .
ASCH 1802	**Interventions for Adults aged 65+:** This work brings together 4 areas of activity: •Improve best practice and decision making in support planning (including in hospital settings). •Increase capacity in reablement •Ensure short term provision is used to maximise independence •Greater provision of Housing with Care (Extra Care). **Example Benefits:** •More adults aged 65+ completing START reablement. • A shorter average time spent in START, helping to increase capacity. • More service users will have benefitted from appropriate short term intervention, to support them to greater levels of independence. • Greater sharing of best practice will allow for improved consistency in support planning across teams, leading to improved outcomes for service users. • More service users are on a more appropriate pathway, giving them a more independent ongoing level of care.	**On Target**	**On Target**	**Same**	**OT**													**Reablement:** This month the transforming reablement project remains on target. The increased number of people completing reablement during September 2018 was on target. The target for 18/19 is 75. The actual increased number of people who completed reablement up to the end of September 2018 was 58. Next month, the main focuses of the project will be the go live of the reablement performance dashboard, continuing to progress the future state service business requirements and identifying ways to increase contact time in the frontline service.
					OT													**Best Practice in Support Planning:** The status remains on target as the use of Promoting Independence Meetings have been successfully rolled out successfully by Younger Adults teams, focus has turned to developing a plan to support OA assessment teams to commence weekly Promoting Independence Meetings. Plans to deliver live dashboards of management information are on track to be delivered in January 2019
					OT													**Commissioning of hospital discharge packages:** Difficulties are being experienced in calculating the cashable savings being delivered, the project status has remained on target on the basis that these issues are anticipated to be resolved during November. The saving target assigned to this project is predicated on a 21% reduction in the average cost of hospital discharge care packages. Work will be ongoing in November between departmental service directors and finance colleagues to discuss the complexities of producing measures and the interdependencies with other projects. The outcome of this work will also inform discussions with Team and Group Managers to agree targets for reduction/increase in volumes of service users entering different services at the point of discharge. The development of performance dashboards continues to progress, these will provide relevant metrics for team members and their managers to have visibility of performance against agreed targets and support the cultural and behavioural change required. Dashboards will be used as part of everyday performance management to reflect on data to identify possible improvements, understand the quality of work, highlight best practice and share learning. This will help teams drive continuous improvements in practice and choose the right pathways for service users.
					EO													**Housing with care:** Status remains experiencing obstacles due to delays being experienced in filling the new units at Gladstone House Extra Care scheme and the opening of the new development at Town View. Work is ongoing to identify mitigating actions to ensure that current voids at Gladstone House are filled as soon as possible. Work is ongoing with Finance to agree the current saving status/profile for Gladstone House and what actions need to be taken to bring savings to the agreed target.

Ref	Programme & Brief Overview	Programme Status (Last Month)	Programme Status (This Month)	Trend	Project Status	Savings Targets (£000)s					Savings at Risk / Slippage / Over delivery (£000)s					Savings delivered in an alternative way	Net at risk amount	Department/Finance/PMO Comments for CLT
						2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	2021/22 (£000)s	Total (£000)s	Previous Years (£000)s	2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	Total (£000)s			
ASCH1803	**Interventions for Adults aged 18-64:** The overall aim of this work is to ensure service users are supported to live as independently as possible with a good quality of life. This work will focus across three areas below: • Promoting independence in current settings. • Supporting service users to live as independently as possible. • Preparing for Adulthood – Improving Transitions between Children's and Adult's Services. **Example Benefits:** • Reduction in the number of support / outreach hours commissioned in existing settings (e.g. supported living schemes / residential care) through active reviewing and better use of shared hours and negotiations with providers. • More people supported to move into a more independent setting (e.g. from residential care to supported living, or from supported living into general needs accommodation. •More people receiving short-term enablement support that helps maximise their independence for longer. • Some service users may have earlier engagement than they might otherwise have done from the Transitions Team.	**Experiencing Obstacles**	**Experiencing Obstacles**	**Better**	**AR**												**Reduction in long-term care placements:** This project retains its At Risk status this month, due to a proportion of the activity and therefore savings forecasted not to be completed by year end. 28 service users have moved to a more independent setting against an annual target of 40. A further 5-6 moves should happen this financial year. However 3 of the completed moves have transpired to cost more than the previous setting due to the complexity of the individuals needs. Community Living Networks - These are developing well and showing early signs of successfully supporting people to live more independently with a different type of community support. The work to develop the Newark network is now delivering savings and work to develop these networks in other areas is underway.
					AR													**Ensuring cost-effective services for younger adults through alternative accommodation:** This proposal builds on the above project and extends the programme of work moving younger people from residential care into supported living with the development of a full accommodation strategy. Whilst the YA Accommodation Strategy is progressing well, the status of this project has been changed to At Risk as the £124k savings target for 2018/19 is attached to 12 moves from residential care to supported living (NB: these moves are in addition to the moves required next year to catch up with slippage against the existing Reduction in long-term care placements project).
					AR													**Promoting Independence in supported living and outreach services:** This project remains reporting as at risk, although the amount at risk has decreased from £70k to £40k for 2018/2019, since last month and only represents 3% of the savings target at risk in 18/19. The project continues to successfully undertake reviews of supported living schemes and outreach packages and seeking opportunities to promote independence and reduce care packages, including working with services to enable a reduction in sleep in night support. Staffing resource remains a risk to the project as contracts will cease in March 2019 and this, if not resolved, will impact on savings forecasted for 2019/2020 and 20/21.
					EO													**Reducing the Costs of residential Placements - Younger Adults:** This project is reporting as experiencing obstacles, this is due to some additional activity being required with providers and not because it has not achieved its savings targets. The savings achieved across all years is currently £2,288k, i.e. a surplus of £299k to the target. Since last month, there have been an additional £12k in year effect savings. There is work taking place on a provider engagement questionnaire to inform a strategy and offer consultation opportunity with providers across the sector. This was due to be published in September but now slipped. In addition an internal facing market position statement has been drafted regarding Younger Adults residential markets to inform the strategy.
					OT													**ASCH Strategy - Improving Lives & Notts Enabling Service:** The Improving Lives savings are on track, currently forecasting £207k against a target of £175k for 2018/19 The Notts Enabling Service (NES) costs avoidance is on track, currently forecasting £316k for Promoting Independence Workers (PIW) and £181k for Community Independence Workers (CIW). £497k overall against a target of £200k for 2018/19 A report has been prepared for ASC&PH Committee on the 12th November recommending that Promoting Independence Worker posts in NES are extended until end of March 2020 . The community involvement and co-production workers in the team are being evaluated by two separate pieces of works which are expected to be complete by mid to late November. To extend the posts which have been agreed so far in NES funded by the Better Care Fund will cost £356k in addition to funding already agreed until 2020 from the Improved Better Care Fund.
					OT													**Preparing for Adulthood:** This project remains on target to over deliver savings. Savings are being delivered as a result of dedicated Transitions staffing capacity working with individuals to maximise their independence and identify support available within the community. More interventions have been undertaken by the transitions team to maximise peoples independence than planned and as a result the 2017/18 savings target was overachieved by £56k, over delivery in 2018/19 has now been projected as £150k against a target of £60k. Due to these higher than anticipated activity levels, savings for 19/20 and 20/21 have been approved at £100k per year. 51k for 19/20 has already been achieved.

Ref	Programme & Brief Overview	Programme Status (Last Month)	Programme Status (This Month)	Trend	Project Status	Savings Targets (£000)s					Savings at Risk / Slippage / Over delivery (£000)s					Savings delivered in an alternative way	Net at risk amount	Department/Finance/PMO Comments for CLT
						2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	2021/22 (£000)s	Total (£000)s	Previous Years (£000)s	2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	Total (£000)s			
ASCH1804	**Cross cutting interventions:** This work refers to intervention that applies to service users aged 18-64 and 65+, and includes work across: • Reviewing. • Direct Payments. • Further Investment in Assistive Technology (AT) to Promote Independence. • Income Generating Projects, e.g. Improved Collection of Continuing Health Care Contribution. • ASC&PH Strategy Phase 2. **Example Benefits:** •More service users will be reviewed earlier or more frequently than previously, maximising the opportunity to increase or maintain their independence and reduce reliance on formal support. •Increased use of community and voluntary support options for existing service users to maximise their independence, and subsequent reduced use of homecare, day services, transport services and other paid for sources of support. •Increase in alternative methods of review utilised. •Increased use of Personal Assistants and Pre Paid Cards. •Increased ability of service users to use Assistive Technology to self-care and remain independent for longer, and increased opportunities to prevent falls and reduce hospital admissions. •Increased income generation.	**On Target**	**On Target**	**Same**	**EO**													**Direct Payments:** In year savings of £1,583k are projected by year end, £303k above the target, this is a significant increase on the £19k over delivery projected in September's reporting. This increase is as a result of additional DP review savings of £468k (£342k in year) allocated to this project. Across all years an over delivery of £420k is now projected. The project status is unchanged as a number of project delivery issues remain: The rollout of the changes to the assessed contribution criteria this month, agreed at October Policy Committee as part of a separate savings project, has increased the assessed contributions many DP recipients are required to pay toward the cost of their support package. In order to ensure individuals have sufficient funds in their DP accounts to pay PAs, as a short-term measure surplus contingency funds held in their DP accounts is being used. The DP calculator only allows for 1 week's total DP package cost as the contingency. Following the changes to the assessed contributions to DP self funders have subsequently confirmed their intention to cancel their care packages. In these cases, where a PA is employed, there will be redundancy costs incurred and legal advice is being sought. Initial data is indicating a downward trend in the commissioning of new PA packages, and the actual number as a % of total DP packages is currently 15.3% against a target of 50%. Between April and July the number of PAs used was increasing, but in August this dropped. Guidance has been sent to Team Managers and attendance at team meetings to encourage take up arranged. As previously reported, embedding the DP calculator into Mosaic is proving challenging but progressing steadily through discussions with staff in the BI Hub, Mosaic Team and Finance. Total value of recouped funds from DP accounts has increased in October by £286k October to £1.3m. The projection is for this to be £2.2m by year end, against a target of £1.769m, i.e. £493k over-achievement.
					OT													**Targeted Reviews:** The % of reviews (of packages of long term care) undertaken in the previous 12 months has increased from 73.23% at the end of September to 73.86% at the end of October, against a target of 80%. In terms of savings, the project is currently over-achieving against its £2.010m target for 2018/19 by £1.538m, and there is already £0.982m worth of savings achieved towards next year's savings target of £2.000m from the full year effect of review activity undertaken already this year. As further savings are anticipated by year end, a change request to accelerating savings currently profiled for delivery in 2020/21 to 2019/20 is being considered.
					OT													**Improved Collection of Continuing Health Care Collection:** The projected over achievement against the £500k savings target for 2018/19 is £4.179m, a decrease on last month of £398k due to further analysis of open packages.
					EO													**Brokerage for Self Funders:** Projected in year income by year end remains at £6k as although there has been an increase in the number of outstanding brokerage agreements returned signed by service users, which means they will now contribute, there has also been a proportionate increase in the number of ceases, and so in year income remains static. However, the shortfall of £22k against the annual income target of £28k continues to be met by over-achievement against other contribution areas. The % of eligible service users contributing has increased from 25% last month to 36% this month. All outstanding brokerage agreements are expected to be in place by mid December.
					OT													**Assistive Technology:** Validation by finance of the cost avoidance savings for the period 01/04/18 to 30/09/18 suggests that the project is significantly over-achieving it's target of £174k for 2018/19, and the position for 2019/20 looks similar, with cost avoidance anticipated to increase following the scheduled introduction of new AT service provision scheduled for the second half of 2018/19.
					No Status													**Review the benefit rates and minimum income guarantee levels used to calculate service users' contributions towards the cost of their care and support:** This proposal was approved by Adult Social Care & Public Health Committee following consultation in October. Initial implementation activity has been initiated with savings profiled for delivery in 2019/20.

Ref	Programme & Brief Overview	Programme Status (Last Month)	Programme Status (This Month)	Trend	Project Status	Savings Targets (£000)s					Savings at Risk / Slippage / Over delivery (£000)s					Savings delivered in an alternative way	Net at risk amount	Department/Finance/PMO Comments for CLT
						2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	2021/22 (£000)s	Total (£000)s	Previous Years (£000)s	2018/19 (£000)s	2019/20 (£000)s	2020/21 (£000)s	Total (£000)s			
ASCH 1801	**Early Resolution**	**Experiencing Obstacles**	**Experiencing Obstacles**	**Same**		507	394	416		**1,317**								Overall programme status remains experiencing obstacles as further finance validation is required to confirm that the role out of the 3 tier model is achieving it's projected savings.
	Programme relates to interventions that occur when someone first contacts/accesses services. This programme extends the existing Early Resolution project through the adoption of the 3 Tier Model to engage with people who approach the Council for care and support: •Tier 1 connects people to local resources •Tier 2 helps where more that Tier 1 support is required, offering swift and appropriate support to help people regain their independence or develop new skills. This may include access to short term support. •Tier 3 helps those people who, after Tier 2, have ongoing care and support needs. This approach applies equally to Service Users and Carers. **Example Benefits:** • A reduction in the number of people assessed for care and support and subsequent long term support by providing an alternative way of meeting their needs earlier. • Less people will be formally assessed, but short term support will be provided to more people to help maintain or increase their levels of independence. • Increased capacity in district social care teams to deal with the most complex cases.				**EO**	**Early Resolution:** The project status remains experiencing obstacles. The reduction of Care and Support Assessments (CASA) is on target (year to date 240 against an annual target of 354 (206 year to date target)) however, there is further work being undertaken to understand if the reduction in CASA's is delivering cashable savings assurance around this should be reached in November. Weekly Promoting Independence Meetings in the Adult Access Service are to commence in November. Performance dashboards will be discussed with the aim of focusing on performance and maximising buy in to 3 tier model.										
					OT	**Carers:** The proposed changes to working arrangements were agreed at ASC&PH Committee in October. Work in October has included discussions with staff about proposed changes to short breaks, further work on the tender for a new carers support service, discussions with CSC about workflow, and work to develop a communications plan - initially focusing on internal staff and health partners to define and refine the new carers offer with communications aimed at carers/service users in early 2019. Work identified for November includes: further work on mapping workflows, discussions with Mosaic team, confirmation of the content of the specification for the new carers support service and consultation with CCG partners about the future arrangements for NHS short breaks.										
ASCH 1805	**Commissioning & Direct Services**	**Experiencing Obstacles**	**Experiencing Obstacles**	**Same**		1,035	1,960	843		**3,838**	180	144	-60		**264**		**264**	The Status for all projects within this programme remains the same as last month and overall the programme is experiencing obstacle. Mitigation actions are in place for each project that is off target. The largest project in the programme, Care and Support Centres, remains on target.
	The main focus of this programme is considering options around the use of some of the Department's Direct Services, in order to optimise opportunities to reduce running costs and increase income through commercial development. **Relevant Direct Services under the scope of this work include:** •The County Horticulture and Work Training Service •Care and Support Centres •Investment in Shared Lives **Outcomes the programme will support:** •Promote greater use of the services and their assets. •Increase income generation and maximise productivity. • Increase in the number of Shared Lives carer households recruited.				**OT**	**Care and Support Centres:** All is on track with the closure of St Michaels Health have said that GP cover for Leivers Court will cease at the end of March 2019. This presents a risk as it would mean that the provision of assessment beds would have to stop taking new admissions from the end of February and the re-commissioned service (currently out to tender) would only be at 2/3 capacity at that date. Seven staff from Leivers Court have been appointed to work at the soon-to-open St Francis Ward based at the City Hospital. This will mean that some agency staff will be required to maintain services through to the closure. The Invitation To Tender (ITT) for the commissioning of assessment beds was published on October 25th and will close on November 23rd. To date, 30 organisations have expressed an interest and it is expected that will have an idea of how things are looking by the middle of December										
					AR	**Investment in Shared lives:** A temporary co-ordinator has been appointed to the team which should ease some of the pressure that the team have been under. One new household has been signed off since last month, another one is just about to be signed off and four are going through the process.										
					EO	**Maximise the income available to the Council's directly provided adult social care services:** As an alternative to the original plan to deliver the savings for this project, the department is looking to ensure that it collects all the possible income from the provision of carers breaks. Meetings have taken place with staff to ensure that the relevant Mosaic episode is being used - as this triggers the requirement for the assessment that allows the income to be collected. Finance will be monitoring the impact of this over the coming months.										
					EO	**County Horticulture and Work Training Service:** The closure of the Skegby site is on track to take place December and all staff affected have been part of ongoing discussions. Arc have been identified a designer for the work at Brooke Farm Due to initial delay with project implementation, the £51k savings target for 2018/19 is being mitigated through underspends within the service.										
					AR	**Integrated Community Equipment Loan Scheme (ICELs):** This project intended to achieve its savings target by negotiating with partners to reduce the Council's contribution to the ICELS pooled budget, in line with a reduction in the Council's prescribing activities and the loaning of community equipment. However, it has since been agreed with partners that there will be no changes to the split of funding, and so alternative methods to deliver the savings are being sought. The project will remain on the project status summary pending delivery of budget savings.										
					Closed	**Merger of Commissioned Crisis Prevention Service for Carers and Rapid Response Service (now called Home First Response Service):** £50k savings target achieved										

	Successful delivery of the project to time, cost and quality is achievable and there are no major outstanding issues at this stage that threaten delivery
	Successful delivery is probable, however, there are minor issues which need resolving to ensure they do not materialise into major issues threatening delivery. This is an early warning category, if the minor issues are resolved in a timely manner, it is unlikely that project savings will be put / remain at risk.
	Based on available evidence, successful delivery still appears feasible but significant issues exist with scope, timescales, cost, assumptions and/or benefits. Issues appear resolvable, but action is required
	Based on available evidence, successful delivery of the project appears to be at significant risk. There are major issues with project scope, timescales, cost, assumptions and/or benefits. Immediate action required to resolve issues.
	Project benefits have been achieved, or there has been an official change to the benefits profile (through change control) so the project is complete or declared undeliverable
	Awaiting major points of clarification / decision-making to enable PID and plan to be completed.

Project exceptions and mitigating action

This document provides further detail on the project exceptions outlined in appendix 1, Improving Lives Portfolio - Programme Status Report.

Interventions for Adults aged 65+:	
Project Exception	**Mitigation**
Housing with care: Of the three schemes to open this year, one scheme successfully opened to time and on track. One scheme is delayed. In the new scheme there a small number of vacancies still to be filled out of 30 units.	This Project's Experiencing Obstacles status is not impacting the overall programme status. Work is ongoing to identify mitigating actions to ensure that current voids are filled as soon as possible. The local Group Manager is overseeing allocations of remaining places in the newly opened scheme – people with lower level needs are being identified to ensure the balance of need matches the levels of care available and maintains a none residential feel. Work is also underway with partners to minimise any potential delay in the opening of the new scheme.
Interventions for Adults aged 18-64:	
Project Exception	**Mitigation**
Reduction in long-term care placements: A lack of supply of suitable housing has meant that less people have been able to move out of residential care and into supported living than planned. This resulted in slippage of £251k from previous years.	Significant progress has been made this year with 28 service users having moved to a more independent setting and a further 5-6 moves planned by year end. As a result it is projects that including full year effect savings only £86k will remain for delivery in 2019/20. Adult Social Care and Public Health Committee on 12th November 2018 approved the extension of 8 Community care Officers and 1 Advanced Social Work Practitioner until March 2020. This resource will continue to support Younger Adults Promoting Independence Interventions projects. As a result the future year's deliverable savings will be reassessed. Over the longer-term, separate but related work is taking place to identify the most suitable accommodation and support package for younger adults living in all current residential, nursing and supported living services, with a view to enabling people to move, where appropriate, to ensure more cost effective

	services which best promote the independence of the individual. It is envisaged that there could be a number of moves from residential into supported living and from supported living into general needs accommodation, as well as the potential rationalisation of existing supported living where larger schemes may be more cost effective and better suited to meeting longer term needs of individuals than smaller shared or isolated services. This work should increase available supported living placements, in order to facilitate moves from residential care.
Ensuring cost-effective services for younger adults through alternative accommodation: This proposal extends the programme of work moving younger people from residential care into supported living with the development of a full accommodation strategy.	The development of the Younger Adult Accommodation Strategy is progressing well and is scheduled to be considered by Adult Social Care and Public Health Committee in January.
The status of this project has been changed to At Risk as the £124k savings target for 2019/20 is attached to 12 moves from residential care to supported living.	As reference above the operational resource that supports moves from residential care to supported living has been extended until March 2020. The deliverability of the 2019/20 savings target is being reassessed following this Committee decision.
Promoting Independence in supported living and outreach services: This project involves reviewing supported living and outreach services with a view to reducing day hours and/or replacing sleep in night provision.	Previous year's savings over achieved targets by £272k and savings of £1.21m have been delivered towards the 2018/19 target.
Savings to date have been made through reviewing and identifying people who no longer need the level of support they initially did. Work has started on a more proactive form of review which is identifying where provider intervention may enable a person to be more independent with a view to reducing packages, especially sleep-in nights, further down the line once mitigating actions have been put in place to manage risks.	Following the identification of at risk savings in 2018/2019 mitigating activity was undertaken to increase the pace and success of work relating to sleep in nights. This has resulted in the projected at risk figure reducing from £250K in August to £40k currently, this figure will continue to be monitored as project reviewing activity continues an it is anticipated that it will reduce further by year end.
Reducing the Costs of residential Placements - Younger Adults: This project has focused on reducing the cost of care through negotiating with care providers about how fees are agreed for	

individual service users whilst considering how people's needs may be met differently in the future. The project status is reporting as experiencing obstacles due to additional activity being required with providers.	The savings achieved across all years is currently £2,799k, i.e. a surplus of £299k to the target. There is work taking place on a Provider Engagement Questionnaire to inform strategy and offer consultation opportunity with providers across the sector.
Cross Cutting Interventions:	
Project Exception	**Mitigation**
Direct Payments: In year savings of £1,583k are projected by year end, £303k above the target, this is a significant increase on the £19k over delivery projected in September's reporting. This increase is as a result of additional DP review savings of £468k (£342k in year) allocated to this project. Across all years an over delivery of £420k is now projected. The project status remains experiencing obstacles as a number of project delivery issues remain, including: Data is indicating a downward trend in the commissioning of new PA packages, and the actual number as a % of total DP packages is currently 15.3% against a target of 50%. Between April and July the trend was increasing, but in August it dropped. The rollout of the changes to the assessed contribution criteria this month, agreed at October Policy Committee as part of a separate savings project, has increased the assessed contributions many DP recipients are required to pay toward the cost of their support package Following the changes to the assessed contributions to DP self-funders have subsequently confirmed their intention to cancel their care packages. In these cases, where a PA is employed, there will be redundancy costs incurred.	As previously reported, embedding the DP calculator into Mosaic is proving technically challenging but progress is being made through work with staff in the Business Intelligence Hub, Mosaic Team and Finance. A pilot of the calculator with the Central Reviewing Team has indicated that its use can facilitate significant savings in DP packages. Teams who are not recruiting PAs are to be targeted with emails and visits to Team Managers, in order to address this. In order to ensure individuals have sufficient funds in their DP accounts to pay PAs, as a short-term measure surplus contingency funds held in their DP accounts is being used. The DP calculator only allows for 1 week's total DP package cost as the contingency. Legal advice is being sought and further mitigating actions will be considered and reported on next month. The shortfall of £22k against the annual income target continues to be met by over-achievement against other fee areas.

Brokerage of Self Funders: Due to delays with the implementation of the charge for our brokerage service projected in year income by year end remains at £6k against a target of £28k.	The % of eligible service users contributing has increased from 25% last month to 36% this month. All outstanding brokerage agreements are expected to be in place by mid-December.
Early Resolution:	
Project Exception	**Mitigation**
Early Resolution: This project sees the roll out of the 3 Tier Model, a new approach which aims to resolve people's needs at the earliest possible opportunity. The status remains experiencing obstacles pending confirmation that the projects savings targets are being achieved.	The reduction of Care and Support Assessments (CASA) is on target (year to date 365 against an annual target of 354), further work is being undertaken to validate that this reduction in CASA's is, in turn, delivering the projected cashable savings. Additionally, Weekly Promoting Independence Meetings in the Adult Access Service are to commence in November. Performance dashboards will be discussed with the aim of focusing on performance and maximising buy in to the 3 tier model.
Commissioning & Direct Services:	
Project Exceptions	**Mitigation**
Investment in Shared lives: Staffing issues within the team have delayed the recruitment of new carers, £60k of savings are projected to slip to 2019/20. **Maximise the income available to the Council's directly provided adult social care services:** Plans are still being scoped resulting in £130k of savings at risk. **County Horticulture and Work Training Service:** There have been some delays with the implementation of this project.	A temporary co-ordinator has been appointed to the team which should ease some of the pressure that the team have been under. One new household has been signed off since last month, another one is just about to be signed off and four are going through the process. As an alternative to the original plan to deliver the savings for this project, the department is looking to ensure that it collects all the possible income from the provision of carers breaks. Meetings have taken place with staff to ensure that the relevant Mosaic episode is being used - as this triggers the requirement for the assessment that allows the income to be collected. Finance will be monitoring the impact of this over the coming months.

Integrated Community Equipment Loan Scheme (ICELs): This project intended to achieve its savings target by negotiating with partners to reduce the Council's contribution to the ICELS pooled budget, in line with a reduction in the Council's prescribing activities and the loaning of community equipment. However, it has since been agreed with partners that there will be no changes to the split of funding, and so alternative methods to deliver the savings are being sought. The project will remain on the project status summary pending delivery of budget savings.	2018/19 savings are planned to be mitigated from other sources, the Skegby site is on track to close in December 2018 and the Grounds maintenance Service by March 2019. Arc have been identified as the designed for the development of the Brooke farm Site. Whilst there were no savings originally planned for 2018/19, the total under delivery against this project is £134k and is identified as being at risk. Updates from the operational ICELs board are fed in to the Commissioning and Direct Services Board who continue to oversee work to identify mitigations for the at risk amount.

The ASCH Improvement and Change Portfolio – September 2018 Update

Programme 1 - Deliver the next stage of the Adult Social Care Strategy		
Programme Outline: This programme will focus on helping more people to help themselves through the provision of good quality advice and information, resolving queries in a timely and responsive way and providing a proportionate and appropriate response where people have social care needs, with the aim of maximising their independence. **Overview of progress:** Work on the milestones described below continues to progress.		
Key Milestones	**Implementation Date**	**Delivery Status, key updates and risks to delivery**
Roll-out of the 3 Tier Model, a new approach which aims to resolve people's needs at the earliest possible opportunity	Autumn 2018	Testing of the new 3 Tier Contact form has been completed and the new form has been successfully rolled out across all districts since 2nd October 2018. This means that the 3 Tier approach is being used at the Customer Service Centre and Adult Access Service for all new enquiries coming into the Council. These services will be attempting to help more people to resolve their problems at the earliest opportunity. The project is on track to deliver good outcomes and achieve savings.
Expansion of social care clinics in community settings	Autumn 2018	The Department has introduced the scheduling of appointments across all older adults' social care and occupational therapy teams. This means that where someone requires a social care assessment they can be booked into an available appointment over the phone. In addition to scheduling appointments the Department has also increased the use of different methods of assessments and reviews, such as assessments in community clinics. Social Care clinics in community settings are available across the County. A review is underway to maximise the benefits of social care clinics in the future.
Review of the carers' strategy with partners to enable carers to access good quality advice, information and support	September 2018	The ASC&PH October 2018 Committee recommended that Policy Committee approve a new carers' strategy, and approved proposals to implement a new carer's support offer for 2019/20.

Deliver the Improving Lives Programme	March 2020	The Improving Lives Programme was approved by the Adult Social Care & Health Committee in March 2018. The programme will support the Department to deliver the next stage of the Adult Social Care Strategy by: • Identifying ways to deliver better outcomes for service users through promoting independence • Making sure that our services remain sustainable • Identifying further ways to improve the quality of the advice, guidance and services we are providing Work has already commenced on some early milestones that will: • increase the number of people we are able to offer a reablement service to • increase the amount of queries that can be resolved as early as possible after contacting social care • identify opportunities to work more actively with people who have potential to achieve more independence • ensure people are on the most appropriate care and support pathway and where short term care is required to recover and rehabilitate, people are supported to regain independence and return home, where possible • provide live information, available at a team level, to help support day to day decision making. The programme commenced working with hospital teams in September, working to identify the main issues and barriers to promoting people's independence, faced by the teams in order to help minimise these. Interim dashboards have been developed and are due to go live in October. This will further support teams to identify areas for improvement Once further progress has been made towards early milestones the focus of the Improving Lives Programme will then turn to

		supporting staff in district teams to use new or enhanced services and approaches to shape practice going forward. There will be a phased approach to the roll out of this work between now and March 2020.

Programme 2 - Commercialisation of the Council's directly provided social care services		
Programme Outline: Working with the Council's Commercial Development Unit to explore and develop a range of initiatives to generate new business opportunities and income within the Council's directly provided social care services, subject to Local Authority powers to trade; promote greater community use of the services and their assets; and create opportunities for people who fund their own care to purchase support from the Council's direct service provision. **Overview of progress:** A proposal to reduce the annual running costs of the County Horticulture & Work Training Service is being implemented. Work continues, with over sight from the Council's Commercial Development Unit, to assess the commercialisation potential of County Enterprise Foods.		
Key Milestones	**Implementation Date**	**Delivery Status, key updates and risks to delivery**
Project: Redesigning the strategic management of assets to generate a revenue return for the County Council.		
Assessment of the commercialisation potential of County Enterprise Foods	Winter 2018	Work on this continues in a design and discovery phase. Proposals to committee are planned for spring 2019.
Implementation of the business plan for the Council's County Horticulture Service	Summer 2022	Following a period of consultation with service users, their carers and staff, the Adult Social Care & Public Health Committee approved proposals in April 2018 to implement a commercial business plan for the Council's County Horticulture Service. The key milestones include making improvements to the Brooke Farm site, vacating the site at Skegby and ceasing all grounds maintenance activity. It is anticipated that the full effect of the business plan will take up to 4 years to deliver.

Programme 3 - High quality and sustainable public health and social care services

Programme Outline: The vast majority of adult social care services are commissioned from independent sector providers, with a mixture of large and small, national and local, private organisations and some not for profit/ charitable organisations. There are various pressures faced by the care and support providers and there is wide recognition that the care market is facing considerable challenges to deliver sufficient volumes of care and support services to meet needs due to difficulties in staff recruitment and retention. The Council is working with care providers to understand their pressures and to ensure the fees paid for care services reflect the cost of delivery of good quality care.

The public health budget is invested in a range of evidence-based services which fulfil statutory duties, and deliver clear public health outcomes and a good return on investment for public money. Many of these services will be due for reprocurement in the period of this plan. Previous rounds of procurement have yielded significant savings and service improvements. The challenge will be to identify ways to sustain outcomes and secure improved value for money using a reduced budget and public health workforce. The scope will include all public health commissioned services, emerging evidence from other areas of innovations which are proving effective, best available intelligence about the national and local market for service provision, and consideration of how best to engage with these markets to get best value for money.

Overview of Progress: This programme is progressing on target and in line with the identified milestones.

Key Milestones	Implementation Date	Delivery Status, key updates and risks to delivery
Home care contracts awarded and services to commence	Autumn 2018	The Council has been exploring outcome based approaches to commissioning home based care that focus on the delivery of support to help a service user achieve identified goals rather than payment by hours of care delivered alone. Current provider contracts were extended until September 2018 to allow for a period of transition, following the start of new contracts in July 2018. A Dynamic Purchasing System (DPS) has also been set up to allow an efficient procurement system for individual or bespoke packages of work. There are 2 elements to the contract awards: a short term countywide hospital discharge and community based support service, and traditional long term home based care. Short Term: The contract for the provision of a Hospital Discharge and Community Based support service to prevent hospital admissions was awarded to the Carers Trust and the service started in December 2017. A technology solution to manage the transfer of referrals to the Carers Trust through a

		portal was launched in July 2018. The portal has been positively received by the Carers Trust who have said that it is easy to use and that it has improved both the quality of referrals to them and their ability to send updates to workers. <u>Long Term Home Based Care:</u> Contracts, commencing in July 2018, have been awarded for the lead provider and additional providers in 5 of the 6 contract areas and processes for monitoring performance are in place. A procurement exercise commenced on 24 July for a lead provider for Rushcliffe and for additional providers in Bassetlaw – the outcome of these tenders will be announced mid-October. The existing Core Provider contract in Rushcliffe has been extended to ensure continuation of service until the start of the new Lead Provider contract. A further procurement exercise for additional providers in Newark & Sherwood and Rushcliffe will be conclude in October.
Fair Price for Care review – fees survey	September 2018	An initial report on the review has been drafted. Some of the project timescales have been extended to reflect further detail required in the report but work is still on track to report to the Adult Social Care and Public Health Committee in December as planned.
Fair Price for Care review – report to ASCPH Committee on outcome of survey and any resulting proposals	December 2018	Report to be presented to Committee.
Consultation and stakeholder engagement on Public Health Commissioning Intentions to 2020 to be undertaken	September 2018	This action has been completed to timeframe. A comprehensive consultation has been completed, including soft market testing undertaken, to inform the development of the service model and service specifications (Integrated Wellbeing Service and Substance Misuse Service).
Complete the pre procurement stage for the Commissioning of Public Health Services (Integrated Wellbeing Service and Substance Misuse Service)	December 2018	Premarket events for the Integrated Wellbeing Service and Substance Misuse Service are taking place in October 2018. Work is on track to invite providers to tender in November 2018.

Commence the procurement stage for the Commissioning of Public Health Services (Integrated Wellbeing Service and Substance Misuse Service)	February 2019	The selection stage will commence in January 2019, followed by a competitive dialogue from February 2019 onwards.

Programme 4 - Work with our local health services		
Programme Outline: We are working with health partners to develop and evaluate new models of care that meet both the social care and health needs of people in the county. **Overview of Progress:** This programme is progressing on target and in line with the identified milestones.		
Key Milestones	**Implementation Date**	**Delivery Status, key updates and risks to delivery**
Embed a home first approach in hospitals to ensure that a significant proportion of people are assessed for long term services outside of a hospital setting	March 2019	In the south of the county performance data is showing that 85% of assessments for long term care are now completed in the community. Work is underway in Mid-Notts and Bassetlaw through the Hospital Discharge Project to develop the same performance monitoring so we can determine our position and further action needed.
Countywide roll out of best practice model for an integrated care team	March 2019	Mansfield Older Adults assessment staff have been co-located with Community Health staff since the 30th July. Ashfield Older Adults staff aim to co-locate from November. Discussions are underway in all other areas of the County to explore options for co-location, develop direct referral mechanisms and undertake necessary organisational development work as appropriate. Smarter Working are supporting the changes. Health partners have been very helpful and welcoming to date.
Develop a multi-agency toolkit on prevention and early intervention for key staff groups and pilot	March 2019	A Workforce Project Manager will take up post in Mid-October. The project will focus on the embedding 'making every contact count (MECC) and embedding person and community centred approaches into organisation's HR systems and processes. A toolkit and training package will be tested out with frontline staff.
Successful testing and delivery of a new joined up approach across Health and Social Care to assessment and support planning	March 2019	This national pilot is underway with participation from health and social care staff in the Rushcliffe and the two Mansfield integrated care teams. The teams are using a new template

		called “All about Me” to capture person-centred information about each service user.
Roll out of information sharing across Health and Social Care, as developed at Kings Mill Hospital, to Bassetlaw Hospital and NUH	November 2018 (Bassetlaw) February 2019 (Kings Mill – Next Phase)	Work is underway at Bassetlaw Hospital to deliver this project and the plan is for live Social Care information to be made available to Health staff at the Emergency Department and in the discharge team at any time of day or night, from the end of October. Work continues at Sherwood Forest Hospital Trust to develop the information sharing process about patient discharge and changes in circumstances, to improve live case management. Nottingham University Hospital initial engagement has started and awaiting assignment of resources from health to support the project.
Access to Health and Care Community Portal	December 2018	The council are “going live” with a pilot team (Rushcliffe Older Adults) to have access to health information through this portal in Mosaic, from November. This information will include hospital activity and admissions, GP information and Mental Health information. Rollout to larger cohort in early 2019 then planned wider to all teams with access needs.

Programme 5 - Promote decision-making across the Council and with partners which prioritises health and sustainability

Programme Outline: The range of functions for which the Council and our partners are responsible means that more or less everything we do can make a difference to people's health. This goes beyond the specific public health and social care responsibilities of the Adult Social Care and Public Health department, and extends to (for example) economic development, transport, leisure, trading standards, community safety, education and housing, each of which make a significant and cumulative contribution to the way our social and physical environment shapes our health and the health of generations who follow.

Overview of Progress: The Council resolved in March to adopt 'Health in all Policies', guidance that supports local government organisations to think about the impact that every strategic decision may have on the health of local residents. Good progress has already been made in sharing this approach with partners through the Health and Wellbeing Board.

Key Milestones	Implementation Date	Delivery Status, key updates and risks to delivery
Implement changes in Council processes	December 2018	Following the adoption of the LGA Health in All Policies approach by Policy Committee in March 2018, colleagues from Public Health and Place are developing revised spatial planning & health guidance to improve the way spatial planning decisions prioritise health and sustainability.
Secure ownership for equivalent changes in the decision-making processes of other organisations, starting with Health and Wellbeing Board partners	March 2019	The Joint Health and Wellbeing Strategy 2018–2022 includes "Healthier Decision Making" as one of its 4 ambitions. Continued engagement is happening with local government colleagues through the Health and Wellbeing Board's Healthy and Sustainable Places Coordination Group, which will meet for the first time in October 2018. The first meeting will focus on physical activity and a countywide approach to the food environment.

Programme 6 - Provide specialist Public Health advice to support commissioning of health and social care services to improve health and wellbeing

Programme Outline: To address the gaps in health and wellbeing, care and finance we will promote a system-wide commitment to embedding prevention in all clinical pathways, a relentless focus on commissioning according to evidence of need and systematically implementing what is known to be clinically and cost effective. The Council has a statutory duty to provide specialist public health advice to local NHS commissioners and assessments of need including the evidence of what works. This will also ensure that the local health and social care system has access to timely public health intelligence with which to prioritise prevention of ill health.

Overview of Progress: Public Health capacity has been aligned to ensure appropriate support across health and social care services, including the allocation of dedicated consultant support aligned to the Clinical Commissioning Groups (CCGs) and dedicated capacity to support the County's Sustainability and Transformation Plan (STP), now known as the Integrated Care System (ICS).

Key Milestones	Implementation Date	Delivery Status, key updates and risks to delivery
Realign specialist public health capacity to emerging CCG, Accountable Care System (ACS) and STP structures and governance processes	November 2018	A framework for action has been developed for the ICS Prevention workstream which indicates the ICS transformation work which requires specialist input. This will be in place for November 2018. (The development of the ICS system architecture and evolution of CCG structures will require further review and adjustment of specialist public health input in 2019 and beyond).
Secure commitment from the STP to enabling health and social care staff and pathways to systematically offer brief advice and referrals to public health services for residents at risk from their exposure to tobacco, excess weight and low physical activity, alcohol or substance misuse.	March 2019	This commitment is now incorporated in the ICS workstream strategy and framework for action for Prevention. Next steps include securing specific commitments from other ICS workstreams.

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 11

REPORT OF THE SERVICE DIRECTOR, STRATEGIC COMMISSIONING, SAFEGUARDING AND ACCESS

INDIVIDUAL CONTRIBUTIONS TOWARDS THE COST OF CARE AND SUPPORT

Purpose of the Report

1. The purpose of this report is to seek approval to phase the introduction of the Council's revised policy for calculating the individual contributions that a person in receipt of adult social care community based services can afford to make towards the cost of their care and support.

Information

2. At Policy Committee on 17 October 2018 it was agreed to adopt in full, as many other councils have already done, the national Department of Health and Social Care guidance to councils about the benefits they can take into account and the Minimum Income Guarantee levels that can be applied when determining the amount people are asked to contribute towards their care costs. This was a decision taken following consultation and in the context of the financial pressures the Council is facing, and the need to ensure the fair distribution of funding across all care services. It was always recognised that any changes of this nature will be contentious. The Council's equality impact assessment provided details of the issues and how the Council would seek to respond to the issues raised by providing as much support as possible to ensure that people continue to receive the care they need and can meet essential costs from their income. The Council had to balance this impact with the need to continue to provide essential services of an appropriate quality in the face of rapidly increasing need, demand and cost.

3. The Department of Health and Social Care guidance allows for the higher rate of disability benefits to be taken into account when calculating contributions. Prior to the policy change, in Nottinghamshire, some higher rate disability benefits have been partially disregarded. The Department of Health and Social Care guidance also sets out the amount of money a week which people are allowed to keep to cover their daily living costs, for items such as food or bills. This is called the Minimum Income Guarantee (MIG). Prior to the policy change, the Council allowed £189 a week for everyone but the Department of Health and Social Care guidance recommends different rates for different age groups. The recommended level for those who are 18-24 years old is £132.45 a week; for those aged 25 to pensionable age it is £151.45 a week; and for those over pensionable age it is £189 a week.

4. The Council currently spends £113.3 million a year gross against packages of care to support people to live at home or in the community. Currently, of this figure, the Council recovers £6.8 million (6% of the total) in contributions. The revised policy will mean that the Council will recover a further £3.8million in contributions, taking the total to £10.6million (9% of the total). The Council will still fund 91% of package costs. The number of people who will contribute towards their care and support will increase by 862 to 4,112 (58%). 2,957 (42%) people will not contribute. The number of people who would be asked to contribute more will be 1,486.

5. The Council's decision to adopt in full the national Department of Health and Social guidance came into effect on 12 November 2018. Following Council approval of the policy change, letters were sent to everyone who receives adult social care community based services from the Council to explain the impact of the change on the level of contribution they will be asked to make towards their care costs. In response, a number of people approached the Council seeking advice about the impact of the changes and the timescales to review their arrangements. In these circumstances every effort has been taken to respond to the issues raised and where appropriate make adjustments to the contributions to be made.

6. As a result of feedback received from some service users, their carers and other people in their support networks, it has been recognised that sufficient time is needed to enable people to adjust to the impact of the changes. In the light of this feedback Committee is asked to consider the timescale over which the changes are implemented in order to allow people sufficient time to prepare and to ensure that people who wish to do so have time to fully discuss their circumstances with the Council.

7. The Government announced this month that some additional temporary funding would be made available for adult social care next year. In a letter dated 21 November 2018, the Council received confirmation of the allocation for Nottinghamshire. Whilst the conditions for this funding have not been confirmed the Council is of the view that it will provide a little more flexibility in the short term to phase in the changes to contributions over a longer period.

8. It is therefore proposed to implement the revised policy from 8 April 2019 and to introduce the changes in two stages: in April 2019 and November 2019.

Phase 1

9. From the 8 April 2019 the Council will adopt the national Department of Health and Social Care guidance to councils about the benefits that they can take into account when calculating contributions. The Council will also introduce an interim change to the Minimum Income Guarantee levels used when calculating contributions. Currently the Council allows a Minimum Income Guarantee level for all age groups of £189 a week. From 8 April 2019 the Minimum Income Guarantee levels that the Council will use to calculate a person's ability to contribute towards their care costs will be as follows:

    - 18-24 years old £160.73
    - 25 years – under pensionable age £170.23
    - Pensionable age and over £189.00

10. Every service user will be informed of their new contribution with a minimum of six weeks' notice. Advice and guidance will continue to be available as always to service users who contact the Council.

11. The Minimum Income Guarantee levels described in **paragraph 9** for 18-24 year olds and for people aged 25 to under pensionable age reflect the mid-point between the current level used by the Council of £189 and the level recommended by the Department of Health and Social Care guidance.

Phase 2

12. Phase 2 will start on 4 November 2019. From this date the Council will implement in full the Minimum Income Guarantee levels recommended by the Department of Health and Social Care guidance. These are:

- 18-24 years old £132.45
- 25 years – under pensionable age £151.45
- Pensionable age and over £189.00

13. Every service user will be informed of their new contribution, with a minimum of six weeks' notice. Advice and guidance will continue to be available to service users who contact the Council at any time between April and November, and beyond.

Other Options Considered

14. Other models for the phasing of the changes were considered including a two stage introduction of the changes to the Minimum Income Guarantee levels in January and April 2019, or in February and November 2019. However based on feedback it was felt that people would benefit from a longer period of adjustment than this hence the proposal to introduce the changes in April and November 2019 instead.

Reason for Recommendation

15. The phasing will allow the Council to implement its approved policy for calculating individual contributions towards care and support costs but will provide time to ensure that people who wish to do so have had the opportunity to fully discuss their circumstances with the Council and to adjust their household budgets.

Statutory and Policy Implications

16. 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

17. Phasing the introduction of the revised policy for the way the Council calculates individual contributions towards the cost of care and support will mean that the full £3.8m per annum will not be realised until 2020/21.

18. The impact in 2018/19 is around £1.5m and the impact in 2019/20 is that the reduction in cost will be around £2.8m rather than £3.8m, so a reduction of £1m.

Public Sector Equality Duty implications

19. An Equality Impact Assessment is available as a background paper to this report.

Implications for Service Users

20. Although each person's circumstances will be different, by providing time for people to discuss their circumstances with the Council and to adjust to the changes, the phasing will benefit those people who will be affected by the change in Minimum Income Guarantee calculation.

RECOMMENDATIONS

1) That the Committee approves the phasing, as detailed in **paragraphs 8-13,** of the implementation of the Council's policy for calculating the individual contributions that a person in receipt of adult social care services can afford to make towards the cost of their care and support.

Paul Johnson
Service Director, Strategic Commissioning, Safeguarding and Access
Adult Social Care and Public Health

For any enquiries about this report please contact:

Jennifer Allen
Strategic Development Manager
T: 0115 9772052
E: jennifer.allen@nottscc.gov.uk

Constitutional Comments (KK 30/11/2018)

21. The proposals in the report are within the remit of the Adult Social Care and Public Health Committee.

Financial Comments (KS 30/11/2018)

22. The financial implications are contained within **paragraph 17 & 18**. The impact in 2018/19 will be included within future budget monitoring reports and the impact for 2019/20 will be fed into the budget construction for 2019/20.

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 the Adult Social Care and Public Health Committee on 9 October 2017: Adult Social Care and Health Consultation

- Report to the Adult Social Care and Public Health Committee on 8 January 2018: Adult Social Care and Health Consultation
- Report to the Adult Social Care and Public Health Committee on 12 March 2018: Outcome of the Adult Social Care and Health Consultation
- Report to the Adult Social Care and Public Health Committee on 9 July 2018: Changes to the way the Council calculates individual contributions towards the cost of care and support
- Report to the Adult Social Care and Public Health Committee on 8 October 2018: Changes to the way the Council calculates individual contributions towards the cost of care and support
- Report to Policy Committee on 17 October 2018: Changes to the way the Council calculates individual contributions towards the cost of care and support
- Equality Impact Assessment for the changes to the way the Council calculates individual contributions towards the cost of care and support, updated on 2 October 2018

Electoral Division(s) and Member(s) Affected

All.

ASCPH610 final

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 12

REPORT OF THE SERVICE DIRECTOR, STRATEGIC COMMISSIONING, SAFEGUARDING AND ACCESS

UPDATE ON THE IMPLEMENTATION OF THE NEW HOME BASED CARE AND SUPPORT SERVICES

Purpose of the Report

1. This report provides an update on the implementation of the new model for home based care services including notification of any further awards of new contracts and the use of the Dynamic Purchasing System (DPS).

2. The report gives an update on the progress of the Home First Response Service (HFRS) and seeks approval for implementing the 'Contributions towards a Personal Budget Guidance' to this service in-line with the recent amendment to the START (Short Term Assessment and Reablement) service.

Information

Background

3. A number of reports have been presented to this Committee over the past few years about the tender for home based care and support services and the new model of service delivery. Previous reports highlighted the considerable work that had been undertaken to understand the complexities and challenges of the home care market both at a local and national level. They also referred to the new model of services which was developed to address some of these issues by offering fair financial remuneration and greater security to providers, whilst in return expecting better quality services that provide person-centred care to service users and their carers.

4. The service will deliver home based care and support services for a period of five years with the option to extend up to a maximum of 10 years in total. It is part of a system of services to keep people living at home including reablement, rapid response, hospital discharge, carers support, assistive technology and housing with care.

Update on the implementation of the new Home Based Care Services

5. The previous report to Committee in July announced the outcomes of the two tenders which were to procure a 'Lead Provider' for each of the six areas or 'lots' plus 'Additional Providers', also for each lot. The lot areas are:

- Bassetlaw
- Broxtowe
- Gedling
- Mansfield and Ashfield
- Newark and Sherwood
- Rushcliffe.

The Lead Providers are also required to provide care and support services to all nominated service users in the Housing with Care schemes within their lot area.

6. After the initial procurement exercise not all areas had sufficient providers so a second phase of tenders was held for a Lead Provider in Rushcliffe and more Additional Providers in Bassetlaw, Newark & Sherwood and Rushcliffe. These were concluded in October and as at week commencing 5 November the overall list of providers is detailed in **Appendix A**.

7. The first phase of the new contracts commenced on 1 July followed by an implementation and transition phase until October 2018. This was successfully completed with little disruption to service users and services have been commissioned with an outcome focus and a payment system that moves away from 'time and task'.

8. New commissioning arrangements for home based care mean all new care packages are sent to the appointed Lead Provider for the Lot who is required to accept a minimum of 75% of these. Packages not picked up by the Lead Provider are sent to the Additional Providers in the Lot. Additional Providers are required to offer on a minimum of 25% of these packages. Any packages not picked up by either Lead or Additional Providers are advertised to a wider pool of providers via the Dynamic Purchasing System (DPS).

9. Over 700 packages of care were recommissioned and transferred to one of the new providers through the new arrangements, the majority in Mansfield/Ashfield and Newark & Sherwood areas. Providers also picked up care packages from the existing waiting list in place on 1 July in addition to requests for new referrals and overall there has been a reduction of the number of people awaiting a long term package from over 250 in July to less than 30 by the end of November.

10. Bassetlaw, a previously difficult to serve area, is working well with both Lead and Additional Providers responding to the majority of referrals for that area. In other areas acceptance rates are generally lower than contractually required for both Lead and Additional Providers. However it is still early in the implementation of the new model and contracts and the measures that have been put in place to rectify this position are starting to be effective with improved pick-up by providers. The measures are described later in this report.

Home First Response Service Overview

11. The HFRS is a short term rapid response service for up to a target maximum of 14 days to facilitate discharge from hospital or to prevent unnecessary admission to short term care or hospital due to a temporary crisis at home. The service is a county-wide service and delivered by one provider, Carers Trust East Midlands, to ensure consistency and

flexibility. The service commenced in December 2017 so has been in operation for almost 12 months.

12. From mid-December 2017 to the end of October 2018 1,169 people have been referred into HFRS. Of these 1,082 had received the service and been discharged and the remaining were ongoing.

13. The service, which is accessible seven days a week, is recognised by staff and service users as an excellent service. In recognition of this and in preparation for winter pressures extra capacity has been commissioned to ensure that people being discharged from hospital are returned home as quickly and as smoothly as possible.

14. As this is a short term reablement type service which is offered pre the Care and Support Assessment (CASA) there is currently no assessed contribution for the service. This report is seeking approval to apply the 'Contributions towards a Personal Budget Guidance' once service users have received a CASA and are identified as being eligible for on-going social care services. This is in-line with the recent change to the Council's START service.

Dynamic Purchasing System

15. The DPS process is now fully operational and provides a further opportunity to place packages that have not been accepted by Lead or Additional Providers. Care packages have been advertised through the DPS process with no significant increase in hourly rates.

Actions to build market resilience and capacity

16. Availability of home care services is a national, as well as local, issue and the recruitment and retention of sufficient workforce remains a challenge. The Council is actively trying to address these difficulties with this different model of home based care which is designed to build and support capacity in the local market over a 10 year period.

17. The Council has invested significant energy and resources into designing this new model and it will take some time to embed the change in culture that is required to realise the vision. The new model of service delivery will provide an opportunity for improved terms and conditions to provider staff as well as greater job satisfaction for care staff. This will encourage a more reliable and consistent workforce which in turn will improve the quality of services being delivered.

18. So whilst there are still challenges in terms of provider capacity there are also opportunities to deliver greater efficiencies in systems and processes as well as supporting providers to collaborate and create a more motivated and vibrant workforce.

19. In order to monitor that staff terms and conditions are improving the new contract requires the provider to evidence year on year increase in the number of staff offered a salaried contract. An example of good practice is that since the introduction of the new contracts one of the main Lead Providers is promoting and encouraging guaranteed contracted hours and is advertising posts at hourly rates up to £10.00 for care staff.

20. More immediately though, and in the context of winter pressures planning, the following activities have been initiated to help provide market capacity over the coming months:

- weekly monitoring of providers' performance and target setting on pick-up of new referrals and recruitment of staff
- strict application of contract requirements which, for those providers who do not meet the standards required, may result in sanctions being applied including termination of contracts
- retendering to increase the overall pool of providers particularly in areas where there are insufficient providers
- support to providers to work together and build capacity through sharing good practice around recruitment and retention or by focusing on particular localities in the area to problem solve issues
- the DPS is fully embedded within the model
- two temporary Community Partnership Officers have been funded from the additional national funding for adult social care[1] to act as link workers with the hospital discharge teams and operational staff to ensure homecare requests for hospital discharge, HFRS and START progress through the system in a timely manner.
- funding for additional capacity in HFRS has also been made available in recognition of the increased demand.

Communications, Engagement and Co-production

21. The Council continues to work with the 'Experts by Experience' engagement group, who were involved in the evaluation of the tenders and have also offered advice to officers on producing appropriate communications for service users and carers. The group is now considering how its members can be involved in the on-going quality monitoring of services and how to attract new members.

22. The Council will continue to inform and involve service users, carers, providers, staff, health partners, stakeholders and the public in the ongoing work and implementation of the new services.

Other Options Considered

23. To not proceed with the proposed amendments to apply the Council's existing home care charging policy to people who continue to receive the HFRS once they have been assessed for on-going social care services and are awaiting a care provider. As already stated, as the proposals are in line with the Council's current charging policy, any recommendation not to proceed would be inconsistent and inequitable.

Reasons for Recommendations

24. The Council is required to procure services in line with its statutory obligations and to oversee and create a diverse and vibrant market on behalf of the population of Nottinghamshire as required under The Care Act 2014.

25. The Council is also required to seek a contribution for services once a service user has been assessed as being eligible for care services, this includes self-funders where the

[1]Approved in the 'Proposals for allocation of additional national funding for Adult Social Care Addendum' report to Adult Social Care and Health Committee on 12 November 2018

individual chooses to have their services arranged through the Council. The amendments described in **paragraph 14** of this report are recommended to ensure a consistent and equitable approach to adult social care charging.

Statutory and Policy Implications

26. 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

27. The current spend on home based care and support services is within the expected budget and the cost of the homecare service is monitored monthly with the forecast costs contained within the monthly budget monitoring. Financially assessing service users who remain in HFRS will also bring this service in line with the START reablement service and other care packages provided by the Council. Any income generated will be included with future budget monitoring reports.

Public Sector Equality Duty Implications

28. The nature of the services being commissioned mean they will affect older adults and people with disabilities, including people who have multiple and complex health and social care needs. The Council completed an Equality Impact Assessment to consider the implications of the tender process on people with protected characteristics.

Implications for Service Users

29. The Council has a statutory duty to ensure there is sufficient provision of a diverse range of services to meet people's social care and support needs. The re-modelling of home based care services has been to enable the Council to commission sufficient volumes of home care services and to ensure these services are flexible, sustainable and able to meet current and future needs.

30. It is expected that the providers of the new services will be able to offer staff improved terms and conditions which will encourage a more reliable and consistent workforce which in turn will improve the quality of services being delivered.

Implications for Sustainability and the Environment

31. The payment rates and method will provide a more realistic rate to independent sector providers who will be able to invest in their workforce.

RECOMMENDATIONS

That the Committee:

1) considers whether there are any further actions it requires arising from the information on the progress of the procurement and implementation of the home based care and support services.

2) approves the implementation of the 'Contributions towards a Personal Budget Guidance' to the Home First Response Service in-line with the Council's current charging policy and recent changes to the Short Term Assessment and Reablement service.

Paul Johnson
Service Director, Strategic Commissioning, Safeguarding and Access

For any enquiries about this report please contact:

Jane Cashmore
Commissioning Manager
T: 0115 9773922
E: Jane.cashmore@nottscc.gov.uk

Constitutional Comments (LM 27/11/18)

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

Financial Comments (DG 27/11/18)

33. The financial implications are contained within paragraph 27 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.

Tender for Home Based Care and Support Services – report to Full Council on 26 September 2013

The Social Care Market: Provider Cost Pressures and Sustainability – report to Adult Social Care and Health Committee on 30 November 2015

Annual Budget 2016-17 – report to Full Council on 25 February 2016

Tender for older people's home based care and support services – report to Adult Social Care and Health Committee on 18 April 2016

Tender for older people's home based care and support services – report to Adult Social Care and Health Committee on 11 July 2016

Tender for older people's home based care and support services - report to Adult Social Care and Public Health Committee on 12 June 2017

Tender for older people's home based care and support services - report to Adult Social Care and Public Health Committee on 13 November 2017

Equality Impact Assessment

New ways of working for Home Based Care Services – review of case studies: February 2018

Tender for older people's home based care and support services - report to Adult Social Care and Public Health Committee on 12 March 2018

Revision to the Adult Social Care Charging Policy - report to Policy Committee on 28 March 2018

Update on Tender for Home Based Care and Support Services - report to Adult Social Care and Public Health Committee on 9 July 2018

Proposals for allocation of additional national funding for Adult Social Care – report to Adult Social Care and Public Health Committee on 12 November 2018

Proposals for allocation of additional national funding for Adult Social Care Addendum - report to Adult Social Care and Public Health Committee on 12 November 2018

Home based care & support services project – presentation - report to Finance and Major Contracts Management Committee on 19 November 2018

Electoral Division(s) and Member(s) Affected

All.

ASCPH603 final

Appendix A

Home Based Care Providers by district as at 5 November 2018

District	Lead Provider	Additional Providers
Bassetlaw	Comfort Call Limited	Leda Homecare Limited Gemini Exclusive Care Limited Gracious Health Solutions Limited
Newark & Sherwood	Fosse Healthcare Limited	Bhandal Care Group (BSB Care) Limited *(formerly Hatzfeld)* Allied Healthcare Gemini Exclusive Care Limited
Mansfield & Ashfield	Fosse Healthcare Limited	Comfort Call Limited Direct Health Radis Community Care Agincare UK Limited Caremark (Mansfield) Leda Homecare Limited Allied Healthcare
Broxtowe	Direct Health	Comfort Call Limited Radis Community Care Fosse Healthcare Limited The Human Support Group Limited Caremark (Broxtowe & Erewash)
Gedling	The Human Support Group Limited	Direct Health Radis Community Care Caremark (Gedling & Rushcliffe) Agincare UK Limited
Rushcliffe	Agincare UK Limited *(new contract commences 1/12/18)*	Westminster Homecare Limited Gracious Health Solutions Limited Direct Health Gemini Exclusive Care Limited Absolute Care Limited

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10th December 2018

Agenda Item: 13

REPORT OF THE DEPUTY CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH, AND SERVICE DIRECTOR FOR MID NOTTINGHAMSHIRE

UPDATE ON THE DEVELOPMENT OF AN INTEGRATED CARE SYSTEM IN SOUTH NOTTINGHAMSHIRE, NOTTINGHAM AND MID NOTTINGHAMSHIRE

Purpose of the Report

1. This report advises Members on progress with the development of an Integrated Care System across Nottinghamshire, including work on transformational change in South Nottinghamshire, Nottingham and Mid Nottinghamshire, and seeks approval of the following:

   a) the proposed next steps for the Council as outlined in **paragraphs 20 & 21** for South Nottinghamshire

   b) that a further report be brought to the Committee before the end of March 2019 setting out the options for the Council in relation to continued membership of the Better Together Alliance in Mid Nottinghamshire

   c) that a further report on the Integrated Care Partnership for South Nottinghamshire and Nottingham be brought to the Committee in June 2019 detailing the options and recommendations, and that Members are kept up to date with progress through the dedicated Members Reference Group for Health Integration.

2. The report also updates Members on the 'Discharge Guidance for Greater Nottingham' (available as a background paper) for Nottingham University Hospitals (NUH).

Information

Background

3. Integrated care systems (ICSs) have evolved from Sustainability & Transformation Partnerships (STPs) and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area.

4. NHS England has confirmed agreement that the Nottinghamshire Sustainability and Transformation Partnership graduate to an Integrated Care System, in 2018/19, recognising the collaborative work and progress being achieved locally in improving health and wellbeing, and quality and affordability of care for the local population.

5. A Memorandum of Understanding (MoU) has been agreed by NHS England, NHS Improvement and all the local ICS partner organisations, including the County Council, outlining the improvements in health and care expected for the people of Nottinghamshire and Nottingham. A second year of national transformation funding has been received to support delivery of the improvement programme across Nottingham and Nottinghamshire.

Aims of the Nottinghamshire Integrated Care System

6. The Nottinghamshire health and social care ICS has confirmed its aims as follows:

- lead the way in integrating health and care services at the population and person level
- re-design and integrate clinical and care pathways to better meet the needs of the local population
- develop population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illnesses and hospitalisation
- take collective responsibility for financial and operational performance, quality of care and health outcomes
- create more robust cross-organisational arrangements to tackle the systematic challenges that the health and care system is facing.

Progress to date

Integrated Commissioning and Integrated Provision across Nottinghamshire and Nottingham

7. In April 2018, the four Clinical Commissioning Groups (CCGs) in Rushcliffe, Nottingham West, Nottingham North and East, and Nottingham City came together under the leadership of one Accountable Officer and shared management team. The new commissioning arrangements aimed to reduce fragmentation and complexity, ensuring commissioning decisions are strategically sound whilst remaining locally sensitive to the diverse population needs.

8. Since this time, with external consultancy support from Deloitte, further work has been undertaken to ensure ‘fit for purpose’ future commissioning arrangements. The proposal is to develop one strategic commissioner across Nottingham and Nottinghamshire (excluding Bassetlaw) which will:

- be strategic, focusing more on outcomes and pathways and less on tendering services in isolation or monitoring process metrics

- provide strong system leadership, focusing on relationships with all system participants supported by a single and clear vision for shared outcomes

- ensure greater consideration of wider determinants of health by drawing more intensively on public health expertise

- work in close partnership with local authorities on shared outcomes and better co-ordinated commissioning, supported by aligned or pooled budgets.

9. Additionally, two Integrated Care Partnerships (ICPs) are being developed in Mid Nottinghamshire, building on the Better Together Alliance Programme, and in South Nottinghamshire and Nottingham further developing the Transformation Partnership.

10. ICPs are collaborative networks of care providers, bringing together healthcare professionals (including doctors, nurses, pharmacists, social workers, and hospital specialists); the voluntary and community sectors; local council representatives; and service users and carers, to design and coordinate local health and social care services.

System Integration in South Nottingham and Nottingham

11. In August 2017, Centene UK were engaged by the South Nottinghamshire and Nottingham Transformation Partnership to support and advise the local health and social care partners with their programme of integration. The 12-month contract, (which has now ended) locally described as Phase 3, followed on from two earlier phases of work:

- Phase 1 was an actuarial analysis, which was a point in time benchmarking exercise which compared South Nottinghamshire and Nottingham with that of well-managed international integrated health and care systems. This analysis has been refreshed during Phase 3, with similar findings although the analysis has highlighted where improvement has already been achieved, for example through the work of the Rushcliffe Vanguard.

- Phase 2, undertaken over a six-month period, was the high-level design solution to achieve the opportunity identified in the actuarial analysis. The resultant output was confirmation of a set of Enablers, which are the conditions that need to be in place, and a set of Integration Functions, which are the ongoing integration activities that need to be performed. These are depicted in the diagram attached as **Appendix 1**.

12. Phase 3 has been far more complex than originally thought and has provided a very detailed baseline assessment of the extent to which South Nottinghamshire and Nottingham currently has each Enabler and Integration Function in place in accordance with the requirements of a well-managed system. **Appendix 1** provides a detailed description of the enablers and functions and outputs from Phase 3. In high level headline terms, the insights gained from this work include:

- most of the Enablers required are not present today, certainly not to the standard required. For example South Nottinghamshire and Nottingham: is not working to one Outcome and Performance Framework for the local population; does not have a comprehensive single set of Referral Best Practice Guidelines in place to support optimal care delivery; and does not have reportable data across whole pathways of care to ensure people are getting the right care in the right place at the right time

- many of the Integration Functions exist in the current system albeit they are being delivered in a fragmented manner from an organisational rather than population and system perspective.

13. Phase 3 has started to address some of the gaps highlighted, including:

  - assessing five outcomes frameworks, including the Social Care Outcomes Framework, to determine the measures against which an ICP could be held accountable for integrated care. The key insight from this is only 18% of the current measures can be measured, reported and impacted by integrated care

  - developing Minimum Data Sets in community health services where traditionally poor, resulting in significant clinical variation

  - developing an Information Model which will provide data on whether the system is achieving the required outcomes and performance ambitions at both a system and provider level is required. Where the system falls short, the Information Model will enable very tailored and precise solutions to be put in place.

14. Additionally Phase 3 has provided an extremely detailed blueprint of what South Nottinghamshire and Nottingham needs to put in place in respect of processes, workforce, quality measures and key performance indicators, data and systems for specified Enablers and Integration Functions to achieve the value opportunity reconfirmed in the actuarial analysis.

Benefits Achieved

15. Examples of progress achieved to date in providing joined up, coordinated care which improves the health and social care outcomes for local people, and enables more care closer to a person's home in the community, including support to promote independence and self-care include:

- a project to promote wellness for the 'at risk' of stroke population, which was initiated in Rushcliffe. Through the diagnosis and treatment of a condition called atrial fibrillation approximately 30 strokes and 10 deaths are being prevented each year across the borough providing benefits to the local population and increasing sustainability of the NHS and care system. This project is now being rolled out further across the system

- the Integrated Personal Commissioning (IPC) programme, which encourages people to take a more active role in their health and wellbeing by offering personalised support plans and personal health budgets, where appropriate. At the end of 2017/18 1,700 people had benefited from the choice and control from a personal health budget. The national evaluation of the IPC programme shows that people who have an integrated support plan and budget results in improved outcomes and an average saving of 17% for people with Continuing Healthcare funding

- between April 2016 and March 2017, the Mid Notts Call for Care service provided urgent care in people's own homes so that 1,520 people avoided having to go to hospital as an emergency and 613 people could be discharged from the Emergency Department back home with care, avoiding an admission

- the redesign and development of an Integrated Discharge process for patients requiring supported discharge from Nottingham University Hospitals NHS Trust, has resulted in an increase in supported discharges, from an average of 180 to 240 per week, but further improvement is still needed.

- evaluation by Nottingham Trent University and PeopleToo, published in December 2017, showed how health and social care staff working together in Integrated Care Teams deliver better outcomes for service users who have a combination of health and social care needs, than health and social care staff working in separate teams to support people. This evidence was reported to Adult Social Care and Public Health Committee in March 2018.

16. Such examples do not combine however to bring about transformation, of the scale and pace needed, to achieve the required improvements in outcomes, quality and sustainability of care. As such, further work is planned centred on integrated commissioning, integrated provision, and system integration.

Public Engagement in South Nottinghamshire and Nottingham

17. Since the previous report to Committee in February 2018, three public events have taken place specifically to share and gain public opinion on the system integration work. These events have been designed and facilitated by members of the Greater Nottingham Citizens Advisory Group, have included Social Care input, and have been held in Radcliffe, Bestwood and Hucknall.

Future Work in South Nottinghamshire and Nottingham

18. Work will continue with partner organisations over the coming weeks and months on both:

- the practical implementation and execution of improvement initiatives for the local population based on the outputs from Phase 3
- the further development of Integrated Commissioning and Integrated Provision arrangements.

19. Additionally, South Nottinghamshire and Nottingham are taking stock of the comprehensive outputs of the Phase 3 system integration work, and hope to co-produce a route map for implementation with the Greater Nottingham Transformation Board in the coming weeks. This will include, wherever sensible, alignment of work programmes across the whole ICS as well as the requirement for any business cases for future development.

20. These next steps on system integration in South Nottinghamshire and Nottingham will also include ‘the asks’ of each of the partner organisations. As a minimum, the County Council can expect to be asked to:

- report on minimum data set information (MDS) for social care services
- report on quality measures against the Outcomes and Performance Framework requirements once confirmed
- provide data on spend and activity at both a service and individual level to support a system level understanding of the impact of activity and investment on population outcomes.

21. Over the coming months the Council can also expect to be asked to consider the level of integration it wishes to pursue, for the local population, in joining up aspects of care such as care co-ordination, referral management, and discharge processes together with elements of supporting the infrastructure such as health and care data and information.

Future work in Mid Nottinghamshire

22. Discussions about the future system architecture for the Nottingham and Nottinghamshire ICS involve Mid Nottinghamshire partners. The Better Together Alliance partners continue to meet to discuss and agree priorities and service transformation for Mid Nottinghamshire at the Better Together Transformation Board. The Council signed up to the Better Together Alliance Agreement as a Full Member in March 2015; this membership continues for a three-year period until March 2019 (as set out at paragraph 40 of the report to Committee in March 2016 on this subject). All partners have the choice to continue with membership beyond this point or break with the Alliance. The future of this Agreement is being considered alongside all the system architecture discussions and a recommendation about the Council's participation in this Agreement beyond March 2019 will be brought back to Committee in early 2019.

Leaving Hospital Guidance South Nottinghamshire and Nottingham

23. Following discussion at the NUH A&E Delivery Board it was agreed that NUH needs to enforce a more robust management procedure for the management of patient choice; many patients remain in hospital after they are medically fit because they are waiting for homecare providers or residential / nursing facilities that they would prefer to use rather than those which are available at the point that they are medically fit.

24. NUH staff have discharge guidance which identifies the need for patients to leave hospital when they are medically fit. The guidance is available as a background paper. However they are now using a national revised approach to ensure that all patients receive the same information and communications to ensure that they are aware that they need to leave the acute setting as soon as they are medically fit and that if the services they would prefer to access are not available e.g. popular nursing or residential units with waiting lists, they will move out of the acute setting into alternative provider services whilst they wait for the services they would prefer to be available.

25. Therefore as a system NUH have asked all partners to support them in these communications to ensure a standardised message is shared with all patients. Once they are medically fit, patients will be expected to leave the hospital setting with the appropriate support provided (if they are eligible) to enable them to leave.

26. This has no policy implications for the Council and is for information only.

Other Options Considered

27. The Care Act 2014 places a duty on councils to promote integration, therefore doing nothing is not an option as it will not adequately meet the needs of the population in the future, or effectively make the best use of resources available across health and social care.

Reason/s for Recommendation/s

28. The outputs from the Phase 3 work have been far more complex than anticipated and further time is now needed for partners to shape the next steps in this transformation journey in South Nottinghamshire and Nottingham, particularly around the “asks” of each organisation.

29. Further time is also required to allow discussions to take place regarding the future of the Alliance contract with partners in Mid Nottinghamshire.

Statutory and Policy Implications

30. 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.

Data Protection and Information Governance

31. Any requests for Council data during the development of an ICS will be reviewed with Legal Services and Information Governance colleagues.

Financial Implications

32. As yet there are no financial implications for the Council in South Nottinghamshire.

Human Resources Implications

33. As yet there are no HR implications for the Council in South Nottinghamshire.

Implications for Service Users

34. It is anticipated the development of an ICS will improve the outcomes of the population through a more joined up approach in the procurement and delivery of health and social care services.

RECOMMENDATION/S

That:

1) the proposed next steps for the Council to explore with partner organisations, as outlined in **paragraphs 20 & 21**, be approved.

2) a further report be brought to the Committee before the end of March 2019 setting out the options for the Council in relation to continued membership of the Better Together Alliance in Mid Nottinghamshire.

3) a further report on the Integrated Care Partnership for South Nottinghamshire and Nottingham be brought to the Committee in June 2019 detailing the options and recommendations, and that Members are kept up to date with progress through the dedicated Members Reference Group for Health Integration.

Paul McKay
Deputy Corporate Director
Adult Social Care and Health

Sue Batty
Service Director for Mid Nottinghamshire

For any enquiries about this report please contact:

Louise Hemment
Transformation Manager South
T: 0115 9772645
E: louise.hemment@nottscc.gov.uk

Constitutional Comments (LM 22/11/18)

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

Financial Comments (CT 28/11/18)

36. The financial implications are contained within paragraph 32 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.

- The Mid-Nottinghamshire 'Better Together' Alliance agreement contract – report to Adult Social Care and Health Committee on 7th March 2016

- Integration of Health and Social Care in South Nottinghamshire, Transformation Programme Update - report to Adult Social Care and Public Health Committee on 12th June 2017

- Update on the Development of an Integrated Health and Social Care Partnership in South Nottinghamshire and Nottingham - report to Adult Social Care and Public Health Committee on 5th February 2018

- Evaluation of the impact of social care staff embedded within Integrated Care Teams – report to Adult Social Care and Public Health Committee on 12th March 2018

- Discharge Guidance for Greater Nottingham: June 2018

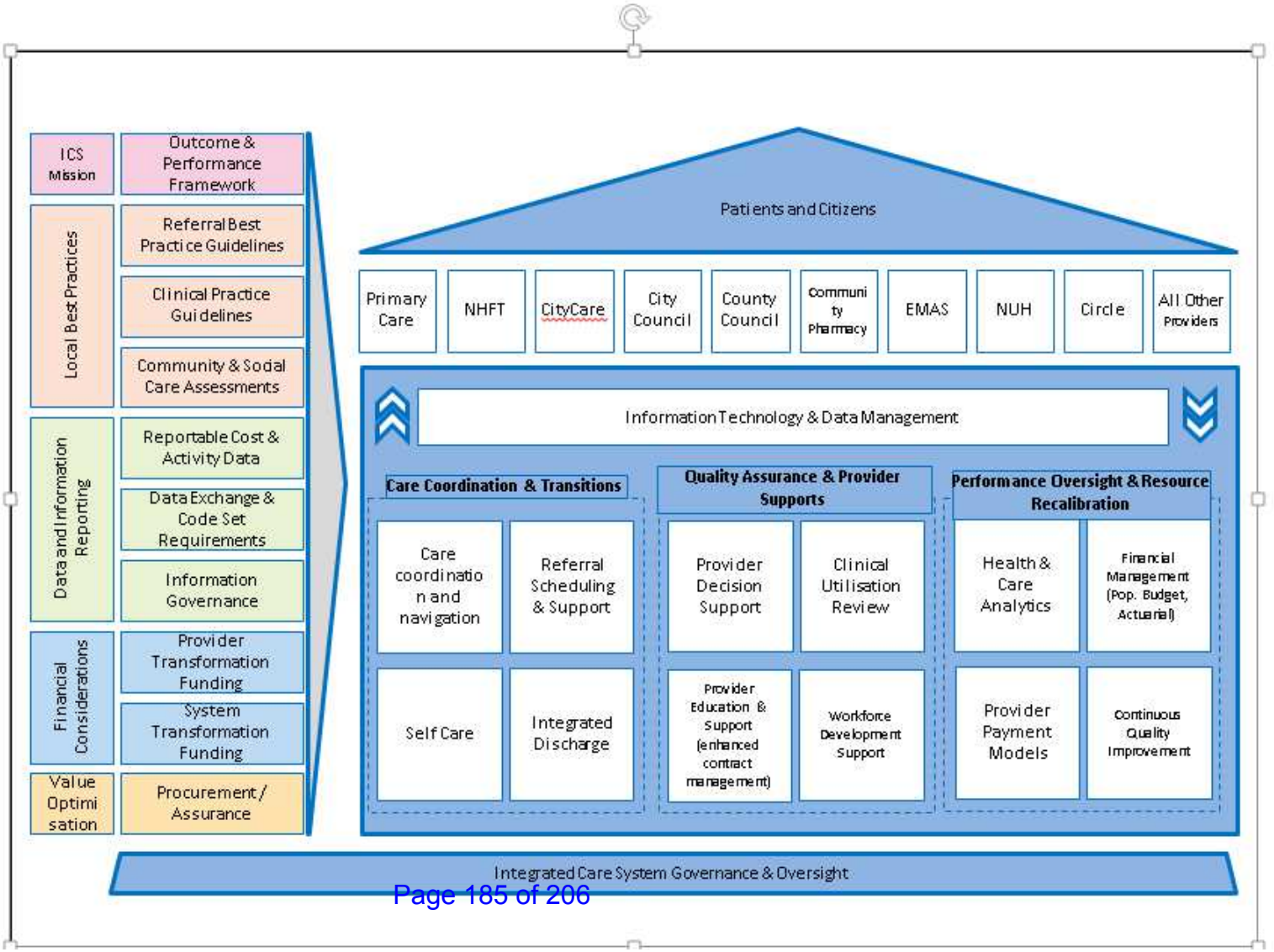
Electoral Division(s) and Member(s) Affected

All.

ASCPH594 final

The Integration Framework

- **Enablers:** The conditions (one-off investments and regulatory/ legal actions) that need to be in place
- **Integration Functions:** Functions and activities that must be performed continuously



Appendix 1: Outputs of Phase 3

Enablers & Integration Functions	Outputs Delivered
Outcomes & Performance Framework Enabler: this provides key metrics for which the ICP will be held accountable for commissioned services in relation to the outcomes the system aims to achieve at a population level. Operational and performance metrics required will be required. The Outcomes and Performance Framework informs accountability arrangements and should be defined by population cohorts and commissioned services.	A detailed assessment of the measures in five Outcomes Frameworks has been completed. The Outcomes Frameworks assessed include the NHS Outcomes Framework and the Social Care Outcomes Framework. This assessment has confirmed only 18% of the measures are of a high integrity. (i.e. the extent to which they can be measured, reported and impacted by integrated care). The measures have also been mapped to a population health cohort framework. It is now for the local system to determine how it wants to reflect this work in finalising an Outcomes and Performance Framework.
Community and Social Care Data & Assessment Enabler: this is the data and tool(s) to enable consistency of key decision making across key points along a service pathway (e.g. access to services, assessments, care planning, discharge). This enables patient needs to be identified in a standard manner and the plan of care / services needed to be allocated with precision and accuracy.	Proof of concept Minimum Data Sets have been developed for community nursing, community mental health services and community mental health services for older people. Additionally, a Minimum Data Set has been recommended for Social Care. It is now for the local system to agree to adopt these Data Sets in support of service improvement, with further developing Data Sets (e.g. for community therapy services) as required based on the learning gained for developing the proof of concepts.
Reportable Data; Data Exchange and Code Set Requirements; Information Governance Enablers: these relate to the system having: • Reportable data for defined populations, scope of services and outcome measures; • Capability to electronically exchange data using agreed upon frequencies, formats etc to have a full picture of how the system is performing; • Compliance with GDPR and best practice requirements re: data use, exchange and storage. Integrated Care is reliant on high quality data to monitor provider and system-wide performance ensuring the delivery of the right care, at the right time, in the right setting.	A 'Logical Information Model' has been developed. This Information Model forms the foundations for system improvement and management. The Information Model will enable: • Understanding of progress against the Outcomes and Performance Framework at system and provider level • Insights into the achievement of the Integration Functions in improving outcomes and performance. The Model has been developed to meet Information Governance requirements. It is now for the local system to implement the recommendations relating to the next steps in operationalising this Information Model.

Appendix 1: Outputs of Phase 3

Enablers & Integration Functions	Outputs Delivered
Information Technology and Data Management Integration Function: this is the ongoing processes, systems and infrastructure and team that ensure the efficient flow of information through the system. An infrastructure must be in place to pull together information that sits in disparate systems and organisations currently.	A report has been provided on the current IT and Data Management processes, systems and infrastructure, with the recommendation that existing systems be utilised where relevant. The report provides detail on the gaps, which need to be addressed and makes a series of recommendations of how the IT & Data Management function could be taken forward, including the recommendation for an agnostic team to deliver this Integration Function on behalf of the system going forward. It is now for the local system to determine how it progresses the recommendations.
Health and Care Analytics Integration Function: this is the ongoing generation and production of actionable intelligence using system-wide data to inform system-level planning, performance, and financial management It enables the ICP to evaluate, moderate and influence the right information, for the right patient, at the right time; ensuring it achieves the best outcome at the best value for each patient and the population.	Analytics was not included in Phase 3, recognising the requirement to develop the other component requirements relating to data, data exchange, IT and data management etc before determining the requirements of the analytics function to produce the actionable intelligence reports. This work will need to be taken forward locally.
Care Management and Self Care Integration Function (also known as Population Health and Wellbeing Management): this is: • The utilisation of a range of resources depending on patient needs that support the co-ordination of care and 'patient compliance' • The deployment of tools (including population segmentation) to effectively identify, stratify and manage the patient's needs • Draws on different levels of skills and expertise ranging from health promotion and support for self-care through to disease management and intensive case management Care Management and Self Care identifies and captures patients that require more help or guidance to make sure they receive the right care. This Function works across the continuum of care and providers to ensure patients have the most appropriate levels of support, including to self-care.	A report has been provided detailing the baseline assessment on processes, workforce, key performance indicators, data and systems for Care Management and Self Care. The report also specifies the requirements of a well-managed system and highlights the gaps and nature of change required. The report confirms that the local system does not have a comprehensive and integrated approach to Care Management and Self-Care for the whole population across health and social care. The report provides a detailed framework to identify and assess the population needs. It also makes recommendations as to how care management is significantly strengthened as a dedicated function going forward. It is now for the local system to determine how it takes forward the recommendations.

Appendix 1: Outputs of Phase 3

Enablers & Integration Functions	Outputs Delivered
Referral Best Practice Guidelines Enabler: this is the guidelines used to determine appropriateness for referral to secondary care. They form the 'blueprint' on which the Referral Scheduling and Support Integration Function operates in a well-managed system. RBPGs aim to minimise clinical variation, ensuring patients receive the right care, which in many cases can be managed in the community when services are in place.	A report that confirms the extent to which Greater Nottingham has a comprehensive single set of Referral Best Practice Guidelines (spanning multiple specialties and pathways of care) and associated governance arrangements to continually update and maintain. This report includes a gap analysis and detailed recommendations to address these gaps. The report also covers Referral Scheduling and Support services for elective care, mental health and social care. The report provides a detailed baseline assessment on processes, workforce, key performance indicators, data and systems. It also specifies the requirements of a well-managed system and highlights the gaps and nature of change required. The costs associated with the current system have been calculated relating to the twenty-one organisations/services currently involved in RSS for the local population. It is now for the local system to determine how it takes forward the recommendations.
Referral Scheduling and Support (RSS) Integration Function: this is the single 'one-stop-shop' referral hub that provides a health system with the means to review and validate the appropriateness of a referral in accordance with Referral Best Practice Guidelines. RSS assists care providers to ensure patients receive care in the right place, right time, right setting while helping patients access the care they need in the most timely and effective manner for them and their treating providers.	
Provider Education & Provider Decision Support Integration Functions: work has focused on general practice and relates to the team of specialists that work closely with general practice on how to best use decision support tools and resources available thereby empowering professionals to achieve optimal performance. The support tools include the actionable intelligence to enable professionals to make cost-effective decisions for the patient and the overall system.	A report covering Provider Education and Provider Decision Support relating to general practice. The report provides a detailed baseline assessment on processes, workforce, key performance indicators, data and systems showing significant variation across the four Clinical Commissioning Groups. It also specifies the requirements of a well-managed system and highlights the gaps and nature of change required. The costs associated with the current system have been calculated for these functions. It is now for the local system to determine how it takes forward the recommendations.

Appendix 1: Outputs of Phase 3

Enablers & Integration Functions	Outputs Delivered
Clinical Practice Guidelines (CPG) Enabler: this is the clinical protocols or medical guidelines (relating to inpatient care) outlining how healthcare professionals should care for people with specific conditions. CPGs form the 'blueprint' on which Clinical Utilisation Review Integration Function operates in a well-managed system. CPGs minimise clinical variation relating to patients receiving treatments at the right level and setting of inpatient care. **Clinical Utilisation Review:** this is an impartial quality assurance process that a patient is receiving inpatient treatment at the right level of care in accordance with Clinical Practice Guidelines. CUR improves patient flow across the system and enables reductions in unwarranted clinical variation.	A report confirming the extent to which the system has a comprehensive set of Clinical Practice Guidelines and associated governance arrangements to continually update and maintain. This report includes a gap analysis and detailed recommendations to address these gaps. The report also covers Clinical Utilisation Review and confirms this function does not currently exist in the local system. The report includes a feasibility study to support implementation and specifies the requirements of a well-managed system. The costs associated with developing this function are provided. It is now for the local system to determine how it takes forward the recommendations.
Integrated Discharge Function: this is the process to determine the next step in care for patients in inpatient settings, with a lead care co-ordinator model in place for patient with complex needs. When done well, IDF enables • A patient to progress toward the goals of his or her plan of care after discharge • Patients have a timely transition to the correct setting for recovery, management, and maintenance (reducing any delayed transfers of care) • Community Care, Social Care, and Primary Care have a single point of contact through Discharge Planning – and are notified of the patients that will require their services. •	A report on Integrated Discharge recognising the recent improvements made in respect to this function but the opportunities for further benefit and impact. The report provides a detailed baseline assessment on processes, workforce, key performance indicators, data and systems. It also specifies the requirements of a well-managed system and highlights the gaps and nature of change required including interdependencies. The costs associated with the current system have been calculated for this function. It is now for the local system to determine how it takes forward the recommendations.
Continuous Quality Improvement (CQI) Integration Function: this is a systematic approach to value improvement using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of care. CQI ensures all Integration Functions are constantly aligned with the targeted Outcomes and Performance Framework and that each provider as well as individual patients have the supports (e.g. information, incentives, etc.) they need for	A report on CQI which highlights that this function does not currently exist in relation to the requirements of a well-managed system. The report provides a detailed baseline assessment on processes, workforce, key performance indicators, data and systems. It also specifies the requirements of a well-managed system and highlights the gaps and nature of change required. The costs associated with activities that could align to this future function have been calculated.

Appendix 1: Outputs of Phase 3

Enablers & Integration Functions	Outputs Delivered
the system to achieve optimal performance. CQI objectively identifies where and why system breakdowns are occurring and the extent to which preventing or addressing a breakdown is within a partner's control. It therefore supports a fair process for holding system partners accountable for their performance.	It is now for the local system to determine how it takes forward the recommendations.
System Transformation Funding Enabler: this is the "pump prime" and other short-term funding for **I**ncreased screening activity, preventative services, primary care, mental health and community care services The mobilisation of the Integration Functions, including training etc A successful transformation requires mobilisation investments and temporary incremental funding prior to the full realisation of future savings ("transition period").	Work on transformation funding was not included in Phase 3. An earlier phase of work confirmed estimates on system transformation funding and provider transformation funding needed. It is now for the local system to further develop and understand the funding requirements associated with this whole system transformation.
Provider Transformation Funding Enabler: this is the one-time or temporary funding allocated to specific provider(s) to enable a stable and responsible transition from the current system to the future state. Acute providers require transitional funding and/or one time investments to responsibly adapt to a well-managed system.	
Provider Payment Models Integration Function: this covers population budgeting; supporting payment structures to providers; contracting and sub-contracting. Commissioning and payment structures should facilitate financial sustainability, innovation, collaborative working and patient centric care.	A refreshed actuarial analysis has been undertaken during Phase 3 which has reconfirmed the value opportunity from integrated care. It is for the local system to now determine how it wants to use the outputs of this analysis to inform activity, financial and efficiency planning. Further work on Provider Payment Models was not included in Phase 3 however, building on an earlier phase of work, an approach to developing a risk based population contract has been provided with expert input from an Actuary. Advice on provider payment structures and contracting / sub-contracting has also been provided. It is for the local system to now determine how to take all this work forward.

Appendix 1: Outputs of Phase 3

Enablers & Integration Functions	Outputs Delivered
Financial Management Integration Function: this is the comprehensive financial management and oversight of the system including continuous monitoring of system performance by population and by service line (type of activities) relative to the forecasted demand for health and care services. This encompasses all the Enablers and Integration Functions constantly reviewing and when necessary re-aligning to the financial targets.	Work on Financial Management was not included in Phase 3 however a Financial Management Model has been provided to support ongoing financial management from a population and system perspective. It is now for the local system to determine whether to adopt this approach.
Procurement & Assurance Enabler: this is the rules governing commissioners and their ability to procure (contract) the necessary health and social care services, Integration Functions, financing, and administrative support (non-clinical) functions needed for a well-managed system. All future contracts must align with the Outcomes and Performance Framework and, where applicable, should incorporate the relevant inputs required to the Integration Functions.	Procurement and Assurance was not included in Phase 3 however a paper outlining a proposed contract and governance model has been provided, which has been developed with legal support and could be implemented within the current legal and operating frameworks. It is now for the local system to determine how to take this work forward.
Integrated Care Governance and Oversight Function: this is the governing body / bodies which will ensure that the ICP is delivering on the outcomes, goals and objectives it was designed for Governance and oversight is required to ensure checks and balances so that no single provider can act in its own interests when such actions have a material and negative impact on patients and/or other providers.	

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 14

REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH

ESTABLISHING AN INTEGRATED CARE SYSTEM BOARD FOR NOTTINGHAM AND NOTTINGHAMSHIRE

Purpose of the Report

1. This report seeks approval for Nottinghamshire Council Council to be a partner of the new Integrated Care System Board, in line with the shadow Terms of Reference.

Information

Background

2. Nottingham and Nottinghamshire has been formally designated as an Integrated Care System (ICS). There are only 14 designated ICSs in England.

3. In brief, the purpose of an ICS is a system in which:

   NHS commissioners and providers and Local Authorities, working closely with GP networks, and other partners including the Voluntary and Community Sector, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes. They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the population they serve.

4. The Nottingham and Nottinghamshire ICS is a partnership which will:

   - re-design and integrate clinical and care pathways to better meet the needs of the local population
   - develop population health management approaches that facilitate the integration of services
   - work with key system partners and stakeholders including patients and residents and their democratic representatives, health and care staff, local government and the voluntary sector to achieve these aims;
   - take collective responsibility for managing financial and operational performance, quality of care and health and care outcomes;

- implement new methods of payment that support integration of services and population health management approaches, whilst enabling delivery of a shared system control total;
- create more robust cross-organisational arrangements to tackle the systemic challenges that the health and care system is facing;
- act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities

5. This report provides an update to the Adult Social Care and Public Health Committee following agreements reached at the October Sustainability & Transformation Partnership (STP) Leadership Board about the next steps in governance arrangements to transition into becoming an Integrated Care System (ICS).

Next steps in developing the new architecture

6. The current STP Leadership Board has undertaken a number of development sessions, some of which have included non-executive director input from the Council. The STP elected members and non-executive directors advisory and oversight group has also participated in discussions about the new governance that we now need to adopt since Nottingham and Nottinghamshire has been designated as an ICS.

7. Making these proposed changes will bring about positive benefits for patients and citizens because they will result in better system management. Establishing an ICS Board and better system oversight should also mean hospitals and other key services are there for the people who really them and be less likely to be overwhelmed by demand. Nottinghamshire County Council has a key role to play in a range of integrated arrangements, including; supporting avoiding hospital admissions, enabling effective discharge planning and the developing local integrated care teams.

8. The new governance 'architecture' is set out in **Appendix A**.

9. Progress is being made in developing all of these areas:

- It is intended to have a single Accountable Officer for the six Nottinghamshire CCGs. This, coupled with a project plan to develop a single CCG, signals a strong direction of travel for a single CCG for Nottinghamshire
- A specific workshop on role, responsibility, function and next steps for Local Integrated Care Partnership (**LICP)** development was held on 11 September 2018
- A specific workshop on role, responsibility, function and next steps for **ICP** development was held on 14 September 2018
- A further two-day workshop took place on 12-13 November to further develop the detail for **ICP and LICPs**
- A detailed programme plan has been established to ensure delivery of the necessary changes.

10. As a result of discussions at the STP Leadership Board and at the STP elected members and non-executive directors advisory and oversight group it was determined that it would be necessary to establish a **Strategic Board (the ICS Board - ICSB)** to oversee the Nottinghamshire Integrated Care System. In the medium term, the **ICSB** will become part

of the architecture itself. In the short term, it would be in shadow form to oversee the development and implementation of the new architecture.

11. The proposed purpose, scope and membership of the **ICSB** are shown in **Appendix B**. The ICSB will fulfil a different role to the current STP Leadership Board and membership needs to evolve to reflect this changed role and purpose, but crucially to also increase accountability and transparency through the direct inclusion of elected members and non-executive directors/Chairs.

12. This overhaul of membership will ensure:

- 'Lay' and executive input from each statutory organisation with improved balance of lay input
- Strengthened links with social care commissioning, provision and public health
- Strengthened clinical representation.

13. The new ICSB would be set up and a review would be undertaken after six months to determine the effective functioning of the group. As the membership of the ICPs, LICPs and Partnership Forum become constituted, further rationalisation of the groups in the current STP governance structure is likely to be required. (The STP elected members and non-executive directors advisory and oversight group can be disestablished, for example).

14. The new arrangements and membership should take effect from December 2018 (with the first meeting of the ICSB replacing the current STP Leadership Board scheduled on 14 December 2018).

Other Options Considered

15. The ICS Board terms of reference have been drafted to reflect the required standards set out in the ICS Memorandum of Understanding agreed between health and social care partners and NHS England and NHS Improvement.

Reason/s for Recommendation/s

16. To ensure that the Council has input to and oversight of progress with the ICS plan and outcomes for the health and social care system across Nottinghamshire.

Statutory and Policy Implications

17. 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

18. There are no financial implications for the Council.

RECOMMENDATION/S

1) That the Committee gives approval for Nottinghamshire Council Council to be a partner of the new Integrated Care System Board, in line with the shadow Terms of Reference.

David Pearson CBE
Corporate Director, Adult Social Care and Health

For any enquiries about this report please contact:

Sue Batty
Service Director, Mid Nottinghamshire
T: 0115 9774876
E: sue.batty@nottscc.gov.uk

Constitutional Comments (SSR 30/11/18)

19. The recommendation set out in the report falls within the scope of decisions which may be approved by the Adult Social Care and Public Health Committee.

Financial Comments (KAS 30/11/18)

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

Background Papers and Published Documents

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

None.

Electoral Division(s) and Member(s) Affected

All.

ASCPH605 final

Appendix A

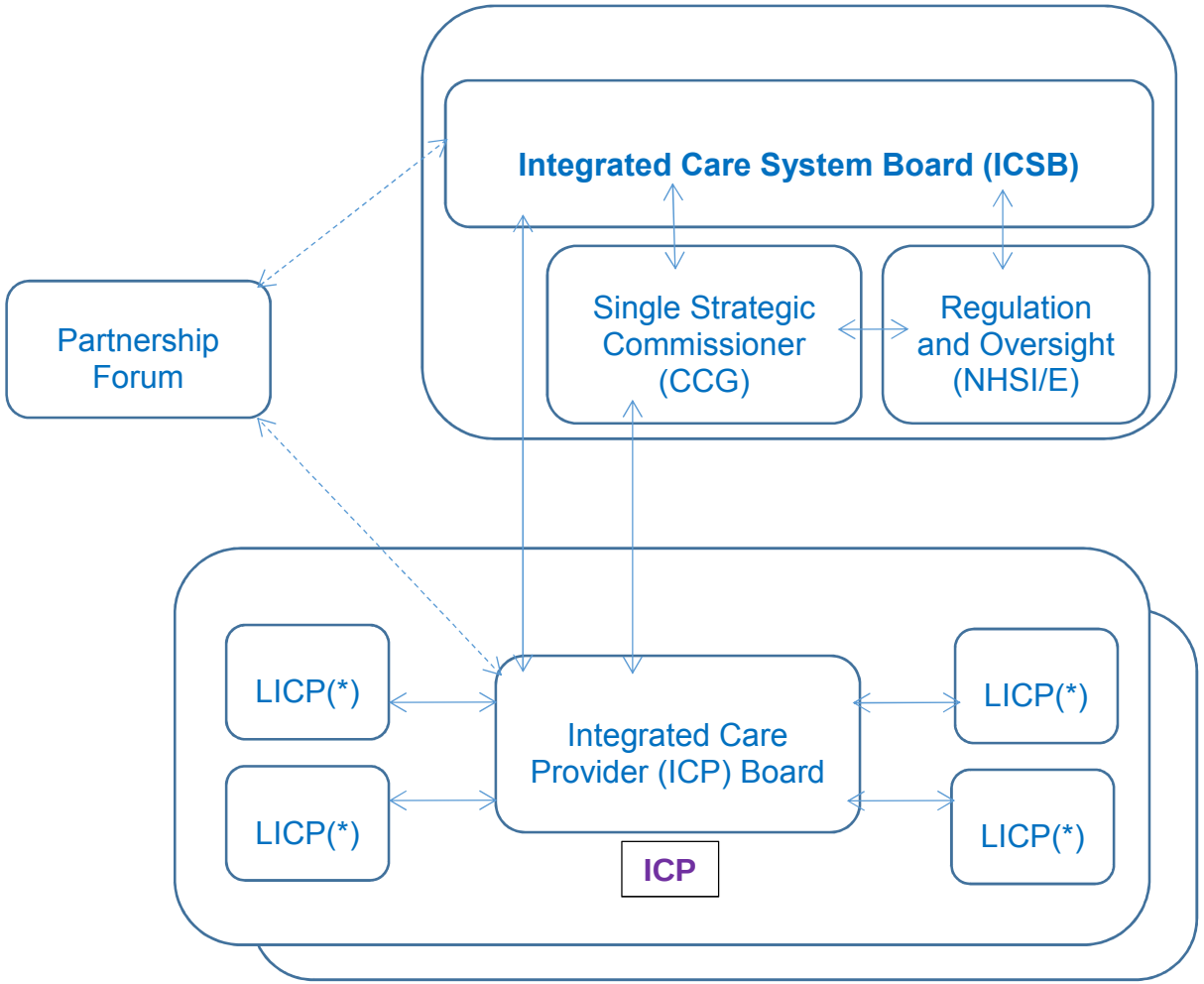
New system 'architecture'

Planning, commissioning and oversight. ICS Board to set strategy and vision, oversight of system objectives and delivery. The CCG(s) will continue to exist as the strategic commissioner to undertake strategic commissioning.

Partnership Forum
To comprise patients groups, citizens, non-statutory providers.

Function is to advise and inform both the commissioners and providers

Local planning and delivery, with devolved population-based budget, coordination and provision of services, with close links between the ICP, LICP and ICS



Relationship with regional regulatory teams, but increasing ability for the ICS to manage and improve performance with minimal escalation

Governance, accountabilities, risk and reward will be realigned across these population-based providers partnerships, with overall alignment with ICS Board objectives and strategy

(*) Locality Integrated Care Provider. Currently a way of describing the organisation of primary care 'at scale' and building capacity for services delivered in primary and community sector.

Appendix B

Integrated Care System Board

Purpose:

The role of the Integrated Care System Board (ICSB) is to provide leadership and development of the overarching strategy for the Nottinghamshire Integrated Care System. The ICSB will also provide oversight and facilitation of the transformation and design of the future state of health and care.

The ICSB will:

- Produce and champion a coherent vision and strategy for health and care in Nottingham and Nottinghamshire
- Develop and describe the high level strategic objectives for the system that are related to health and wellbeing
- Produce an outcomes framework for the whole geography to deliver increasing healthy life expectancy, addresses local variation and seeks to reduce health inequalities
- Work with the ICPs and LICPs to determine the service offer to be expected of each.
- Undertake stakeholder engagement which will include engaging with staff, patients and citizens
- Develop a coherent approach to measuring outcomes and strategic objectives within the framework
- Ensuring the delivery of high quality outcomes, putting patient safety and quality first.
- Be responsible for the allocation of financial resources and the overall management of the system financial control total.

Meeting arrangements:

The ICSB will meet on a monthly basis to consider progress and risks in the implementation of the Integrated Care System's aims and objectives and approve any mitigation measures and other action required to ensure success, in line with the approved programme.

Membership will comprise:

Membership	Notes
Chief Executive Nottinghamshire Healthcare NHS FT	John Brewin (Julie Attfield, interim)
Chair or non-executive Director Nottinghamshire Healthcare NHS FT	To be nominated
Chief Executive Sherwood Forest NHS FT	Richard Mitchell
Chair or non-executive Director Sherwood Forest NHS FT	To be nominated
Chief executive Nottingham University Hospitals NHS Trust	Tracy Taylor

Chair or non-executive Director Nottingham University Hospitals NHS Trust	To be nominated
Chief/Accountable Officer, CCG	To be confirmed
Clinical lead/Chair CCG	To be confirmed
EMAS Chief Executive	Richard Henderson
Nottinghamshire County Council CEO or nominee	To be confirmed
Nottingham City Council CEO or nominee	To be confirmed
Nottinghamshire County Council elected member (Portfolio holder or chair of HWB)	To be confirmed
Nottingham City Council elected member (Portfolio holder or chair of HWB)	To be confirmed
NHSE representative	Wendy Saviour
ICS Chair	David Pearson
In attendance	
ICS Managing Director	Wendy Saviour
The ICP lead from Greater Nottingham ICP	To be confirmed If not already part of membership
The ICP lead from Mid Nottinghamshire ICP	To be confirmed If not already part of membership
A clinical lead from Greater Nottingham ICP	To be confirmed If not already part of membership
A clinical lead from Mid Nottinghamshire ICP	To be confirmed If not already part of membership
Clinical lead from two LICPs	Mid Nottinghamshire LICP Greater Nottingham LICP
ICS finance director lead	Helen Pledger
Chair of Clinical Reference Group / ICS Medical director	Andy Haynes
ICS Nursing/Quality director	To be confirmed

Principles

Membership provides an improved balance of Executive/Non-Executive and Local Authority representation and better reflects the nature of the ICS in its partnership role.

These governance arrangements provide a fair approach to representation from individual organisations. No single member (or the organisation they represent) will have a right of veto over system-wide decisions.

The recommendations that emerge from the priority work streams of the partnership can be passed en-route to the ICS Board through a number of advisory groups for assurance.

This includes assurance on clinical priority by the CRG, economic priority by the Finance Directors Group and commissioning feasibility by the Planning Group.

Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

10 December 2018

Agenda Item: 15

REPORT OF SERVICE DIRECTOR, CUSTOMERS, GOVERNANCE & EMPLOYEES

WORK PROGRAMME

Purpose of the Report

1. To consider the Committee's work programme.

Information

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

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

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

Other Options Considered

5. None

Reason/s for Recommendation/s

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

Statutory and Policy Implications

7. This report has been compiled after consideration of implications in respect of crime and disorder, 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.

RECOMMENDATION/S

That the committee considers whether any amendments are required to the work programme.

Marjorie Toward
Service Director, Customers, Governance & Employees

For any enquiries about this report please contact: Sara Allmond – sara.allmond@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

- None

Electoral Division(s) and Member(s) Affected

- All

ADULT SOCIAL CARE AND PUBLIC HEALTH COMMITTEE – WORK PROGRAMME 2018-19

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
7 January 2019			
Direct Payments Support Services		Service Director, Strategic Commissioning, Access and Safeguarding	Laura Chambers
Outcomes of the consultation on Protection of Property and Funeral Arrangements Policy	Feedback on the outcomes of the consultation and recommendations for progression.	Service Director, Strategic Commissioning, Access and Safeguarding	Ellie Davies/Halima Wilson
Younger Adults' Accommodation Strategy, and development of Community Living Networks	To share progress on this Strategy and provide an update on development of Community Living Networks and seek approval from Committee.	Service Director, North Nottinghamshire and Direct Services	Jenni French/Mark Jennison-Boyle
Supported Employment Services	Report in response to a request from the Committee for an overview report on supported employment	Service Director, North Nottinghamshire and Direct Services	Jane McKay / Naomi Russell
National Children and Adult Services Conference 2018	Report back on attendance at conference.	Corporate Director, Adult Social Care and Health	David Pearson
Quality auditing and monitoring activity - care home and community provider contract suspensions	Regular report on contract suspensions and auditing activity, and to include update on progress with implementation of new home based care contracts.	Service Director, Strategic Commissioning, Access and Safeguarding	Cherry Dunk
National and local Adult Social Care workforce recruitment campaign		Service Director, Mid-Nottinghamshire	Veronica Thomson
Adult Social Care and Health – update on		Corporate Director, Adult Social Care and Health	Jennie Kennington

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
departmental projects and priorities			
Adult Social Care and Public Health – events, activities and communications	Approval for range of activities and events planned by the department over the coming months (as required).	Deputy Corporate Director	Jennie Kennington/ Kay Massingham
4 February 2019			
Nottingham and Notts Mental Health Strategy	Report outlining the work to progress a new MH Strategy.	Service Director, Strategic Commissioning, Access and Safeguarding	
Update on Chlamydia Screening for 15-24 year olds in Nottinghamshire	Update on progress made towards improving the detection rate, how this has been done and information, including the evaluation undertaken, about the online testing service.	Director of Public Health	Gill Oliver/Matthew Osborne/Daniel Flecknoe
Progress update on integration and partnerships in North Nottinghamshire	Update on the development of the South Yorkshire & Bassetlaw Integrated Care System and the Bassetlaw Accountable Care Partnership	Service Director, North Notts and Direct Services	Steve Jennings-Hough/Ainsley MacDonnell
4 March 2019			
Performance Update for Adult Social Care and Health	Quarterly update report on the performance of Adult Social Care and Public Health.	Deputy Corporate Director	Celia Morris/ Matthew Garrard
Progress report on savings and efficiencies	Regular update report to committee on progress with savings projects within the department	Transformation Programme Director	Ellie Davies
Recommissioning of Domestic Violence and Abuse Services	To seek approval to proposed commissioning intentions for this service	Consultant in Public Health	Gill Oliver
Deprivation of Liberty Safeguards Strategy		Service Director, Mid-Nottinghamshire	Annie Greer
1 April 2019			
Public Health Services Performance and Quality Report for Funded	Regular performance report on services funded with ring fenced Public Health Grant (quarterly)	Consultant in Public Health	Nathalie Birkett

Report Title	Brief Summary of Agenda Item	Lead Officer	Report Author
Contracts			
Quality auditing and monitoring activity - care home and community provider contract suspensions	Regular report on contract suspensions and auditing activity.	Service Director, Strategic Commissioning, Access and Safeguarding	Cherry Dunk
Progress on self-assessment and support planning	Update on the introduction and implementation of self-assessment and support planning for people who need services.	Transformation Programme Director	Asche Jacobs/Suzanne Kerwin
13 May 2019			
Adult Social Care and Public Health Departmental Strategy - Performance report	Update on performance relating to the department's contribution to commitments in the Council's Strategic Plan	Transformation Programme Director/Director of Public Health	Jennie Kennington/Kay Massingham
10 June 2019			
Single Homelessness support service - procurement	To seek approval to tender for the single homelessness support service	Consultant in Public Health	Dawn Jenkin / Susan March
Performance Update for Adult Social Care and Health	Quarterly update report on the performance of Adult Social Care and Public Health.	Deputy Corporate Director	Celia Morris/ Matthew Garrard
Progress report on savings and efficiencies	Regular update report to committee on progress with savings projects within the department	Transformation Programme Director	Ellie Davies
8 July 2019			
Public Health Services Performance and Quality Report for Funded Contracts	Regular performance report on services funded with ring fenced Public Health Grant (quarterly)	Consultant in Public Health	Nathalie Birkett
Quality auditing and monitoring activity - care home and community provider contract suspensions	Regular report on contract suspensions and auditing activity.	Service Director, Strategic Commissioning, Access and Safeguarding	Cherry Dunk