Annex 2

Nottinghamshire County Council

Service Planning 2016-17

Name of service	**Public Health**		
Completed by	**Kay Massingham**	**Date**	**21 March 2016**
Approved by	**Chris Kenny**	**Date**	**23 March 2016**

Service Plan

1. Outcomes

a. What outcomes does the service aim to deliver for its customers?

The main outcomes the Public Health service aims to deliver for its customers are:

- Health and wellbeing in the population is improved
- Health inequalities are reduced
- The health of the population is protected

It delivers these outcomes through activity in three main headings:

- Health improvement
- Health protection
- Healthcare public health and preventing premature mortality

Public Health is mainly concerned with population-level interventions that will influence the health of the population. The Public Health system combines science (technical skills, information analysis, evidence of effectiveness) with art (using opinions and views of experts, service users and stakeholders) to produce an effective approach to improving health and wellbeing in the population and at the same time reducing health inequalities. The results of many Public Health initiatives can only be assessed over the very long term. Markers towards the achievement of long-term outcomes related to improved health in the population and reduction in health inequalities are monitored instead, in the form of interim performance measures and quality indicators.

The Council has a set of mandatory functions and duties related to Public Health enshrined in the legislation of the Health and Social Care Act 2012. It currently receives an annual Public Health grant allocation which pays for the function. In 2016/17 the Nottinghamshire Public Health grant will be £43.26m. The Council has a duty to ensure that this grant is spent effectively and for the purpose for which it has been provided, i.e to contribute to Public Health outcomes.

Public Health outcomes are set out in the national Public Health Outcomes Framework. These cover overarching indicators such as life expectancy and healthy life expectancy, and indicators linked to specific Public Health issues such as smoking prevalence, low birth weight, excess winter deaths, diagnoses of particular illnesses etc.

The requirement to demonstrate effective performance in relation to eventual Public Health outcomes needs to be embedded in all contracts for commissioned services and in service level agreements or similar in respect of realigned Public Health grant to other parts of the Council.

Public Health aims to deliver relevant activity by working together effectively with partners, and to ensure that Public Health grant is used appropriately and effectively. Most of the Public Health function is delivered through commissioned services. Elements of health protection and health improvement are undertaken through partner collaborations. Advice and support to the Clinical Commissioning Groups (CCGs) is provided in line with an existing Memorandum of Understanding (MoU) (due for renewal in 2016).

b. How do they support / contribute to the Council's strategic outcomes? and the outcomes of other local organisations and partnerships?

ie The Strategic Plan, Redefining Your Council, Key Strategies etc

NCC's Strategic Plan 2014-18
This Plan sets out the overall vision for Nottinghamshire to be a better place to live, work and visit. It contains five core priorities, of which two contain specific outcomes related to Public Health, as follows (extracts in tables below taken from NCC Strategic Plan document):

Supporting safe and thriving communities

Outcome	***How will we measure progress***	***Role of the Council***
The health and safety of local people are protected by organisations working together	*A multi-agency plan is agreed to lead a response across partners to health emergencies from infectious diseases, environmental, and chemical hazards*	*We will provide leadership across partner organisations to protect the health and safety of local people. We will contribute to planning for health emergencies.*

Providing care and promoting health

Outcome	***How will we measure progress***	***Role of the Council***
The health inequalities gap is narrowed, improving both health and wellbeing	*Effective health and wellbeing interventions are targeted to where they are most needed*	*We will work in partnership to maximise the use of resources to target the areas of greatest need, highest demand and tackle inequality*

In relation to the first outcome above, health protection is one of the statutory functions of Public Health and we will continue to provide leadership within the Public Health arena and contribute to planning for health emergencies.

In relation to the second outcome above, as the use of tobacco is significantly linked to deprivation, a drop in smoking prevalence across Nottinghamshire would demonstrate an impact on health inequalities. Smoking prevalence will therefore be used as a proxy measure to assess this. Progress will be demonstrated by a drop in smoking prevalence of 0.5% or more by 2017. In 2016/17, we will contribute to the outcome on Health Inequalities in relation to Tobacco Control as follows:

- We will implement the new Tobacco Control commissioned service, with a focus on populations with the highest smoking prevalence, in order to tackle health inequality

- We will ensure that all HWB members and named key partners have live action plans to achieve their organisational and HWB aspirations with regards to Tobacco Control

Our detailed targets for this work in 2016/17 are contained in the Action Plan below.

Redefining Your Council
Redefining Your Council is the overarching strategic context for developing Nottinghamshire County Council as an organisation. Through this strategy, the Council seeks to integrate its functions more closely in order to deliver services more effectively. During 2015/16, Public Health became part of the Adults and Health department within the Council. In 2016/17, a staffing restructure within Public Health will take place to integrate the function further.

Public Health also contributes to the Council's values, as identified in Redefining Your Council, as follows:

Treating people fairly - through the use of Public Health analysis of data to develop evidence-based policies and service commissioning. We will also prioritise appropriate target groups within society in relation to smoking prevalence across Nottinghamshire, in order to address the health inequalities gap.

Value for Money - the performance management function and contract monitoring within Public Health focus on delivery of outcomes. Contracts are designed to elicit good performance whilst ensuring the most efficient use of resources through the use of collar and cap arrangements. In 2016/17, a staffing restructure within Public Health will take place to integrate the function further within the council and to deliver anticipated savings.

Working together – through the Health and Wellbeing Board and through its work with all other partners, Public Health will work to improve the health and wellbeing of the people of Nottinghamshire.

Health and Wellbeing Strategy
The Health and Wellbeing Board (HWB) is the primary body overseeing overall Strategy for Health & Wellbeing in Nottinghamshire. The Health and Wellbeing strategy identifies four main ambitions:

- For everyone to have a good start in life
- For people to live well, making healthier choices and living healthier lives
- That people cope well and that we help and support people to improve their own health and wellbeing, to be independent and reduce their need for traditional health and social care services where we can
- To get everyone to work together

Our aims to improve health and wellbeing in the population, and to reduce health inequalities, support the first three of the ambitions above. Our aim to work effectively with Public Health partners links directly to the fourth ambition.

The four ambitions drive work around a wide range of priorities, which include support to families and children, drugs and alcohol, obesity, sexual health, and emotional and mental health of children and adults. Public Health is responsible for commissioning many of the services related to the priorities; therefore the delivery of the strategy is embedded in the work of Public Health.

2. Objectives

a. What are the key objectives of the service for 2016 - 17

1. **To deliver quality and efficiency in commissioned Public Health services during 2016-17 by the successful re-commissioning of some services and contract management of all commissioned services, in order to maintain quality whilst delivering financial savings.**

Priority actions for 2016/17 are as follows:

- Re-commission IT services for NHS Health Checks and the Healthy Child Programme for children age 0-19
- Manage Public Health commissioned services contracts and activities supported through PH grant realignment to deliver financial savings targets
- Strengthen clinical governance and quality arrangements in commissioned services

2. **To work effectively with partners in 2016-17 to improve health and wellbeing in the population of Nottinghamshire and to reduce health inequalities**

Priority actions for 2016/17 are as follows:

- Refresh the Health and Wellbeing Strategy by the end of the 2016-17 financial year
- Continue to work with Health and Wellbeing Board partners to promote joint and aligned strategy to tackle tobacco use, reducing health inequalities linked to tobacco use and focusing on the implementation of Action Plans related to the Nottinghamshire Declaration on Tobacco Control
- Develop proposals for Council-wide approaches to the delivery of mental health services
- Implement Year 1 of the 3-year Young People's Health Strategy Action Plan

3. **To fulfil statutory obligations during the year and provide Public Health leadership and oversight**

The Council has statutory obligations around Public Health leadership, such as publishing the Director's Annual Report, refreshing sections of the Joint Strategic Needs Assessment and providing health advice and support to CCGs across all three of the planning localities in Nottinghamshire (Bassetlaw, Mid-Notts, South Notts/Greater Nottingham.)

Priority actions for 2016/17 are as follows:

- Refresh the Memorandum of Understanding with CCGs by the end of 2016
- Maximise the health gains that the planning system can offer through the development of protocols for closer working between planners and health

4. **To maximise value for money within the Council by implementing an efficient Public Health staffing structure, engaging effectively with partners to ensure budgetary savings are achieved in 2016-17 and effectively planning for future savings.**

Allocations for Public Health grant have been announced for the next two years, with notional figures available for the two years after that, indicating a continued reduction in funding. The Options for Change agreed during 2015/16 include a reduction in staffing budget linked to a restructure. The overall climate is therefore one of reducing resources.

Priority actions for 2016/17 are as follows:

- Identify with partners plans for future budget reductions in light of the reducing Public Health grant.
- Complete and implement the restructure of Public Health including refreshing the workforce development plan to address changes in staff complement and structure
- Achievement of budgetary savings required during 2016-17.

3. Pressures and Challenges

a. What pressures specific to the service may impact on service delivery or achievement of the service objectives in 2016 - 17

1. Public Health planned for a reduction in Public Health grant of £3m in 2016/17 against original anticipated funding, taking into account the inward transfer of resources to support the additional responsibilities for Family Nurse Partnership and Health Visiting. Three Options for Change were approved to achieve this reduction, with some use of reserves in 2016/17 to mitigate part of the impact.
2. Public Health grant allocations announced in February 2016 included a further reduction of £0.748K in 2016/17 on top of the anticipated £3m reduction, and another £1.0m reduction in 2017/18, with additional reductions anticipated in the following two financial years. The £750K shortfall in budget in 2016/17 can be met from Public Health reserves in 2016/17 but further reductions will need to be identified from 2017/18 to accommodate this and future reductions. This means that during 2016-17 the service will need to focus some of its resource on how to achieve the savings required in future years.
3. Changes to senior staffing, reduction in overall staff complement and changes to structure may affect the levels of service able to be delivered and the capacity to take on pieces of work.

b. Based on 2015 – 16 and benchmarking in the service profile are there any areas of performance or cost to be addressed in 2016 – 17?

Cost – reserves to be used to support shortfall in Public Health grant (£748K), mitigation of Realignment reductions (£850K) in 2016/17.

Performance - There were some areas of underperformance in commissioned services in 2015/16 which have been addressed through re-commissioning from 1 April 2016. Addressing further underperformance may have budgetary implications and will need to be considered in the context of overall budget planning.

4. Actions for 2016 - 17

What are the key actions required to deliver the 2016 -17 objectives

Using objectives and challenges identified above what are the key actions for the service will do over the next year to achieve its objectives, improve outcomes & service quality and deliver options for change to reduce costs. Are there any risks associated with the action and have these been considered? Will any of the planned changes impact on service users/customers? If it will have an adverse impact on any particular group an Equality Impact Assessment should be completed

Actions to be completed in 2016/17 (also include actions from any relevant Council strategies or Options for Change)	Risks / Impact	Responsible Officer	Timescale	
			Start	Finish
1. Deliver health improvements and identify opportunities to make value for money improvements, whilst still delivering public health outcomes, in the re-commissioning of the NHS health checks IT service and children's public health services 0-19	Requirement to maintain statutory functions may affect VFM improvements achievable. Mitigation: risk provision in reserves. Achieving savings on contracts carries potential reputational risk. Mitigation: consultation with partners during service specification development.	Consultants in Public Health	1 April 2016	31 March 2017
2. Review and manage existing contracts (including contracts due to start 1 April 2016 and activities supported through PH grant realignment) to deliver financial savings targets contained in OFC APH002 and OFC APH003	Provider / contract transition has potential to affect performance. Mitigation: PH contracts team experience in managing transition. Savings targets are subject to performance on volume-based contracts: savings may be at expense of lower performance. Mitigation: provision has been made in PH reserves.	Group Manager contracts & perform-ance / Consultant in Public Health	1 April 2016	31 March 2017
3. Strengthen clinical governance and quality arrangements for commissioned services,	Weak clinical governance can impact on quality of service provided. Mitigation: PH quality leads are experienced in implementing clinical governance to minimise risk for service users	Consultant in Public Health	1 April 2016	March 2017

4. Refresh the Health and Wellbeing Strategy	Reducing capacity of HWB members to contribute to and implement strategy.	Consultant in Public Health	April 2016	March 2017
5. Continue to work with partners to promote joint and aligned strategy to tackle tobacco use, focusing on the implementation of action plans related to the Nottinghamshire Declaration on Tobacco Control, and expansion of the Declaration to third parties	Reducing capacity of HWB members, named partners and staff within Public Health.	Consultant in Public Health	1 April 2016	31 March 2017
6. Develop proposals for council-wide approaches to the delivery of mental health services	Requires partnership approach between ASCH and Public Health	Consultant in Public Health	1 April 2016	31 March 2017
7. Implement the first year of the Young People's Health Strategy Action Plan, (three year strategy)	Impact –improved health and wellbeing of young people, increased awareness of issues faced by the group. Risks - Lack of budget to implement recommendations and action plan limit scope for implementation. Partners' ability to contribute likely to be limited.	Consultant in Public Health	April 2016	March 2017
8. Refresh the Memorandum of Understanding with CCGs	Partner expectations may exceed available capacity. Mitigation: management of partner expectations as part of stakeholder engagement.	DPH	April 2016	October 2016
9. Maximise the health gains that the planning system can offer through the development of protocols for closer working between planners and health	Capacity within Districts and within Public Health to contribute to and implement working methods. Mitigation: consider in allocation of	Consultant in Public Health	1 April 2016	31 March 2017

	resources.			
10. Engage partners and plan for future budget reductions in light of reducing Public Health grant	Reductions may put at risk statutory requirements. Mitigation: planning will need to ensure statutory requirements are considered.	DPH	April 2016	October 2016
11. Complete the restructure of Public Health in line with OFC APH001 and follow this by refreshing and expanding the Public Health workforce development plan to take account of changes in staff complement, the need to support and develop staff in the new structure, and support for revalidation of professional status.	Sufficiency of staffing/budget to deliver mandatory functions. Mitigation: work allocation to ensure statutory requirements are prioritised and staff training also takes into account.	DPH	April 2016	October 2016
12. Achievement of budgetary savings identified in OFCs APH001, APH002 and APH003	Some savings are contingent on contract performance; savings may be at expense of performance. Mitigation: provision made in reserves for 2016/17	DPH	April 2016	March 2017

Is this a critical service?	**Y**	**- Critical - does the service have a business continuity plan in place?**	**Y**
		- Non critical - has the service undertaken a Business (Continuity) Impact Assessment?	

5. Measures

How will you know if the actions are making a difference, that the service is achieving its outcomes and that you are providing a quality service?

How can we measure if our customers/service users are better off?

Outcome measures	Baseline (2015-16)	Target					or Range		Responsible officer
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual	Lower	Upper	
£ financial savings achieved on commissioned services (Action 2)	£2.65m less than equivalent budgets in 2015/16	25%	50%	75%	100%			Expenditure within budget	Nathalie Birkett / Kate Allen
Tobacco control and smoking cessation contract: No of four week quitters reported (Action 5)	Target set in new services contract. Scheduling being finalised.				6800	6800			John Tomlinson
HWB members and named key partners have signed the Nottinghamshire Declaration on Tobacco Control (Action 5)	82%	90%	100%	100%	100%	100%			John Tomlinson
HWB members and named key partners have a Tobacco Declaration action plan agreed by their organisation (Action 5)	41%	60%	80%	100%	100%	100%			John Tomlinson
HWB members and named key partners are actively implementing their Tobacco Declaration action plans as evidenced by a quarterly self-assessment template (Action 5)	Newly established target	20%	40%	80%	100%	100%			John Tomlinson
Improvement in Mental Wellbeing score WEMWBS with PH realignment mental health services (Action 6)	To be set in Q1	Estab-lish baseline			Increase from baseline	Increased			Barbara Brady / Susan March

How will you measure, benchmark and compare the quality of the service?

Quality measure	Baseline (2015-16)	Target					or Range		Responsible officer
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual	Lower	Upper	
Submission of health contracts quality and performance reports to Public Health Committee containing detailed performance data on commissioned and realigned services (Action 2)	Quarterly reporting schedule	1	1	1	1				Nathalie Birkett
Quality standards are contained in individual commissioned services specifications and quality schedules (Action 3)	Require-ments set in service specs					Require-ments of specs are met			Nathalie Birkett / Sally Handley

What other measures will help you to plan and manage the service?

Deliverable/quantity/cost measures	Baseline (2015-16)	Target					or Range		Responsible officer
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Annual	Lower	Upper	
The NHS health checks IT and children's 0-19 procurements are completed by 31 March 2017 (Action 1)	Planned time schedules			Contract Awards	Mobilis-ation				John Tomlinson / Kate Allen
Senior managers receive training in quality and clinical governance within six months of restructure taking place (Action 3)	Planned time schedules			2 workshop s held					Jonathan Gribbin / Sally Handley
The refresh of the Health and Wellbeing Strategy is completed by the end of March 2017 for implementation starting 1 April 2017 (Action 4)	Existing HWB strategy previously agreed				Refresh complete				Consultant in PH
Proposals are developed for a Council-wide approach to mental health services (Action 6)	New activity in 2016/17	Report to Public Health Ctte		Proposal develop-ed					Barbara Brady / Susan March
Year 1 of the Young People's Health Strategy Action Plan is implemented by end of March 2017 (Action 7)	Action Plan previously agreed				Identified actions complete.				Kate Allen

The refreshed MoU setting out levels of service to CCGs is in place by October 2016 (Action 8)	Existing MoU extended to 30 Sept 2016			New MoU in place					DPH
Partner engagement between health and spatial planning is established by the end of December 2016 through the development of an agreed spatial planning and health document and an engagement protocol (Action 9)	Planned time schedules		7 districts signed spatial planning and health document	Engage-ment protocol publish-ed					Barbara Brady / Anne Pridgeon
Budget plan is developed to deliver required savings from 2017 (Action 10)	Public Health grant announce ments 2016			£1.75m of recurrent savings identified	Savings plans approved by Council				DPH
Restructure of Public Health is implemented (Action 11)	Proposals and results of consulta-tion		Complete restruc-ture						DPH
Financial savings are achieved in line with OFCs (Action 12)	Budget set for 2016/17 takes OFCs into account	25%	50%	75%	100%			Spend is within approved budget	DPH

Notes:

If performance is monitored at intervals other than quarterly (e.g. monthly, termly) alter column headings or add columns as needed.

Additional Guidance should be followed on the use and reporting of measures/indicators and setting targets. Please discuss with your Performance Business Partner.

Nottinghamshire County Council

Service Profile
2016-17

The Service Profile template provides additional information that has previously been contained with service plans or sought as part of the service review process. The following questions about your service's customers and resources should provide you with a tool

- for identifying needs and opportunities for your service as part of the development of your service plan for 2016 – 17 and
- for sharing those needs with enabling services and transformation programmes such as ways of working so that they can understand your requirements and plan support for your service and
- to provide information for service reviews and future budget development as part of the redefining your council framework and to support the overall the strategic management of the Council.

A. Customers

i. Who are your customers and service users?

Public Health customers are primarily partners. Although PH commissions services at a population level, it is the commissioned providers who deliver these services to relevant target or client groups.

Public Health works with partners in delivery of the statutory health protection role, provision of advice to CCGs, and delivery of health improvement functions. This last category covers a range of behavioural and lifestyle initiatives, generally delivered through partnership arrangements with healthcare providers, employers and organisations. Examples are initiatives to address long term conditions, improve workplace health, and improve health of specific groups, such as older people.

Public Health has an influential role in bringing the key stakeholders together within forums to enable whole system planning, and from a population and health inequality perspective. For Nottinghamshire this is a core remit of the Health and Wellbeing Board.

ii. How and where do they access the service?

For commissioned Public Health services – through arrangements set up by the contracted organisations in accordance with service specifications. This may include access via GP referrals or via pharmacies. Individuals could find out about services through libraries, charitable or third sector organisations, or the internet. Alternatively, other parts of the Council that deliver services directly may provide information on lifestyle initiatives, for example.

Partners can access Public Health services through various partnership working and collaborative arrangements. Identified Public Health Consultants provide links to CCGs and sit on partnership and transformation boards.

iii. What feedback have you had from users about their needs and quality of current service? And how does this compare with others?

Include or reference benchmarking data

For commissioned services: Service specifications for commissioned services are all drawn up with extensive input in terms of needs assessment and analysis, consultation, including with potential service users, and soft marking testing. Benchmarking data is always part of the development of services.

Public Health places a strong emphasis on a variety of science and social science research and evaluation methods to build an informed, explicit and judicious body of current evidence. The basis for establishing need looks beyond simple demand, to PH intelligence and epidemiological data and to scientific evidence about effectiveness and cost-effectiveness. This is used to inform an understanding of need and how best to address this within available resources.

Evidence is gathered as part of the planning process before any soft market testing is started. This information is used to determine the level of need and the most effective approaches to service delivery, which set the scene for all re-commissioning exercises. This stage also involves analysis of data, such as predicting anticipated growth in disease and uptake of services using various limiting factors, for example, differences in level of disease and alternative treatment pathways.

Public Health concentrates on improving outcomes and maximising value for money from the services that it commissions and avoids a focus on ‘outputs’ or activity. This approach requires strategic commissioning, where the provider has control over the delivery process, and Public Health (PH) receives assurance through interim performance measures, quality indicators and long term health and wellbeing outcomes.

Commissioning intentions, procurement activity and service models are therefore not based on perceived short-term opportunities, but on a review of the best evidence regarding effective approaches to service provision.

Soft market testing is a method of gathering market intelligence by engaging with the providers and users of the services in question. The process also looks for innovation and/or alternative delivery models, alongside looking for efficiencies and best value. As most PH services have not been subject to re-tender previously, this is critical for finding out how ready the market is for providing these services to deliver identified PH outcomes.

Engagement with current and potential service users takes place throughout the intelligence gathering and soft market testing phases through equity audit, evaluation and needs assessment. This prolonged period of activity takes place prior to formal consultation.

Consultation follows the soft market testing to formalise the re-commissioning process. PH carries out consultation with relevant stakeholders (which includes providers) to ensure that the preferred models defined by the gathered evidence are the right ones for the community. PH works to the required standards set out by the Council on all consultations to ensure that service changes are properly consulted, fair and transparent. PH will consider all the responses to consultation in finalising their plans for procurement.

The above information relates to service commissioning. Partnership working involves maintaining relationships with partner bodies and through the development of joint and agreed Memorandum of Understanding, Strategies and Action Plans, working together on mutually agreed programmes of work and in line with agreed working methods. Review of these documents provides an opportunity to seek feedback and judge overall satisfaction of partners.

B. Service Design

i. What are the main activities that the service is commissioned to deliver

Commissioned services:
Three of the mandatory functions (NHS health checks, sexual health, National Child Measurement Programme) are directly commissioned, along with the following:

- Tobacco control including smoking cessation
- Combating substance misuse
- Tackling obesity and promoting healthy weight
- Domestic violence and abuse
- Oral health and water fluoridation
- Public health services for children and young people age 0-19 including school nursing, health visiting and the Family Nurse Partnership

Health protection
The local authority statutory health protection role covers the provision of information and advice to relevant parties within their area in order to promote the preparation of, or participation in, health protection arrangements against threats to the health of the local population. It is delivered partly by agreement with NHS (Infection Control service) and partly through partnership working and collaborative roles (e.g. Public Health links to emergency planning).

Health improvement
Public Health works closely with health and other statutory and voluntary stakeholders to support providers and commissioners to engage with Nottinghamshire's populations main illness/premature mortality concerns (including cancer, stroke, CHD, dementia), through a whole system, population approach, enabling NICE evidence, and demographic, financial and equity elements to be incorporated in local developments.

Public Health organises a range of behavioural and lifestyle initiatives, some of which are to address cancer and long term conditions, and some of which are targeted at older people, such as to reduce excess deaths as a result of seasonal mortality, to reduce falls, and to support people with dementia and their carers. There are also initiatives to address the needs of specific groups, such as prisoners or people with a mental illness. Such initiatives are often delivered through partnership arrangements with other organisations.

Advice and Support
Provision of advice to the CCGs is a mandatory function. Advice to the Clinical Commissioning Groups (CCGs) is delivered through a Memorandum of Understanding (MoU) – this includes provision of population health advice, information and expertise to support the commissioning of evidence-based, cost-effective health services.

ii. Do these contribute to or fulfil any statutory requirements or duties

The activities listed above demonstrate that Public Health delivers its five identified mandatory functions, which are as follows:

- NHS health checks,
- Open access sexual health services,
- National Child Measurement Programme
- Health protection statutory role
- Provision of Public Health advice to CCGs
- Statutory functions of DPH

In addition, it is required to use the Public Health grant to support activities which contribute to Public Health outcomes. All the activities supported with the Public Health grant must contribute to Public Health outcomes as set out in the national Public Health Outcomes Framework. These cover overarching indicators such as life expectancy and healthy life expectancy, and indicators linked to specific Public Health issues such as smoking prevalence, low birth weight, excess winter deaths, diagnoses of particular illnesses etc.

iii. To what extent is there scope to reduce the costs of the service through the re-engineering of business processes (eg use of LEAN+)

Service redesign for re-commissioning of services includes identification of value for money efficiencies. Contract design and payment mechanisms are performance-related and drive positive outcomes from commissioned services.

In the light of reducing Public Health grant over the next four years, resource planning is necessary, to review how and at what level services are provided. Plans to do this are included in the service plan, and this will include consultation and engagement with stakeholders.

iv. What anticipated changes in service design will be implemented in 2016/17? What is the anticipated impact?

Restructure with changes to working arrangements – potential to affect staff in terms of managerial location, workload, portfolio areas, and conditions.

Budget reductions in commissioned services – pressure on contracted services to achieve savings

Removal of elements of realigned Public Health grant (some offset by use of reserves) - impact on other parts of the Council.

Changes in arrangements for contracted services – sexual health services and tobacco control are both due to transfer to a new provider on 1 April. Anticipated impact will be to improve service and performance.

C. Resources - Financial

i. What is the service budget?

Actual Expenditure 2015/16 (excluding redundancy costs):

Employees £000	*Running Costs £000*	*Capital Charges £000*	*GROSS EXP £000*	*Grant Income £000*	*Other Income £000*	*NET EXP £000*
			39,705	-39,338	-828	**-461**

Revenue Budget 2016/17:

Running Costs £000	*Capital Charges £000*	*GROSS BUDGET £000*	*Grant Income £000*	*Other Income £000*	*NET BUDGET £000*	
		45,284	-43,260	-1,275	**749**	

Current Budget Pressures & Agreed Savings in MTFS:

	2017/18 £000	*2018/19 £000*	***TOTAL £000***
Budget Pressures	0	0	0
Agreed Savings			0
Projected Budget Changes	0	0	0

- *Note1: Although the Public Health grant appears to be increased from 2015/16, when the additional responsibilities for health visiting and Family Nurse Partnership programme (transferred to Council in October 2015) are factored in, grant for 2016/17 represents a £3.75m decrease.*
- *Note2: Although there are no budget pressures currently identified in the MTFS, the Nottinghamshire Public Health Grant is £750K less than expenditure in 2016/17 and forecast to decrease by a further £1m in 2018/19. Savings of c. £1.8m will be needed to address this cumulative reduction in Public Health grant by 2017/18.*

ii. Does the service generate or rely on any external income? What is the expected income for 2016/17?

Public Health is principally funded through Public Health grant, which has been announced at £43.26m for 2016/17. Other funding is received in respect of specific items e.g. funding from CCGs to support costs of Children's Integrated Commissioning Hub; funding from PCC office as contributions to substance misuse and domestic violence contracts. Overall there is a shortfall of £0.749m in the Public Health budget in 2016/17 and reserves will be used to balance the budget this year whilst options for reductions are identified from 2017/18.

CCGs make contributions to the Children's Integrated Commissioning Hub. There are some small contributions from other organisations e.g. Public Health England, Health Education East Midlands, in respect of specific allowances or activities delivered by staff. Additional resource is also transferred in from CFCS in respect of Family Nursing. Anticipated total income in addition to the Public Health grant in 2016/17 is £1.275m.

iii. How does the cost of the service compare with others?

Include or reference benchmarking data

Public Health grant is allocated by the Department of Health based on a formula which takes account of population, need, health inequality and local service costs.

National allocations for 2016/17 and 2017/18, together with details of all the allocations made to upper tier Local Authorities in England, are available at https://www.gov.uk/government/publications/public-health-grants-to-local-authorities-2016-to-2017

D. Resources - Workforce

i. How many FTE staff provide the service as at 1 April 2016?

48 staff in proposed new structure, of which 7 are on fixed-term contracts owing to time-limited funding / roles.

Plus 4-5 hosted staff on NHS rotational training arrangements - Registrars (in training to become Consultants in Public Health) and FY2 s (trainee doctors) on short term placement.

ii. Are there any known workforce needs or issues during 2016/17?

A restructure of Public Health is planned for implementation in 2016 with changed management structures. Business support staff are due to be transferred to corporate business support. Reduction in staff establishment is being achieved by the removal of vacancies. There will need to be both prioritisation of future work taking account of reducing staffing resource, and support for staff in the changed working environment.

E. Resources - Technology

i. What use is currently made of ICT in the provision of your service?

Hot-desking workstations in standard NCC office accommodation
Remote working through a mix of Get Connected and Lenovo tablet devices. Some individuals have laptops instead of tablets.
Mobile telephony - principally Nokia phones.

A small number of individuals have fixed workstations owing to the presence of adapted equipment or special software to meet either access to work needs or to support specific areas of work.

ii. What planned developments are there for the increased use of ICT?

None.

F. Resources - Property

i. Which properties are currently used in the provision of your service and what are the current staff-to-desk ratios?

Third floor riverside south wing at County Hall (36 workstations) and two bays on ground floor of Meadow House (15 workstations). Staff use these spaces flexibly according to home and meeting locations.

The Meadow House areas are under-utilised 15 workstations in designated area and 12 individuals with MH base. The County Hall space is only just sufficient: staff frequently have to work in nearby Touchdown Zone as there are no available workstations in the Public Health designated area.

ii. Are these properties suitable for the service's needs? Could service delivery be improved or costs reduced by co-locating with any other local organisations or service?

PH reduced its office utilisation at Meadow House during 2015/16 to free up space for others (12 workspaces given up for reallocation).