

Health and Wellbeing Board

Wednesday, 05 June 2013 at 14:00

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

AGENDA

- 1 To note the appointment by the County Council of Councillor Joyce Bosnjak as Chair.
- 2 Appointment of Vice-Chair.
- 3 Minutes of the last meeting held on 17 April 2013 3 - 8
- 4 Apologies for Absence
- 5 Declarations of Interests by Members and Officers:- (see note below)
 - (a) Disclosable Pecuniary Interests
 - (b) Private Interests (pecuniary and non-pecuniary)
- 6 Membership and Terms of Reference 9 - 10
- Mid Notts Transformation Board Presentation 11 - 32
Mid-Nottinghamshire NHS Integrated Care Transformation Programme -
Presentation by Amanda Sullivan and Lucy Dadge.
- 8 Joint Working to Improve the Care of Frail Older People 33 - 38
- 9 Health and Social Care Integration "Pioneers" 39 - 52
- 10 Loneliness in Older People 53 - 66
- 11 Needs Assessment for Children and Young People with Disabilities and/or Special Educational Needs 67 - 126

12	Health and Wellbeing Strategy Consultation Plan 2014-15	127 - 134
13	Work Programme	135 - 140

Notes

- (1) 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

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

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

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday, 17 April 2013 (commencing at 2.00pm)

membership

Persons absent are marked with `A`

COUNCILLORS

Reg Adair
Mrs Kay Cutts
Martin Suthers OBE (Chairman)
A Alan Rhodes
Stan Heptinstall MBE

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

A David Pearson - Corporate Director, Adult Social Care, Health and Public Protection
Anthony May - Corporate Director, Children, Families and Cultural Services
Dr Chris Kenny - Director of Public Health

CLINICAL COMMISSIONING GROUPS

Dr Steve Kell - Bassetlaw Clinical Commissioning Group (Vice-Chairman)
Dr Raian Sheikh - Mansfield and Ashfield Clinical Commissioning Group
Dr Mark Jefford - Newark & Sherwood Clinical Commissioning Group
A Dr Guy Mansford - Nottingham West Clinical Commissioning Group
Dr Jeremy Griffiths - Rushcliffe Clinical Commissioning Group
Dr Tony Marsh - Nottingham North & East Clinical Commissioning Group

LOCAL HEALTHWATCH

Joe Pidgeon - Healthwatch Nottinghamshire

NHS ENGLAND

A Helen Pledger - Nottinghamshire/Derbyshire Area Team,
NHS England

SUBSTITUTE MEMBERS IN ATTENDANCE

Dr James Threlfall - Nottingham West CCG
David Hamilton - Adult Social Care, Health and Public Protection
Department

ALSO IN ATTENDANCE

Councillor Joyce Bosnjak

Lucy Dadge - Programme Director, Mid Nottinghamshire
Integrated Care Transformation Board
Tom Gold - Mid Nottinghamshire Integrated Care
Transformation Board

OFFICERS IN ATTENDANCE

Kate Allen - Public Health
Paul Davies - Democratic Services
Sally Handley - Public Health
Cathy Quinn - Public Health

MINUTES

The minutes of the last meeting held on 6 March 2013 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Rhodes, Dr Mansford, David Pearson and Helen Pledger.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

DEVELOPING VIABLE OPTIONS FOR SHERWOOD FOREST HOSPITALS TRUST AND SURROUNDING HEALTH ECONOMY THROUGH A PARTNERSHIP APPROACH

Lucy Dadge and Tom Gold introduced the report. In summary, a number of care design groups had developed proposals for integrated approaches which would be presented to the Integrated Care Transformation Board on 24 April 2013. At the same time, Sherwood Forest NHS Foundation Trust was reviewing quality, board and financial governance (as required by Monitor) and had participated in the review of quality of care in 14 hospital trusts announced by the Prime Minister in February. Ms Dadge drew particular attention to the involvement of patients and public, and welcomed input from the Health and Wellbeing Board.

Page 4 of 140

During discussion, Board members' comments included:

- The willingness of Healthwatch to become involved.
- The need to look beyond Sherwood Forest Hospitals Trust and the two local CCGs to other hospitals and CCGs.
- Concern about the duplication of scrutiny and effort.
- The Board would wish to know the plans arising from the reviews and their effect on services, particularly services in the community; it might be necessary to mothball some buildings or parts of buildings.
- The blueprint to be presented on 24 April would give detail about the proposals, including the use of the trust's estate and community-focussed.
- The County Council's Adult Social Care and Health Department had been fully involved in the review. Furthermore, there were similar discussions about integrating services in other parts of the county.
- How much influence did the Health and Wellbeing Board have on major providers? This might best be exercised through the Health and Wellbeing Implementation Group.
- Ms Dadge stated that the plans, to be shared the following week, were built around the right configuration of services. She referred to a possible £70 m - £140m funding gap in ten years time. The review was looking at the use of the Trust's estate, including King's Mill, Newark and Mansfield Community Hospitals. Some frail elderly patients could be treated outside hospital, and beds used instead for intermediate care. It was expected to become clearer where care would be accessed and provided.
- How much had the capacity of primary care featured in the reviews? - Mr Gold replied that primary care capacity had not been looked at specifically. However primary care had input to the review. The integrated front door would involve both health and social care.
- To what extent could the hospital estate be used for other purposes, given the commitments under the PFI (private finance initiative) contract? - Ms Dadge referred to the possibilities of disposing of parts of the hospital site, and of backfilling with services currently provided off-site. She emphasised that the PFI contract was not the whole of the financial challenge which the trust faced. Dr Jefford added that decisions on use of the estate would follow decisions about what services were required.
- In terms of the role of the Health and Wellbeing Board in relation to the plans, it was concluded that the Board should continue to monitor progress by way of an item at each meeting. Healthwatch, health scrutiny and CCGs' patient forums would also have a monitoring role.

RESOLVED: 2013/017

- (1) That the Board continue to monitor progress by way of reports to each meeting;
- (2) That the Board notes the progress made to date in the programme of work underway to secure a vision for sustainable hospital and community based services in mid-Nottinghamshire in the future.

HEALTH OF VULNERABLE CHILDREN AND YOUNG PEOPLE

Kate Allen introduced the report on the impact of children and young people's vulnerability on health and wellbeing. The report also outlined a multi-agency response to meet those needs, including the creation of an integrated commissioning function. The Board was invited to sign up to the Department of Health's pledge for better health outcomes for children and young people. Comments made during discussion included:

- If the major determinants of children's poor health were economic, how much difference would the proposals make? - Some local interventions had successfully reduced the impact of vulnerabilities on children's health and wellbeing.
- The integrated commissioning proposals showed the benefits of location Public Health and other services in the County Council. The County Council had continued to follow the principles of Every Child Matters.
- How would the impact of the proposals be measured? - The Children's Trust Board would monitor the impact and submit its findings to the Health and Wellbeing Board.
- The proposals offered excellent opportunities, including working with the wider family.
- It was recognised that accurate data was key. Currently there were too many inefficiencies and data protection issues, as illustrated by the Multi-Agency Safeguarding Hub (MASH) being unable to access health data.
- It would be important to keep a balance between prevention and reaction.
- With so many agencies involved, the Health and Wellbeing Board's oversight would be crucial.
- The range of 7,000 to 12,000 for children with a disability seemed large. - There was no local record of children with a disability, so these numbers had been extrapolated from national figures.
- Particular schools were associated with pupil exclusions. The Education Attendance Service formed part of an integrated approach.
- Why was the current activity of so many 16-18 year olds "not known"? - Partly this was because of the ending of Connexions. Its successor, Futures, continued to offer support to vulnerable young people.

- Placing children in care outside their home area increased their vulnerability. What was the local practice? How did the Police respond when young people went missing? - With the rise in the number of looked after children, and the requirement for high quality placements, the local authority did sometimes place children outside the area. There was a coherent missing child protocol in Nottinghamshire. Further information could be provided.
- The estimated number of young carers seemed low. - The number came from the 2011 census. It was recognised that there could be under-reporting. Nottingham University was undertaking work with young carers.
- Chris Kenny assured the Board that good systems for MMR inoculation were in place locally, and take up was good. He would report later in the year.
- Problems in childhood could result in poor brain development, poor social skills and behaviour, and a lack of confidence. - Primary schools in particular had an effective programme for dealing with this.

RESOLVED: 2013/018

- (1) That the approach summarised in the report to improve the health and wellbeing of vulnerable young people in Nottinghamshire be welcomed.
- (2) That no additional developments are identified to reduce the vulnerability or the impact on health and wellbeing of children and young people.
- (3) That the health and wellbeing of vulnerable children, young people and families be considered when developing the Health and Wellbeing Strategy for Nottinghamshire, recognising the importance of proactively identifying and targeting services to those children and young people who are most vulnerable, whilst reducing contributory health inequality factors.
- (4) That the Board signs up to the Department of Health pledge to improve health outcomes for children and young people.
- (5) That the Board endorses the establishment and scope of work of an Integrated Commissioning Function, as set out in Appendix 2 to the report.

UPDATE ON THE LIVING AT HOME PROGRAMME

David Hamilton gave an update on the Living at Home Programme in Adult Social Care, and responded to questions and comments from the Board.

- In Gedling, the Department was looking at an option with Gedling Homes, and also at the possibility of an extra care project in the longer term.
- He acknowledged the issue of timely assessments of older people in hospital. Often assessments were repeated as people's condition

changed. The Department might move to doing assessments outside hospital.

- The Department was looking at possible duplication with district council projects to keep people in their own homes, and the scope for rationalisation. This work would include an evaluation of what services were most effective.
- What plans were there to encourage older people and carers to focus on alternatives to residential care? - There would be a programme of workshops with partners, which included a presentation to consultants at NUH. There was increasing buy-in from partners.
- It was acknowledged that more could be done to address cultural sensitivities in services which were delivered at home.

RESOLVED 2013/019

That the report be noted.

CODE OF CONDUCT AND DECLARATIONS OF INTEREST

RESOLVED: 2013/020

That the Code of Conduct requirements for Board members, and the arrangements for registering and declaring interests be noted.

WORK PROGRAMME

RESOLVED 2013/021

That the work programme be noted.

DR TONY MARSH

This was Dr Marsh's last meeting before retiring as a GP and Board member. The Chairman thanked him for his contribution to the Board.

The meeting closed at 4.00 pm.

CHAIRMAN

5 June 2013**Agenda Item: 6****REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND
CORPORATE SERVICES****MEMBERSHIP AND TERMS OF REFERENCE****Purpose of the Report**

1. To note the Board's membership and terms of reference.

Information and Advice

2. The membership of the Health and Wellbeing Board is:

County Councillors Joyce Bosnjak, John Peck, Martin Suthers, Muriel Weisz and Jacky Williams

District Council Representatives: Councillors Jenny Hollingsworth and Tony Roberts

Corporate Director of Adult Social Care, Health and Public Protection: David Pearson

Corporate Director of Children, Families and Cultural Services: Anthony May

Director of Public Health: Dr Chris Kenny

Clinical Commissioning Groups: Dr Jeremy Griffiths, Dr Mark Jefford, Dr Steve Kell, Dr Guy Mansford, Dr Raian Sheikh and one vacancy

Local Healthwatch: Joe Pidgeon

NHS England: Helen Pledger

3. The Board's terms of reference are:

3.1 To prepare and publish a joint strategic needs assessment.

3.2 To prepare and publish a health and wellbeing strategy based on the needs identified in the joint strategic needs assessment and to oversee the implementation of the strategy.

3.3 Discretion to give Nottinghamshire County Council an opinion on whether the Council is discharging its statutory duty to have due regard to the joint strategic needs assessment and the health and wellbeing strategy.

- 3.4 To promote and encourage integrated working including joint commissioning in order to deliver cost effective services and appropriate choice. This includes providing assistance and advice and other support as appropriate, and joint working with services that impact on wider health determinants.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To assist the Board in its work.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

- 1) That the Board's membership and terms of reference be noted.

Jayne Francis-Ward
Corporate Director, Policy, Planning and Corporate Services

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

Constitutional Comments

1. As the report is for noting, no constitutional comments are required.

Financial Comments

2. .

Background Papers

None.

Electoral Division(s) and Member(s) Affected All

Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP)

Presentation to the Nottinghamshire County Council Health and
Wellbeing Board

June 5th 2013

Transformation Partnership – leadership vision

- During 2012 and in light of economic and demographic pressures, Health and Social Care leaders agreed that a whole-system strategic service review was required to identify options for a sustainable health economy across Mid-Nottinghamshire.
- Both Commissioners and Providers of services to the locality have agreed that the work must focus on meeting population health needs, and that whilst organisational impacts will be differential, they must not take precedence over reaching a system-wide solution.
- It was recognised early on that to create a whole system solution would require **fully integrated hospital, community, primary and social care**
- This requires incremental and transactional service improvement, but also **transformational change**.
- Patients, not organisations, must be at the centre of the transformation; and able to manage their own care where possible and easily access the right services at the right time.
- The first phase of work comprising detailed analysis of current baseline, together with clinical leadership to scope new ways of working that meet population health needs completed in April. This has produced a **“blueprint” for how services should look in 3 to 5 years**. This now needs wider stakeholder engagement to support implementation over 1 to 2 years.

What do we mean by integrated care ?

Definition

Integrated care refers to a way of organising services whereby the patient's journey through the system of care is made as simple as possible. It is:

“Care, which imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless.” (Lloyd and Wait (2005))

Five principles

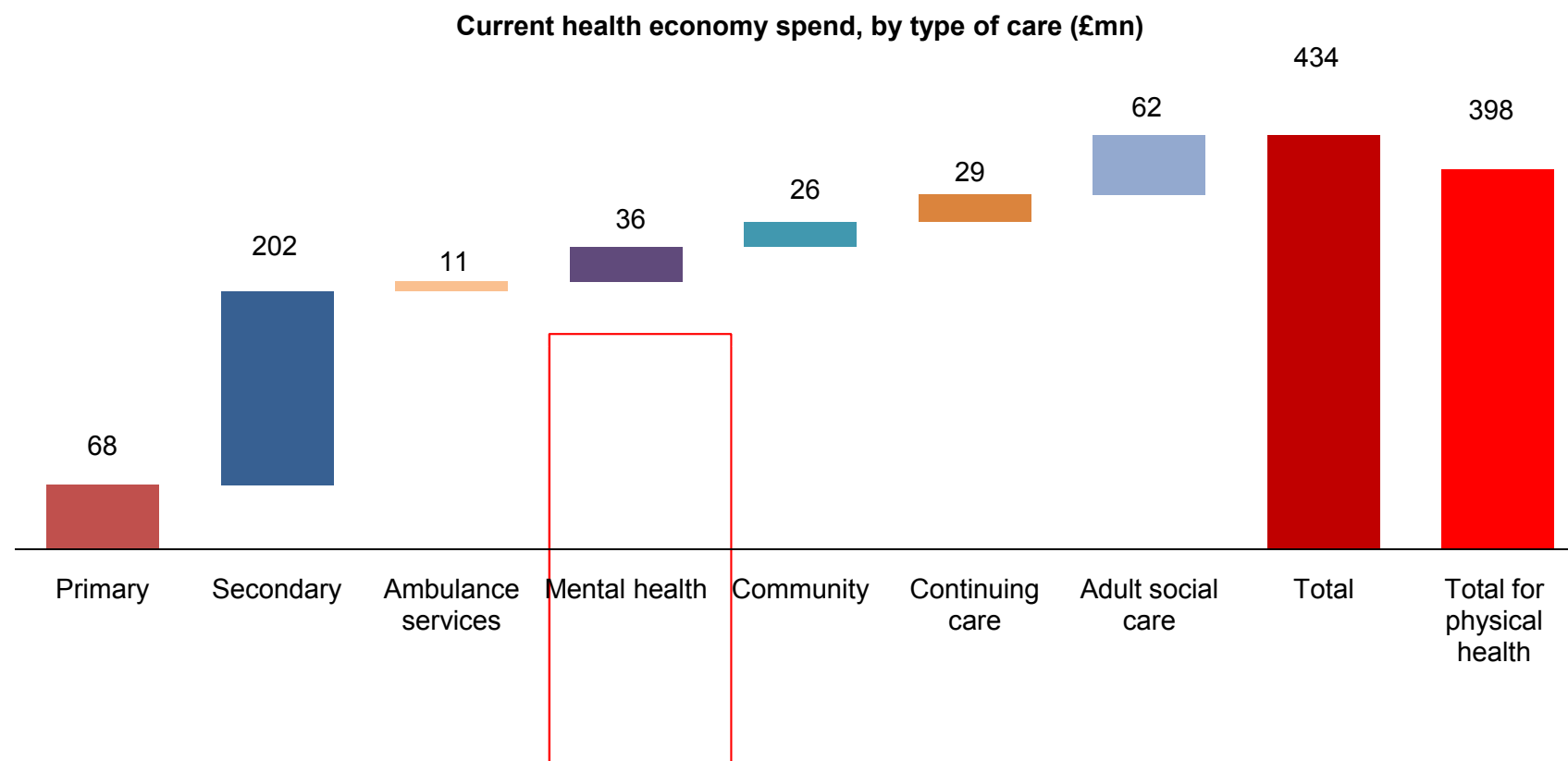
- Integrated care must focus on those patients for whom current care provision is disjointed and fragmented, mainly complex patients with co-morbidities.
- Effective clinical leadership must exist, to promote changes in clinical behaviour.
- The interaction between generalist and specialist clinicians must promote real clinical integration.
- There must be integrated information systems that allow the patient's journey to be mapped across a care pathway at any moment in time.
- Financial and non-financial incentives must be aligned to provide the conditions to ensure that care delivery is of high quality and cost-effective.

What do we know about our local services ?

Through discussions with care professionals, patients and their representatives and carers the following were established as key challenges to how care is delivered to the public:

- Poor communication across organisations and a lack of integration of services;
- A lack of understanding of the services available and how to access these services;
- A lack of focus on prevention and treatment of patients in an out of hospital community setting
- A significant increase in the number of frail and elderly people in the population who require higher levels of care
- A significant increase in the number of births, putting an increased demand on services
- The relatively low proportion of local people accessing the local acute hospitals for elective services

How much do we currently spend on local services ?



Sources: Newark and Sherwood CCG Integrated Plan, Community data, CCGs' 'Plan on a page' documents, Audit Commission Value-for-money profiles

Why do this work now ?

The population of over 75s in Nottinghamshire is set to increase by 25% by 2020. For Mid Nottinghamshire alone, the impact of the projected population growth in 2013/14 amounts to;

- Circa **4,000 additional A and E attendances**
- Circa **2,200 additional non-elective admissions**
- Circa 23,000 additional occupied bed days = **66 additional beds**

Whilst the current overall spend across this health economy is £434m, by the end of FY12/13, there will be a financial gap of **£19m**. Population growth and costs of provision are due to increase far ahead of funding, meaning that:

- Long term conditions currently account for 50% of GP consultations and 70% of hospital in-patient bed stays. The number of people with long term conditions is expected to rise by over 250% by 2050
- In 5 years, the **£19m** gap will have grown to **£70m**, in 10 years, the gap will be **£140m**

The current health and social care system of provision is unsustainable

Blueprint proposals– Maternity and children's care

Initiative	Quality benefit	Measure
Short stay paediatric assessment unit – offers assessment as opposed to admission	Consultant led, but with community nurse support, providing better decision-making. Less stressful for patients as fewer and shorter hospital stays	Reduce short stay admissions by up to 70%
Short stay ante-natal assessment unit – 24 hours	Less time in hospital, enhanced delivery outcomes, and additional support to complex social care needs	Reduce short stay admissions by up to 50%
Paediatric referral optimisation	Increased clinical input to reduce inappropriate referrals and un-necessary emergency admissions. Less stressful for patients and improved support for GPs.	Reduce emergency admissions by 20%. Make better use of out-patients clinics
Integrated Children and Young Peoples Health Care Programme	Providing co-ordinated support to enable children and young people with complex needs to lead normal lives, improve safeguarding outcomes and the social, health and economic prospects of carers	Reduced emergency admissions and in-patient lengths of stay

Implementing these initiatives could give rise to financial savings of £4m p.a.

Blueprint proposals– Elective services

Initiative	Quality benefit	Measure
Review and improve referral processes	<p>Reduction in inappropriate referrals frees up clinic time for better use.</p> <p>May result in more patients being able to access local services where they are viable and high quality</p>	Where referral rates exceed national average, they will be normalised
Service viability review	Ensure that services are commissioned on basis of best outcomes, and that patients can receive the right highest quality secondary services in their locality with appropriate tertiary support/referrals as required	More high quality secondary care services provided from local hospital facilities

A work in progress, but

Implementing these initiatives could give rise to financial savings of £7m p.a.

Blueprint proposals – Urgent Care; responding to crises for the whole population

Initiative	Quality benefit	Measure
Crisis Hub/clinical navigator	Improves patient experience, removing their problems navigating around providers, and keeps them at home where possible Avoid un-necessary A and E attendances	Reduce A&E attendance by 12% and admissions by 10%
Integrated urgent care service at Newark and Mansfield – “single front door” – primary, social, community and A&E/MIU and assessment/ clinical decision units	More clarity for staff/patients on appropriate care pathway when in crisis, and better experience from reaching right destination quickly Less variation in service and more capacity through joint working with secondary and primary care	Productivity improvement across A&E and GP out of hours of 20% Reduction in NEL length of stay =3,500 bed days
GP Provision – same in the early evening as early morning	Fewer sub-acute patients will present early evening where the demand profile is significantly greater than the regional average	Reduction in A&E attendances and resultant admissions
Streamlining urgent care referrals – enhanced role for ambulance service	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings should result in more patients being treated at home/in the community, rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances and admissions

Implementing these initiatives could give rise to financial savings of £10m p.a., but will require re-investment in community and other services

Blueprint proposals.... Integrated pro-active care for frail elderly and those with long term conditions

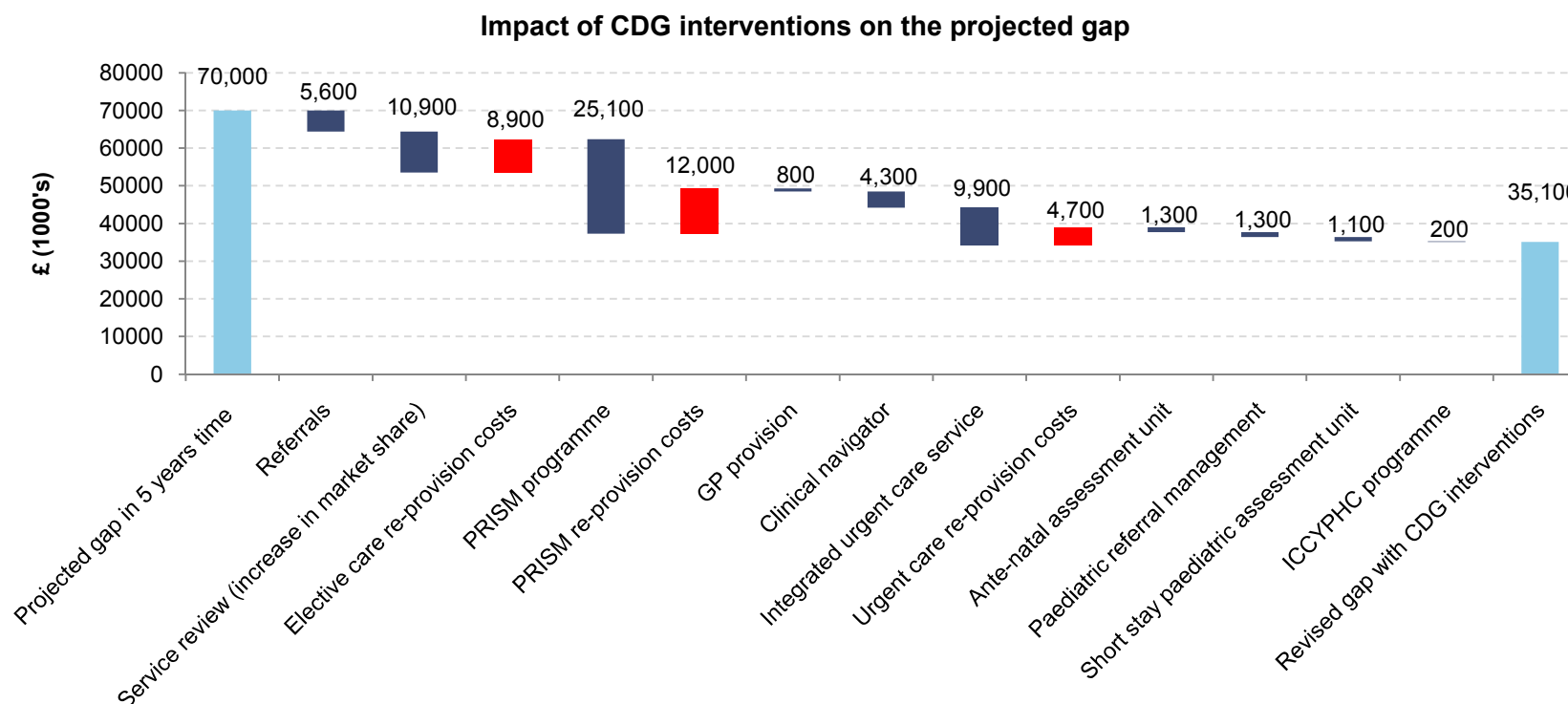
Initiative	Quality benefit	Measure
Enhance domiciliary and intermediate care	Patients able to live more independently, stay at home longer, and have emotional, physical and social care needs assessed together	Reduce hospital admissions and re-admissions and length of stay Reduce nursing/care home use
PRISM – Profiling Risk Integrated Care Self Management	By identifying and case-managing at risk citizens within the community, emergency admissions will be reduced and the outcomes for the frail elderly and those with long-term conditions (including cancer) will be improved Patients and carers will be more involved in managing their own care and will feel less isolated	Reduce admissions by up to 30% and re-admissions by 10% Reduce length of stay by 30% Reduce prescribing costs by £1m Reduce residential care demand by 25%
Extend the integrated community discharge service	Better patient and carer experience Reduction of hospital acquired complications Prompt and pro-active identification of end of life care Patients discharged for assessment where possible – reducing burden of S2 and S5 assessments	Increased discharges to home and reduced time from discharge to home Reduced patients in long term care Reduced average length of stay
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment should reduce hospital acquired complications, maintain function level of patients and improve end of life care	Reduce number of admissions from care homes, and length of stay for care home admissions

Implementing these initiatives could give rise to net financial savings of £13m p.a., but will require circa £12m re-investment in community and other services

Summary financial impact of blueprint proposals

Financial Savings

The graph below provides a breakdown, by intervention, of the estimated savings (against current model / cost of provision) to be made through the delivery of the future model of care. In summary, the interventions identified will reduce the potential 5 year financial gap of **£70m** to **£35.1m**.



Source: PwC analysis – This analysis is based on the PRISM programme achieving a 30% reduction in admissions

What does integrated care look like in practice?

Already piloted in Newark and Sherwood, the locality based “virtual ward” or multi-disciplinary team (MDT) comprising:

- Community matrons
- District nurse
- Occupational therapist
- Physiotherapist
- Mental health worker
- Social worker
- Health care assistants
- Voluntary/third sector workers
- Ward co-ordinator/manager

Underpinned by

- Increased provision of intermediate care beds (Step up and Step down)
- Community based clinics (e.g. cardiovascular disease, COPD, diabetes) with secondary consultant specialist support
- Rapid Assessment and Intervention Service
- Care homes integrated into the “virtual wards”, so patients treated as if they were in their own home
- Specialist case managers for COPD, heart failure, diabetes and care homes
- GP practice teams integrated and aligned with “virtual ward teams”
- Improving provision of carer support, information and education
- Engagement of voluntary sector services to improve patient/carers support

How does integrated care make a real difference ? A case study

Pat's story;

- 60 year old lady, endocrines disease, recurrent pneumonia (due to complex lung and heart disease), anxiety and previous history of alcohol abuse
- Risk score of 98% risk of admission – admitted every winter for the last 4 years with recurrent chest symptoms
- Discussed at MDT and admitted to “virtual ward” – input from respiratory physio, OT, mental health worker and community matron
- Learnt new breathing techniques, knows when to use rescue antibiotics and has a number to call when she feels she needs assessment/advice
- Biggest change to her ability to cope with her illness at home has been work done to reduce her anxiety. Mental health worker has worked with her and her family to help them deal with panic symptoms
- Risk of admission dropped to 73%; she has not been admitted to hospital for over 4 months now, even though she has had 2 chest infections

Some testimonials from the PRISM integrated care pilot.....

Community Matron;

- *“ One of my patients had been regularly calling 999 and being admitted to hospital. He is in his 80s and his needs are really social rather than medical. We discussed how we could best give this gentleman the care he really needs. Within 60 minutes our Ward Social Worker had arranged a respite bed. Instead of hours spent on the phone trying to refer, things happened immediately”.*

Social Worker;

- *It's just fantastic how quickly I can get services in place for my patients – from hours spent previously via phone and e mail trying to refer PRISM integrated care allows it to happen immediately”.*

Nurse;

- *Sitting in the MDT meeting today, listening to all these people involved in caring for your patients, was such a humbling experience. I feel so proud to be part of this project – I think it's probably the most important thing I've ever been involved in as a nurse”.*

Patient;

- *(Before) I only had my GP and Community Matron. I didn't want to bother people. I felt I would never get better. (Now) I have had less hospital visits, I understand my body better, am determined to carry on, feel more confident and supported.*

Integrated care – the headlines

Before	The future
Different people looking after various conditions for a single patient	Integrate care across the whole system and embed care planning and shared decision making in to everyday practice
Hospital often the only option for a patient when their condition worsens	Incorporate a population wide approach to care and not just a reactive response
Services only available within office hours with little or no joined up arrangements out of hours	Deliver services where patients need them and make access available seven days a week

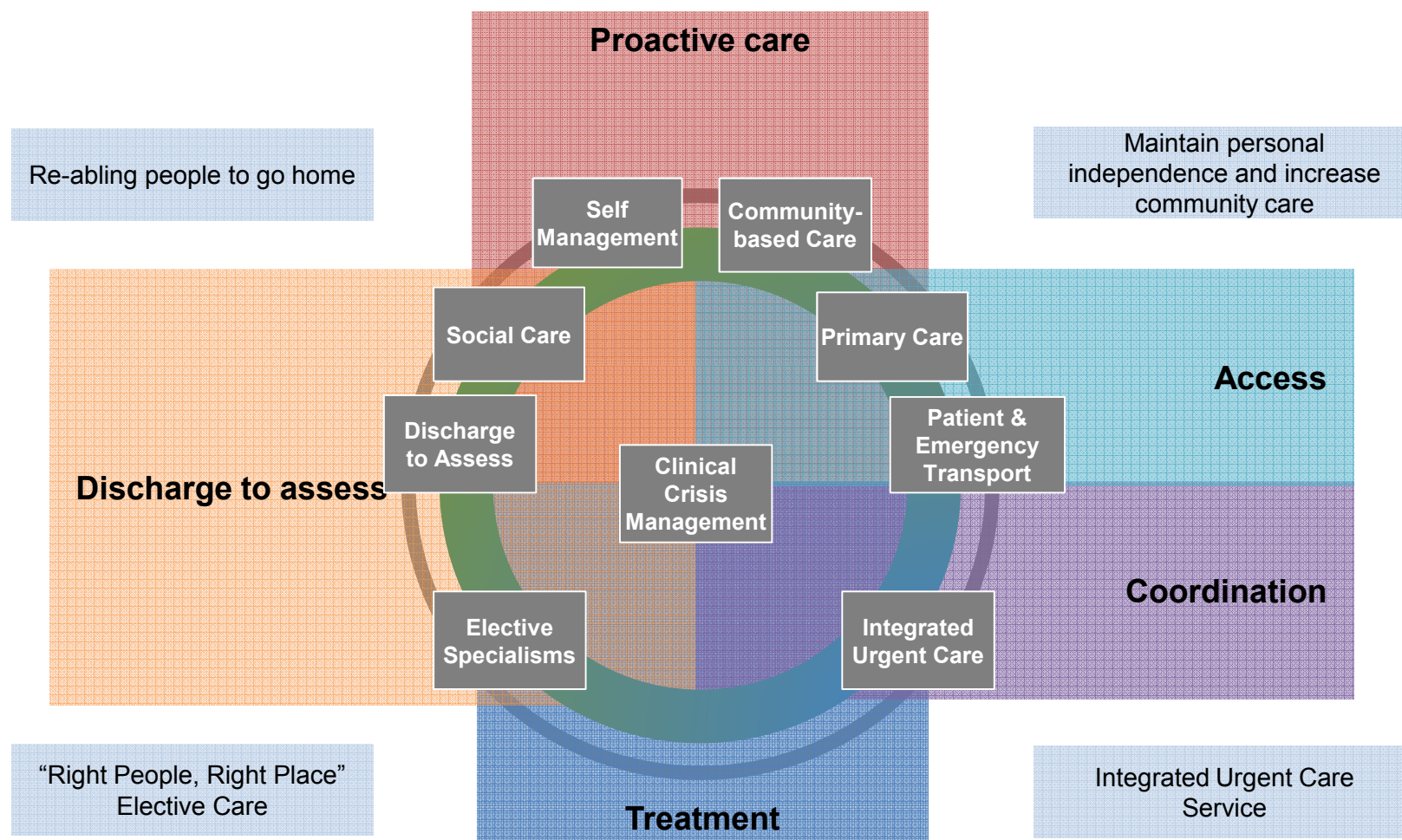
Systematically implement;

Risk profiling, integrated services, care planning and self-management



Fewer unplanned admissions, better patient outcomes and satisfaction, improved quality of care

Future Model of Care for Health and Social Care Services



Conclusions

Truly integrated health and social care in Mid Nottinghamshire should;

- Enable care to be at home or close to home wherever possible, thus optimising patient and carer independence
- Improve the experience of patients in crisis – offering a “single front door” approach where all of the services come together; acute, community, mental health, primary and social care
- Significantly reduce acute hospital admissions, freeing up in excess of 100 acute beds
- Provide opportunities to use our best quality local hospital facilities to increase sub-acute and intermediate care capacity
- Bridge at least 50% of the projected financial gap based on current population health projections
- Create a more highly skilled workforce, with time to innovate

Next steps - learning from other systems

Positive precursors for success of the Transformation Partnership

- Foundation of joint working between health and social care exists
- Shared understanding of integration
- Joint desire to deliver vision regardless of organisational challenges
- Strategy fits with JSNA

Possible challenges

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

Ensuring successlearning from other systems

- Establish joint governance and accountability early on
- Have a high tolerance of risk to achieve the vision – don't be scared to press on even if every detail isn't worked through
- Use front-line teams to design services and don't miss simple and inexpensive innovations that can have a major impact
- Invest in organisational development and change management to overcome cultural and organisational differences, financial and other risks
- Base the strategy on benefits to patients ... then specify, communicate, monitor delivery, and iterate

And

- Health and Wellbeing Board actively engaged to ensure that transformation is evidence based and responds to local community's needs through joined-up provision

Next steps - timescales

A detailed delivery “roadmap” is being prepared, but key steps include;

Immediately

- Individual organisations continue to work through the impacts of the new integrated care models e.g. financial, workforce, estate
- Care professionals and stakeholder/citizens representatives to take forward detailed design of new services and pathways

Summer 2013

- Engagement exercises to run alongside development of new models of care
- CCG and Local Authority commissioning forum to be established to develop appropriate commissioning/contracting models
- On-going evidence-based analysis of outcomes of new care model
- System-wide estate and ICT strategy to be developed

2014 onwards

- Changes to be implemented from years 2015/15, with whole system changed embedded within 5 years

**REPORT OF THE CHIEF CLINICAL OFFICER, NOTTINGHAM WEST
CLINICAL COMMISSIONING GROUP****JOINT WORKING TO IMPROVE THE CARE OF FRAIL OLDER PEOPLE****Purpose of the Report**

1. This report provides an update on the work of the Strategy and Implementation Group for Nottingham South (SIGNS) It confirms the Frail Older People's programme's strategic priorities for change and outlines shared principles and campaign to improve care for frail older citizens.

Information and Advice**Introduction**

2. Supporting older people is a stated priority in the Nottinghamshire County Health and Wellbeing Board Strategy, the draft Nottingham City Joint Health and Wellbeing Strategy and the Clinical Commissioning Group (CCG) Commissioning intentions.
3. Health and social care commissioners and providers have been working together since August 2012 to develop a shared understanding of how to deliver improvements in care and support for older people/citizens, initially through Productive Notts, but latterly through the Frail Older People programmes in the South under the Strategy and Implementation Group for Nottingham South (SIGNS) group and through the North Notts Care of the Elderly Network (NNCEN - Mid Notts).
4. This report provides an update on the work of the SIGNS group in the South of the County. This group includes representatives from Nottinghamshire County Council, Nottingham City Council, Nottingham City CCG, Rushcliffe CCG, Nottingham West CCG, Nottingham North and East CCG, County Health Partnerships, Nottingham CityCare Partnership, Nottinghamshire Healthcare NHS Trust and Nottingham University Hospitals (NUH). Nottingham is used in this report to refer to the South of the County and Nottingham City.

Context

5. Nottingham's services are under pressure, in particular because of demography (ageing population) and financial constraint. Nottingham City Council must save £20m during 2013 /2014, Nottingham University Hospitals £50m during 2013 /14 and Nottinghamshire County Council £70m over the next 4 years. Many other health and social care systems have

responded to similar pressures, with varying degrees of success, by integrating a whole system response.

6. Nottingham has, thus far, responded somewhat less coherently with waves of incremental projects and new pilots, funded by transformation and other monies. Promisingly, these will shortly provide (multiple) single points of access to health and social care, improvements to some community services and improvements to some hospital processes.
7. Despite, or perhaps because of this approach, in winter 2012 / 2013, 128 new beds opened at NUH to meet demand for emergency care and emergency admissions. It has been estimated that if we continue to deliver services in the way that we currently do, then we will collectively need an additional £80m across Nottingham City and Nottinghamshire County by 2020 to care for our ageing population by expanding all of our current services.

Our Campaign: how might we care better for Nottingham's Frail Older Citizens?

8. The SIGNS group has endorsed a shared a set of principles and a shared campaign to improve care for frail older citizens:

OUR PRINCIPLES

Together, we focus on the needs of our citizens

- We enable our citizens to remain independent
- We integrate around our citizens

Together, we take and share responsibility

- We plan together, work together and improve together
- We solve problems together and we share credit

Together, we simplify how our system works

- We work to achieve and then exceed our shared Standards
- We assess frail older citizens' needs using Comprehensive (Geriatric) Assessment (CGA) to ensure:
 - early identification and intervention if the risk of illness or decline in function is high
 - a rapid and flexible response in case of functional decompensation or social crisis
 - access to a wide spectrum of reablement (recovery and rehabilitation) support to maximise return to independence

What are the problems we need to work together to address in the way that we deliver care?

9. People are admitted to hospital when alternative services could have met their needs and stay in hospital longer than they need the services of an acute hospital (Utilisation review 2010).

10. Not all patients who need it are under the care of old age specialists in an appropriate ward in hospital.
11. Despite improvements, there are still 60-70 patients a day waiting to leave Nottingham University Hospital who are medically safe to move to their next place of care.
12. We send people to care homes who may not need to be there (average age on admission to care homes is 83 in the County against a national average of 87).
13. We have not aligned our processes to be as efficient as possible (multiple assessments by different clinicians/providers).
14. Different models of community based services are emerging in CCGs which risk complicating pathways out of NUH.
15. Services delivered by Social Care do not all align with emerging CCG models.
16. We have an ageing population and demand for services increases exponentially with age.

How might citizens explain our campaign?

OUR CAMPAIGN

Part One: Support to Thrive

- I wish to retain my independence.
- All services that I use are seamless as I move between them.
- My needs are assessed using Comprehensive (Geriatric) Assessment of Frail Older People (CGA) to ensure that support is there when I need it:
 - to try and stop a predictable problem getting worse
 - to help me recover and rehabilitate after illness
- If I go into hospital for a planned operation, my rehabilitation is booked at the time I agree to my operation and my home aids (such as a walking frame) are delivered before I am admitted.
- I receive support at home which reduces the need for me to move to a care home.
- If I move to a care home, the staff are properly trained and supported. They look after me in obvious partnership with any other services needed.

Part Two: Choose to Admit

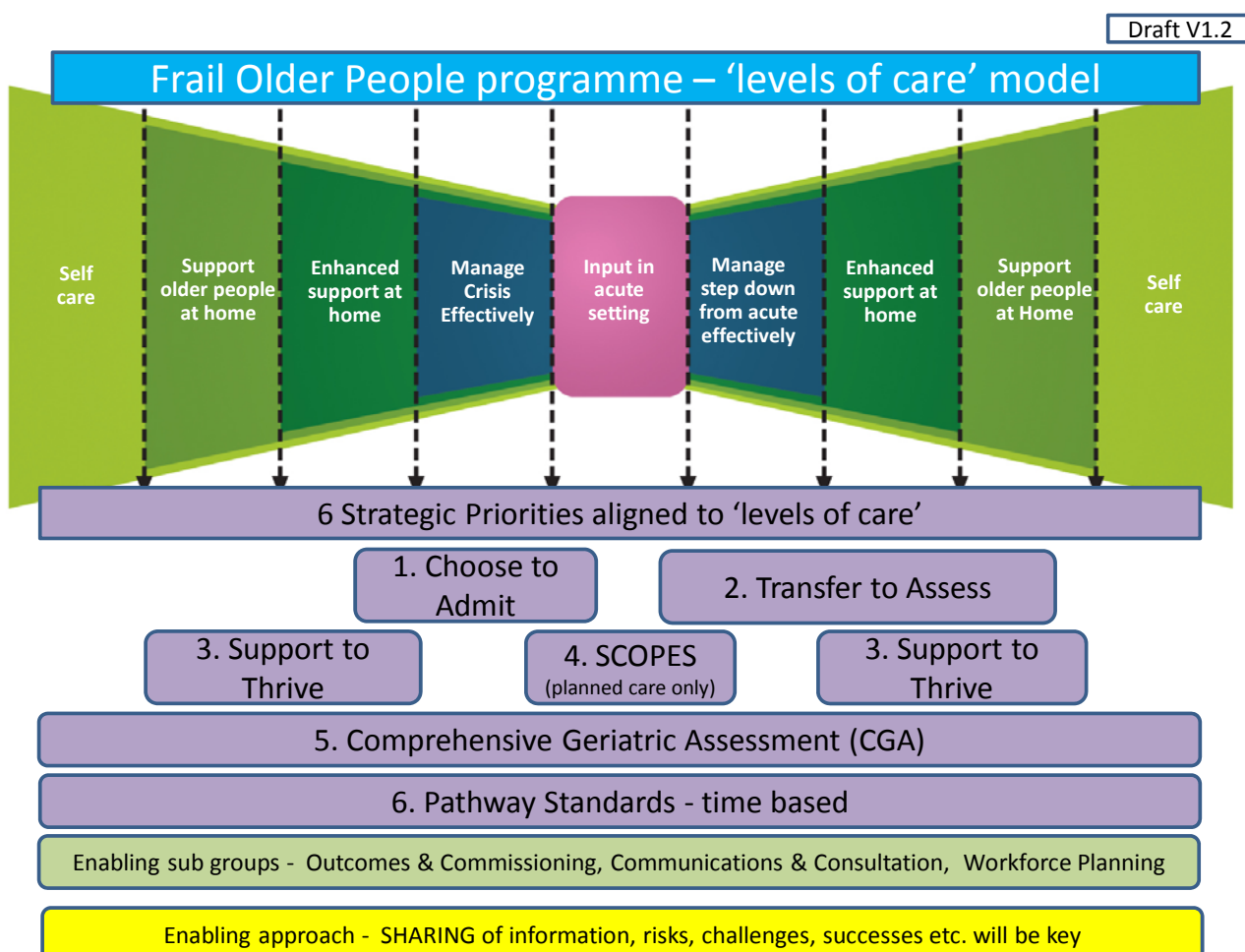
- I wish to retain my independence.
- I am not admitted to hospital because other services are not available when I need them.
- Hospital is there for me if I have a life threatening illness or if I need an operation.
- If I go into hospital for a planned operation, my rehabilitation is booked at the time I agree to my operation and my home aids (such as a walking frame) are delivered before I am admitted.
- I will see a doctor who is a specialist in medicine for older people if this is needed.

- When I am unwell, I am assessed using Comprehensive (Geriatric) Assessment to ensure that support is there when I need it:
 - all my needs are considered
 - there is a clear plan to which everyone works (including me).

Part Three: Transfer to Assess

- I wish to retain my independence.
- I leave hospital as soon as my health is stable enough for me to do so.
- I do not stay in hospital because other services are not available when I need them.
- Staff on my ward organise what is needed for me to leave hospital.
- If I need ongoing care or rehabilitation out of hospital, I receive it.
- While I am recovering, my care is planned using Comprehensive (Geriatric) Assessment to ensure that support is there when I need it:
 - all my needs are considered
 - there is a clear plan to which everyone works (including me)

What are we doing?



17. At its meeting on 14th May 2013, the SIGNS group confirmed that the Frail Older People's programme's strategic priorities for change are:

- Choose to Admit
- Transfer to Assess
- Support to Thrive
- SCOPES (Systematic care for older people in elective surgery)

18. These are all underpinned by:

- Comprehensive geriatric assessment (CGA)
- Time based pathway standards

What are the next steps?

19. Health and social care colleagues will be building on existing work and collectively developing a more detailed set of proposals under the themes of Choose to Admit and Transfer to Assess which will be brought to the next SIGNS group in June 2013. Some proposals will aim to deliver change by September 2013; others will have longer timeframes.

20. An overriding principle is to build on best practice but to develop a model that fits local needs in Nottingham. A new opportunity to express interest in becoming a national health and social care integration 'pioneer' has been received enthusiastically but the implications of this are still being considered.

21. A presentation will be taken to the JHSC on 11th June 2013.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) The Health & Wellbeing Board is asked to note the report

Dr Guy Mansford

Chief Clinical Officer, Nottingham West Clinical Commissioning Group

For any enquiries about this report please contact:

Jane Laughton

Strategic Lead, Choose to Admit and Transfer to Assess

Jane.Laughton@nottshc.nhs.uk

Constitutional Comments

23. As this report is for noting only constitutional comments are not required.

Financial Comments (KAS 22/5/2013)

24. There are no financial implications contained within this report.

Background Papers and Published Documents

None

Electoral Division(s) and Member(s) Affected

All

5 June 2013**Agenda Item: 9****REPORT OF CORPORATE DIRECTOR OF ADULT SOCIAL CARE, HEALTH
AND PUBLIC PROTECTION****HEALTH AND SOCIAL CARE INTEGRATION ‘PIONEERS’****Purpose of the Report**

1. The report will provide a brief update of the current situation in Nottinghamshire with regard to integration ‘pioneers’.

Information and Advice

2. On May 14th 2013 the first ever system-wide shared commitment involving 12 of the national leaders of health and social care was issued. The collaborative of national partners signed up to a series of commitments on how they will help local areas integrate services. [‘Integrated care and support: our shared commitment’](#) sets out how local areas can use existing structures like Health and Wellbeing Boards to bring together local authorities, the NHS, social care providers, education, housing services, public health and others to make further steps towards integration.
3. Partners involved in this initiative include the Association of Directors of Adult Social Services (ADASS), the Association of Directors of Children’s Services, the Care Quality Commission, Department of Health, Local Government Association, Monitor, NHS England, NHS Improving Quality, Health Education England, the National Institute for Health and Care Excellence, Public Health England, the Social Care Institute for Excellence and Think Local Act Personal in association with National Voices.
4. The plans, which will be delivered by national leaders and local areas working closely together, include:
 - an ambition to make joined-up and coordinated health and care the norm
 - the first ever agreed definition of what people say good integrated care and support looks and feels like, developed by National Voices
 - new ‘pioneer’ areas around the country to be announced in September 2013
 - new measures of people’s experience of joined-up care and support by the end of this year

5. Since the publication of the commitment and the opportunity to complete an expression of interest in becoming a pioneer there have been a number of conversations between health and social care leaders in Nottinghamshire about the latter. There is great deal of enthusiasm across most local commissioners and providers about putting forward a bid to be considered as a pioneer in the first cohort.
6. In order to be selected as a pioneer the expression of interest has to address the required criteria, and be submitted by 28th June 2013. The selection criteria can be found in the paper **attached**. Successful pioneers will be announced in September 2013 and will then receive specialist support from the Department of Health over a 5 year period.
7. Pioneers will be expected to act as exemplars and contribute to accelerated learning across the national health and social care system.
8. Chief Operating Officer for Newark and Sherwood CCG, Amanda Sullivan, has offered to co-ordinate submission of the expression of interest and an initial conference call to scope out the work required for completion of this by the deadline took place on Friday 24th May.
9. The involvement and support of the local Health and Wellbeing Board is seen as an essential pre-requisite for any area to become a pioneer.

Reason/s for Recommendation/s

10. There is already a lot of work going on in the county to improve and speed up the integration of health and social care services and this is seen as an excellent opportunity to take this forward.

Statutory and Policy Implications

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

Implications for Service Users

The intention of the commitment, and the pioneers, is to encourage improved integration and the removal of barriers for the benefit of patients, service users and local communities.

Financial Implications

The pioneers will have the opportunity to look at different ways of contracting services and different payment systems.

Equalities Implications

Expressions of interest to become pioneers have to demonstrate how better outcomes will be delivered across the whole social care and health system, and how the locality will deliver greater prevention of ill health and deterioration of health through better integrated care and support and the involvement of the community and voluntary sectors.

RECOMMENDATION/S

- 1) That the Health and Wellbeing Board notes the contents of the report
- 2) That the Health and Wellbeing Board supports the submission of an expression of interest to become an integration pioneer.

David Pearson

Corporate Director, Adult Social Care, Health and Public Protection

For any enquiries about this report please contact:

Jennie Kennington

Senior Executive Officer

Constitutional Comments (LMc 28.05.13)

12. The recommendations in the report fall within the remit of the Health and Wellbeing Board.

Financial Comments (NR 28.05.13)

13. There are no financial implications arising directly from 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.

Department of Health Guidance, May 2013: ['Integrated care and support: our shared commitment'](#)

Electoral Division(s) and Member(s) Affected

All

LETTER INVITING EXPRESSIONS OF INTEREST FOR HEALTH AND SOCIAL CARE INTEGRATION 'PIONEERS'

To:

Local authority chief executives
Chairs of Health and Wellbeing Boards
CCG clinical leads
Provider CEOs across the social care and health system – public, private and voluntary

Dear colleagues,

The Government is encouraging all areas to develop their own reforms to public services. This approach involves all services and builds on experience from the community budget pilots supported by the Department for Communities and Local Government. A collaborative of national partners¹ has now set out an ambitious vision of making person-centred coordinated care and support the norm across the health and social care system in England over the coming years. ***Integrated Care and Support: Our Shared Commitment*** published today, signals how this national partnership will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better integration for the benefit of patients, people who use services, and local communities.

All localities need to develop plans for integration. There is no blueprint. While elements of different models will be transferable, every locality is unique and needs to develop its own model of integration to suit the needs of local people. But we know that delivering better coordinated care and support, centred on the individual, is difficult and that there are barriers at national and local level that are getting in the way.

The national partnership is therefore inviting expressions of interest from local areas to become integration 'pioneers' as a means of driving forward change at scale and pace, from which the rest of the country can benefit. We are looking for pioneers that will work across the whole of their local health, public health and social care systems and alongside other local authority departments and voluntary organisations as necessary, to achieve and demonstrate the scale of change that is required. The local area could comprise of the area covered by a particular CCG or local authority, or a larger footprint in which different authorities and health bodies work together to enable integrated services. What is important is that it would be at a scale at which a real difference can be made.

¹ Association of Directors of Adult Social Care, Association of Directors of Children's Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

We will provide tailored support to pioneers. In return, we expect them to be at the forefront of disseminating and promoting lessons learned for wider adoption across the country.

National partner organisations are already working to clarify the scope and extent of the freedoms and flexibilities in the system. These will allow localities to innovate and develop their chosen models for integrated care and support. We will seek to address at local level any additional barriers that emerge as pioneers and other local areas push forward on integrated care and support, and we will assess whether any rules should be changed at the national level, as a result.

The attached annex sets out our vision for pioneers, the criteria and process for selecting them, and the offer of support from national partners, helping us succeed together in meeting our shared aspirations. As we want to enable and encourage local innovation², we would be interested to receive expressions of interest from commissioners and providers. This includes any that might not yet have all of the prerequisites in place but nevertheless have innovative ideas and proposals worthy of further consideration. Any gaps against the criteria could be addressed during the process of pioneer selection for inclusion in the first, or subsequent, cohorts.

If you would like to be considered to become a pioneer, please send an expression of interest, addressing the required criteria on no more than 10 pages, to pioneers@dh.gsi.gov.uk by 28 June 2013. This is the first call for expressions of interest, and we expect there will be further calls in future years as momentum builds and progress is made across England.

We are working closely with the Department for Communities and Local Government and the Public Service Transformation Network – a multi-agency organisation with secondees from across national and local government and local public services - to ensure that the health and social care pioneers programme is closely aligned and integrated with support that the Network will provide to local public services. If you have already submitted an expression of interest to work with the Network and wish also to be considered as a health and social care pioneer, please send an expression of interest. We will work with the Network to ensure that we take account of this as part of the pioneer selection process.

If you have any queries, please contact us at pioneers@dh.gsi.gov.uk.

We look forward to receiving your proposals.

² Innovation: “An idea, service or product, new to the NHS or applied in a way that is new to the NHS, which significantly improves the quality of health and care wherever it is applied.” **Innovation, Health and Wealth (2011)**

Pioneers in integrated care and support: Selection criteria, process and national support offer

1. Introduction

In our joint publication today, ***Integrated Care and Support: Our Shared Commitment***, a collaboration of national partners³ has set out an ambitious vision of making person-centred coordinated care and support the norm across England over the coming years. We have signalled how we will work together to enable and encourage local innovation, address barriers, and disseminate and promote learning in support of better person-centred, coordinated care for the benefit of patients and people who use services, their carers and their local communities more generally.

For the most ambitious and visionary localities, we will provide additional bespoke expertise, support and constructive challenge through a range of national and international experts to help such pioneers realise their aspirations on integrated care. This approach builds on the community budget pilots, which provided insights into co-designing integrated health and care at scale and pace. The pioneer programme will link directly with the development of a Public Service Transformation Network extending across government and participating localities.

We want everyone to innovate and we have highlighted in our publication today the freedoms and flexibilities in the system. We will seek to address at local level any additional barriers that emerge as pioneers push forward and we will assess whether any rules should be changed at the national level, as a result.

We aim to stimulate successive cohorts of pioneers, supporting them for up to five years. In return, we expect them to contribute to accelerated learning across the system.

³ Association of Directors of Adult Social Care, Association of Directors of Children's Services, Care Quality Commission, Department of Health, Health Education England, Local Government Association, Monitor, NHS England, NHS Improving Quality, National Institute for Health and Care Excellence, Public Health England, Social Care Institute for Excellence, Think Local Act Personal.

2. Our expectations from pioneers

Within five years, we expect pioneers to:

→ **be regarded as exemplars:**

- deliver improved outcomes, including better experiences for patients and people who use services
- tackle local cultural and organisational barriers
- realise savings and efficiencies for re-investment

→ **have used the Narrative developed for us by National Voices, in association with *Making it Real*, to help shape good, person-centred coordinated care and support for individuals in their area**

→ **have demonstrated a range of approaches and models involving whole system transformation across a range of settings**

→ **have demonstrated the scope to make rapid progress**

→ **have tested radical options**, including new reimbursement models and taking the risk of 'failure to integrate' in some cases

→ **have overcome the barriers to delivering coordinated care and support**

→ **have accelerated learning across the system to all localities**

→ **have improved the robustness of the evidence base** to support and build the value case for integrated care and support

3. Selection criteria

Against this background, we are requesting expressions of interest from areas that wish to become pioneers. We will announce the first of these in late summer 2013.

We will not be prescriptive about the specific models for local adoption; it will be for localities to decide, based on their own judgements and circumstances. However, to be selected as a pioneer, we would expect a locality to satisfy six key criteria:

Primary criterion	Supporting considerations
<p>Articulate a clear vision of its own innovative approaches to integrated care and support</p>	<p>This should include how it will:</p> <ul style="list-style-type: none"> • adopt the Narrative developed by National Voices, aligned with <i>Making it Real</i>; • integrate around, and deliver better outcomes, including experiences for, individuals, families, carers and communities; • align with outcome frameworks; and • identify potential financial efficiencies for reinvestment; and identify potential measures of success.
<p>Plan for <i>whole system</i> integration</p>	<p>This should encompass mental and physical health, social care and public health, as well as other public services, such as education, involving the community and voluntary sectors, as appropriate, across their local areas.</p> <p>The plan should include how the locality will deliver greater prevention of ill health and deterioration of health and personalisation through better integrated care and support.</p> <p>The plan should include those who would benefit most from person-centred, coordinated care and support, such as intensive users of services who repeatedly cross organisational boundaries or who are disproportionately vulnerable.</p> <p>It should also take into account how public services should be integrated with the unpaid contributions of families and communities.</p>

<p>Demonstrate commitment to integrate care and support across the breadth of relevant stakeholders and interested parties within the local area</p>	<p>This should include local executive and political leadership, staff groups, including clinicians, patient groups, people who use the services, carers and families.</p> <p>Areas will also need to demonstrate robust governance structures, including for information sharing, to sustain the approach, as well as a robust plan for engaging local Healthwatch, people who use the services, all staff groups and the public in local service reform.</p> <p><u>The involvement and support of Health and Wellbeing Boards</u> (as a minimum, by the end of the selection process) will be an <u>essential prerequisite</u> for any area to become a pioneer.</p>
<p>Demonstrate the capability and expertise to deliver successfully a public sector transformation project <i>at scale and pace</i></p>	<p>This might be evidenced by:</p> <ul style="list-style-type: none"> • a proven track record in this area, strong local leadership and accountability; and/or • demonstrable and robust plans to address key local barriers to integrated care and support; and • risk management mitigation strategies, to maximise the likelihood of the area delivering its vision for integrated care and support across its locality.
<p>Commit to sharing lessons on integrated care and support across the system</p>	<p>This would be expected to include involvement in peer to-peer (including clinicians) promotion, dissemination and learning networks.</p>
<p>Demonstrate that its vision and approach are, and will continue to be, based on a robust understanding of the evidence</p>	<p>This will include:</p> <ul style="list-style-type: none"> • plans that have taken account of the latest available evidence; • understanding of the potential impact on the relevant local

	<p>providers and intended outcomes;</p> <ul style="list-style-type: none"> • a commitment to work with national partners in co-producing, testing and refining new measurements of people's experience of integrated care and support across sectors; and • a commitment to participate actively in a systematic evaluation of progress and impact over time
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4. Selection process

The selection process will be fair and transparent, whilst avoiding unnecessary bureaucracy. It will involve the following steps:

- Potential pioneers have six weeks to develop and return their Expressions of Interest, addressing the selection criteria above and not exceeding 10 pages in length. Expressions of interest can be submitted as joint applications, such as from a CCG and its local authority.
- In early July, the national partnership organisations will undertake an initial review of the Expressions of Interest. We will draw on additional sources of information, including the perspectives of local representatives of people who use services; information provided through the NHS planning round; information from CQC; any relevant information from Monitor and National Trust Development Authority; the recent ADASS/NHS Confederation survey of local authorities; and the selection of the new phase of community budget sites being run by the Department for Communities and Local Government as part of the wider Public Service Transformation Network.
- In mid-July, a Selection Panel made up of representatives from the national partners, three UK and three international experts will consider the Expressions of Interest and any additional information. The Panel will be chaired by Jennifer Dixon, Chief Executive of the Nuffield Trust (other panel members are being confirmed). The Panel will select any areas that meet the evaluation criteria in full or sift in any prospective candidates subject to receiving further information and clarification. National partners will obtain any additional information that might be necessary for the Panel to reach its view.
- The Selection Panel will make final recommendations to the national partners by the end of August, for their approval.

- The first cohort of pioneers will be announced in September 2013.

5. National support for pioneers

During the process of selection, national partners will discuss with pioneers their specific needs and proposed models of integration, and tailor their support accordingly. Based on what the system more generally has told us it needs from national organisations, the support that we envisage providing specifically to pioneers could include some or all of the following:

Capability Need	Support available
Changing the strategic/executive level culture	Organisational development Priority setting Action Learning sets Workshops, including peer-to-peer and champion support
Developing local payment systems	Payment design Contract design and models Cost collection Risk underwriting
Understanding the framework of rules on choice, competition and procurement	Clarification of rules and how integrated solutions can comply with them
Workforce flexibility	Employment law advice Workforce development
Public and professional opinion and engagement	Implementation of the Narrative National political support Engagement expertise
Analysis and evidence	Data and service audits Analytical support Financial modelling and health economics expertise to build the value case Evaluation expertise

In addition, we will:

- provide a dedicated ‘account manager’ as the main day-to-day point of contact with each pioneer to help them access the specialist support they need;

- draw together the current learning from literature and sites where integrated care has already been successfully adopted and other related initiatives, such as Year of Care implementer sites; and
- connect the pioneer sites through a strong community of practitioners to enable rapid and real time sharing of best and emerging practice across the pioneers, as well as more generally across the rest of the country.

Please submit your applications to pioneers@dh.gsi.gov.uk by 28th June 2013
If you have any queries or questions about the process these can also be submitted to pioneers@dh.gsi.gov.uk

5th June 2013

Agenda Item: 10

**REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE,
HEALTH & PUBLIC PROTECTION AND THE DIRECTOR OF PUBLIC
HEALTH****LONELINESS IN OLDER PEOPLE****Purpose of the Report**

1. This report describes the health risks of loneliness and factors that increase older people's vulnerability to loneliness. Members of the Health and Wellbeing Board are asked to comment on the report and support actions that can be taken to combat loneliness as set out in the recommendations

Information and Advice**Why is loneliness an issue for the Health and Wellbeing Board?****Background**

2. Loneliness is difficult to define since it is partly subjective and a matter of perception; people can be alone and not feel lonely, or they may be with others and feel very lonely, as many people do who live in care homes. Loneliness can affect people of all ages but older people are particularly vulnerable since they are more likely to suffer poor physical or mental health and live alone. Research has found a fairly constant proportion (6-13 per cent) of older people feel lonely often or always¹. **This paper focuses on the impact of loneliness on older people and on the Campaign to End Loneliness.**

- **More than half of those over the age of 75 live alone – with about one in ten suffering 'intense' loneliness;**
- **Half of older people - more than five million - say that the television is their main company;**
- **17 per cent of older people are in contact with family, friends and neighbours less than once a week**

Safeguarding the convoy: a Call to Action from the Campaign to End Loneliness
Age UK Oxfordshire 2011

Health risks

3. 'Safeguarding the Convoy: a call to action from the Campaign to End Loneliness' was published by Age UK Oxfordshire in 2011 with the aim of understanding the problem and summarising the evidence presented at its research symposium in 2010. In this paper, the World Health Organisation rates loneliness as a higher risk factor than lifelong smoking. The key message is: **Loneliness is bad for your health**¹. Specifically research has found that people who are lonely:

- exercise less, have unhealthy diets and drink more
- have poorer cognitive function
- double their risk of dementia
- are more likely to become depressed, rising to 40 per cent aged over 85
- increase their risk of heart disease
- reduce the effectiveness of their immune system
- are more likely to be admitted to residential or nursing care

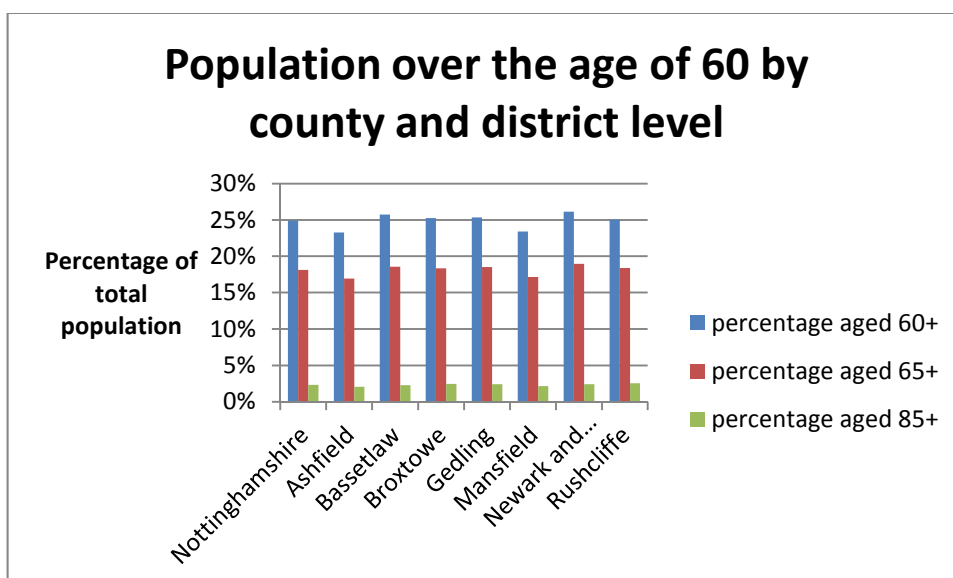
Factors leading to loneliness

4. The report highlights evidence for key risk factors which can lead to loneliness and isolation and to which older people are particularly vulnerable. These factors are inter-related and affect a person's physical, mental, social and psychological functioning. The problem may be one of social isolation (insufficient social contact) or emotional loneliness (missing a specific person).

- | | |
|--|----------------------------------|
| • Living alone | • Visually impaired |
| • Living in isolated rural areas or deprived urban communities | • Hard of hearing |
| • Single pensioners | • Poor physical or mental health |
| • Bereavement | • People with dementia |
| • Retired | • Suffering from poor mobility |
| • Struggling financially | • Later old age (over 80 years) |
| | • Living in a care home |

Local prevalence

5. Nottinghamshire already has a higher population of older people than the national average. Latest estimates for 2010 indicate that 18.2% of the total population is aged over 65².



12.8% of county's population who are over the age of 65 years live in single person households (out of all households). However 45% % of the county's population over the age of 65 years live in single person households if **only** one person households are considered.

Based on national figures of 6-13% of older people who felt lonely often or always	8546.82	18518.11
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Based on the 2011 census and national figures of 6-13% of older people (65+) who felt lonely often or always, Nottinghamshire has figures which range from 8547 to 18518.

6. Three local studies give a local picture of loneliness and social isolation in Nottinghamshire:

- a) Older people and Village services, Age Concern, 2008
- b) Nottinghamshire County Council Satisfaction Survey 2012
- c) Nottinghamshire County Council Adult Carers' Survey 2012

A Rural Study

7. *'Older people and Village services: Exploring the impact of community-based services in Rural England'*, was a piece of research sponsored by Age Concern and published in 2008. This research studied older people living in very rural areas in the Midlands and East Anglia suffering loneliness and isolation and the benefits of local community services³.

“It’s so nice to go out of my front door and have a little walk and see somebody you know”

“I can go all day and not see a person”

Two different views from ‘Older people and Village services’ (above)

Report of Findings from Nottinghamshire County Council’s Satisfaction Survey 2012

8. The County Council’s Annual Satisfaction Survey included the loneliness question in 2012 for the first time. This is carefully phrased to encourage a truthful response.

Loneliness questions

- **How often do you feel that you lack companionship?**
- **How often do you feel left out?**
- **How often do you feel isolated from others?**

Revised UCLA Loneliness Scale

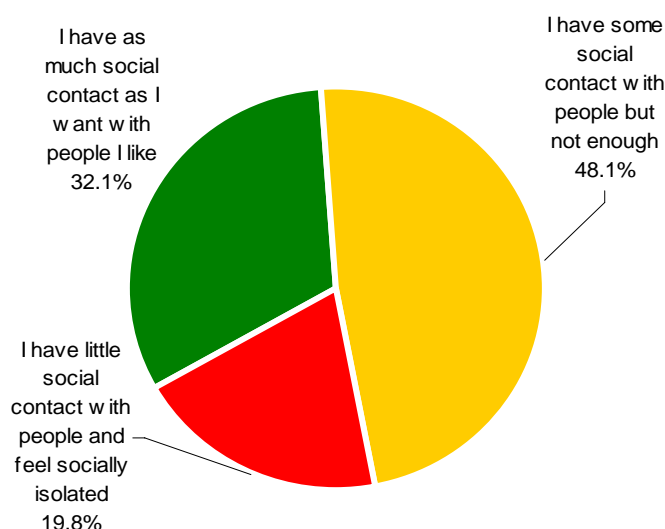
Analysis by Age

9. The results generally show that only 5% of people of all ages interviewed felt they lacked companionship often or all of the time. However **people aged over 75 were much more likely to say that they lacked companionship** some of the time (24%), or often (8%) than ages 18-74⁴. This is broadly comparable with national figures quoted above of 6-13% of all older people feeling lonely some of all of the time.

Report of Findings from the Personal Social Services Survey of Adult Carers in Nottinghamshire – 2012-13

10. In 2012, Nottinghamshire County Council sent out a survey to Adult Carers aged 18 or over, who are helping or looking after someone aged 18 or over, and who have been assessed or reviewed, either separately or jointly with the cared for person, by Adult Social Care and Health during the past 12 months prior to the sample being extracted⁵.
11. The survey was run to find out more about whether or not services received by carers are helping them in their caring role, their life outside of caring, and also their perception of services provided to the cared for person.
12. 1828 carers were identified from records of whom 803 were randomly selected; 419 completed questionnaires were received (52% return rate). One of the questions asked carers about social contact.
13. The results showed that most carers who responded are predominantly women (71%), predominantly white (96%), the majority are between the ages of 55 to 74 (55%) and perhaps most significantly the majority have a health or care issue of their own (68%).

14. Thinking about how much social contact you've had with people you like, which of the following statements best describes your social situation?



15. 414 people answered this question. Almost a third of respondents, 32%, said that they have as much social contact as they want with people they like. Nearly half of respondents, 48%, said they have some social contact with people but not enough and 82 people (20%) said they have little social contact with people and feel socially isolated.

Evidence

16. Research evidence falls into two main categories: first, research on loneliness itself, its prevalence, impact on health and factors affecting loneliness; and secondly, research on how to combat loneliness and isolation. Prevalence and factors affecting loneliness are discussed in the first section of this paper. This section will consider how services can target loneliness effectively.
17. *Safeguarding the Convoy* and other Age UK work¹ set out to collate evidence about the effectiveness of different types of intervention. Services are grouped into three types. Some specific ideas about what works are set out in the table below.

Some examples of effective interventions	
One to one	Telephone befriending One to one advice from neighbourhood wardens
Groups	Lunch clubs Creative arts Walking/exercise groups
Community involvement	Museums and libraries: social events, advice sessions Timebanking *

* 'Timebanking' is a rewarding way to bring people together in their community and share their skills, where every hour of work done is rewarded with a 'time credit'. Skills are both offered and requested.

18. In addition the research makes some general findings which are helpful¹:

- It is important to involve older people in planning, developing and delivering schemes
- Having friends is more important than how often a person sees friends
- Successful befriending depends on matching volunteers and service users
- Intergenerational contact is effective
- The loss of a successful service is worse than never having had a service
- It is very difficult to engage some groups of people, whatever the resources
- Interventions at age 75 and over may come too late⁶

In relation to the last point, there is a case for addressing loneliness earlier to prevent a person's health deteriorating and possibly, moving into a care home.

19. A very recent study assessed the impacts of social isolation and loneliness on mortality, looking at them both together and independently. It found that while social isolation is associated with higher mortality in older people the effect is independent of the emotional experience of loneliness. So while both are important for well-being, efforts to reduce isolation might have greater benefits in terms of mortality⁷.

20. There is a good evidence base for the creative arts promoting health and wellbeing and reducing loneliness and social isolation including: singing, dancing, music making and visual arts. Locally *Art at the HeART of Wellbeing* is a programme for socially isolated older people with or at risk of developing mental health problems. This was initially set up in Erewash and has been very successfully introduced in Gedling.

The Campaign to End Loneliness

21. The Campaign calls for action at an individual, local and national level. It invites us all, as individuals, to make a pledge. An event was held at County Hall, in conjunction with the local Age UK and collected 45 pledges ranging from telephoning elderly relatives more often to volunteering. The campaign has also been promoted through the County Council's website, social media and other communications channels.

22. Public Health and Social Care policy recognises the link between loneliness and poor physical and mental health. In the context of reducing national resources, the question arises as to how far publicly funded agencies can prioritise financial expenditure on loneliness compared with pressing statutory responsibilities. This points to approaches which build on voluntary activity, and encourage local communities and neighbours to take action in a way which is consistent with the Age UK campaign. At the same time, it is important that local agencies ensure that their existing provision is accessible and welcoming for older people and adults with disabilities. The role of a health and social care professional would be in identifying

where loneliness is problematic, and the opportunities that exist in local communities. It is proposed that current voluntary sector activity be reviewed, in addition to investigating possible new community initiatives such as a Circles scheme which is a social enterprise, whose primary aim is to develop networks of support within the local area. This year the County Council intends to review its strategic approach to Prevention and Early Intervention services to ensure that they are evidence based and target those who can most benefit from them. Key stakeholders will also be engaged as part of this work.

23. Currently the County Council is undertaking the 'Living at Home' programme, which aims to support people to live at home independently safely and for longer. Part of the support will be focussed on reducing social isolation. Care and Support Centres are actively reaching into local communities to support service users and their carers to combat isolation and the development of extra care services across Nottinghamshire will also support more people to live in environments that support connective activities amongst older people.
24. The County Council is also currently reviewing the delivery of domiciliary care/home based services. New service specifications are being developed which will require providers to develop person-centred support plans which promote independence, health and well-being. As such, providers will be expected to have a good understanding of local communities and support individuals wishing to maintain/develop community links.
25. An Ageing Well seminar was held in October 2012 to capture activity to combat loneliness within Nottinghamshire: examples are set out below.

Examples of what Nottinghamshire is already doing to combat loneliness

- | | |
|--|--------------------------------|
| ◇ First Contact * | ◇ Faith groups |
| ◇ Community Outreach Advisers ** | ◇ Advocacy support |
| ◇ Voluntary transport | ◇ Handypersons |
| ◇ Local senior forums | ◇ Adaptations*** |
| ◇ Websites e.g. Notts50+ | ◇ Supporting carers |
| ◇ Care & support centres offering social activities | ◇ Befriending schemes |
| | ◇ Libraries |
| | ◇ Hospital at Home **** |
| | ◇ Extra care housing |

From Ageing Well Seminar October 2012

*** First Contact:** First Contact is a signposting service, involving one simple checklist helping people aged 60 or over to stay safe and independent in their own homes; it saves people contacting lots of different organisations (e.g. Fire Service, Pension Service, Crime Reduction) to find out what they offer.

**** Community Outreach Advisers:** The Community Outreach Service is a free and confidential service for people over 50 to help them to remain safe and independent in their own homes. The advisor will usually visit the person at home to assess their situation and needs, and then offer advice and information on a range of topics such as

home safety and security, home adaptations, mobility aids, transport, social activities and benefits.

*** **Handypersons Adaptations:** The Handy Person Adaptation Service provides the help and support people need to keep safe and secure in their home with low cost but high quality essential adaptations and small practical jobs.

**** **Hospital at Home:** This is a scheme offered to vulnerable people on discharge from hospital, designed to help them to quickly regain their independence and confidence. Services offered include:

- Preparing the home for return and a welcome home pack
- Assisting with visits to outpatients' appointments, shopping, collecting prescriptions and social activities
- Helping to write and send letters
- Sit and have a chat if needed

What the Health & Wellbeing Board can do about loneliness

Local framework for action

26. The Campaign has published a toolkit for Health & Wellbeing Boards setting out why addressing loneliness is important, what action Boards can take and giving examples. The toolkit outlines 4 steps and gives examples by region – so far there are no examples for the East Midlands. The toolkit can be accessed on line at:

<http://www.campaigntoendloneliness.org.uk/campaign-news/new-toolkit/>

- a) **Gather the data about the extent of loneliness, map current services.** An innovative example is Essex County Council which has created an Isolation Index using Mosaic to map 11 variables at LSOA level

<http://campaigntoendloneliness.org/toolkit/casestudy/essex-isolation-index/>

Essex County Council is now working with the voluntary sector more closely to design a behaviour-change approach to encourage individuals and communities to build social networks and reduce their risk of loneliness

- b) **Use the information gathered to strengthen the information in the JSNA and the Health and Wellbeing Strategy.** This would then inform the development of local services and encourage innovative local solutions.
- c) **Strengthen partnership working** with e.g. District Councils and the voluntary sector to develop and test innovative approaches. An example is North Yorkshire County Council which has invested in a number of pilot projects e.g. Community café hubs as an alternative to day care.

- d) **Monitor and Evaluate** – collect evidence about what works locally. The Marmot review⁸, the Public Health Strategy⁹ and the Care and Support White Paper¹⁰ identified tackling loneliness and social isolation, as a priority. The Adult Social Care Outcomes Framework¹¹ (ASCOF) and the Public Health Outcomes Framework¹² (PHOF) both include new measures to promote this. The findings will help to identify how serious the problem is and what action is needed to tackle it.

Public health outcomes framework

- ◇ **Domain 1 – improving the wider determinants of health**
 - **1.18 Social isolation (*to be defined*)**

Adult Social Care & Health framework 11

- ◇ **Domain 1 – enhancing care and support for people with care and support needs**
 - **11. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.**

27. The indicator will initially focus on social care users and carers (of all ages), rather than the broader population. The Department of Health (DH) will also continue to develop a population based measure of loneliness, with a view to including this in future years.

Interventions for CCGs

28. Health interventions designed to address other key health challenges facing older people can, if properly targeted, also impact loneliness and social isolation. Conversely, failure to recognise the extent of loneliness and to provide services in a way that is sensitive to this issue can limit the effectiveness of broader health interventions. For example:

- Efforts to increase physical activity – to meet new guidelines for activity among the over 50s – also create opportunities to increase social interactions and build social networks.
- Health screening and preventative interventions can be capitalised upon to also identify, and address, or build resilience to, loneliness and isolation.
- Falls prevention programmes can be understood as not just a means of reducing costly hospital admissions, but also an opportunity to maintain mobility and existing social connections.

Other Options Considered

29. None.

Reason/s for Recommendation/s

30. To ensure that the Health and Wellbeing Board has a full appreciation of the impact of loneliness on older people, the consequences for health and social care and to support actions that can be taken to combat loneliness.

Statutory and Policy Implications

31. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATIONS

The Health and Wellbeing Board are asked to:

- 1) Support the roll out of the Campaign to end loneliness across partners in Nottinghamshire.
- 2) Promote the incorporation of evidence based measures to combat loneliness in all service proposals for relevant care groups.
- 3) Promote work with non-statutory sector partners to combat loneliness.
- 4) Continue to monitor the impact of measures to address loneliness locally through both the Outcomes Frameworks and the Annual Satisfaction Survey.

DR CHRIS KENNY
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Constitutional Comments (SG 16/05/2013)

32. The Board is the appropriate body to decide the issues set out in this Report.

Financial Comments (ZKM 17/05/13)

33. There are no financial implications arising directly from this report.

Background Papers

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

- a. Nottinghamshire Joint Strategic Needs Assessment 2012
- b. Nottinghamshire Health and Wellbeing Strategy 2012.

Electoral Division(s) and Member(s) Affected

All

References

1. Safeguarding the convoy: a call to action from the campaign to end loneliness
Age UK Oxfordshire 2011
2. Nottinghamshire Joint Strategic Needs Assessment, Nottinghamshire Health & Wellbeing Board, 2012
3. Older people and Village services: Exploring the impact of community-based services in rural England, Age Concern, Nottingham Trent University, 2008
4. Nottinghamshire County Council Satisfaction Survey, 2012
5. Findings from the Personal Social Services Survey of Adult Carers in Nottinghamshire, 2012-13
6. Promoting health and improving survival into very old age, Glymour & Osypuk, BMJ, September 2012, volume 345
7. English longitudinal study on Aging accessed May 2013
http://www.ifs.org.uk/conferences/AShankar_ELSA_Presentation.pdf
8. Fair Society, Healthy Lives: The Marmot review, UCL Institute of Health Equity, February 2010
9. Healthy Lives, Healthy people, Strategy for Public Health in England, DH, November 2010
10. Caring for our Future: reforming care & support - White Paper, DH, July 2012
11. The Adult Social care Outcomes framework, 2013-14, DH November 2012
12. Public Health Outcomes Framework, Improving Outcomes and supporting transparency, DH, November 2012
13. Combating Loneliness: A Guide for Local Authorities, LGA, March 2012

Appendix 1

Loneliness Framework for Action: A Guide for Local Authorities¹³

Combating Loneliness: A Guide for Local Authorities, LGA March 2012

Key messages

- Loneliness is a significant and growing issue for many older people.
- Its impacts are devastating and costly – with comparable health impacts to smoking and obesity; and close links to deprivation.
- Loneliness is amenable to a number of effective interventions, which are often low cost, particularly when voluntary effort is harnessed.
- Taking action to address loneliness can reduce the need for health and care services in future.
- Effective action to combat loneliness is best delivered in partnership.
- Action to combat loneliness should take place in the context of a wider strategy to promote older people's wellbeing.

Framework for action

- Include 'addressing loneliness' as an outcome measure of council strategies for ageing – ensuring that it is recognised and acted upon across every area of the authority's work.
- Work at the neighbourhood level, to understand and build on existing community capacity and assets.
- Recognise and respond to individual needs and circumstances by both making sure general services are geared up to meet the needs of those who are lonely, as well as providing specific interventions as required.

First steps

- Engage with other partners – loneliness is a multi-faceted issue and effective responses should be delivered in cross authority partnerships including the voluntary and community sectors.
- Define the local loneliness issue – understand the nature of the problem and who is at risk in your area.
- Agree a plan of action to reduce loneliness, and a way of measuring progress over time.
- Involve older people, including those experiencing or at risk of loneliness, in mapping local assets, determining responses, and co-producing solutions

5 June 2013**Agenda Item: 11****REPORT OF THE CORPORATE DIRECTOR FOR CHILDREN, FAMILIES AND
CULTURAL SERVICES AND THE HEAD OF HEALTH PARTNERSHIPS****NEEDS ASSESSMENT FOR CHILDREN AND YOUNG PEOPLE WITH
DISABILITIES AND/OR SPECIAL EDUCATIONAL NEEDS IN
NOTTINGHAMSHIRE****Purpose of the Report**

1. To inform members of the Health and Wellbeing Board of the main findings of the needs assessment for children and young people with disabilities and/or Special Educational Needs (SEN) in Nottinghamshire, published in 2012.
2. To inform the Health and Wellbeing Board of work underway to develop integrated commissioning of services for children and young people with disability and/or SEN.
3. To inform the Health and Wellbeing Board of plans being developed to meet the proposed new duties for local partners to cooperate in the provision of health, education and social care, as detailed in the draft Children and Families Bill.
4. To sign up to the Disabled Children's Charter for Health and Wellbeing Boards.

Information and Advice**Background**

5. Children and young people with disabilities, long term health conditions and special education needs (SEN) experience poor health outcomes¹. This group of children and their families need services which are provided by multiple agencies, and therefore they are disproportionately affected by poor integration between services and by a lack of co-ordinated commissioning. Too often, they report frustration at fragmented services and the failure to deliver appropriate services at the right time. This leads to significant distress².

¹ Department of Health (DH) (2012) Report of the Children and Young People's Health Outcomes Forum
<http://www.dh.gov.uk/health/2012/07/cyp-report/>

² The Children's Trust (2012) Disabled Children and Health Reform
http://www.ncb.org.uk/media/428980/health_reform_report.pdf

National and Local Drivers

6. The new health system presents a unique opportunity to improve the quality of life experienced by children and young people with disabilities, long term health conditions and SEN, by improving the integration of the services they use.
7. In 2012 the Department for Education published '*Support and Aspiration: a new approach to SEN and disability - Progress and Next Steps*'. This guidance restated the Government's commitment that by 2014:
 - a new assessment process will be introduced leading to a single plan, the Education, Health and Social Care (EHC) Plan
 - the assessment process will cover children and young people aged 0-25 years
 - the process will include an offer of a personal budget for all families with an EHC plan as a means of offering more freedom of choice to families (detailed in the NHS Mandate)
 - a local offer will be in place, describing the support available to children and young people with SEND (special educational needs and disability), and their families
 - Local Authorities and Clinical Commissioning Groups (CCGs) will make arrangements to ensure that the needs of children and young people with disabilities and/or SEN are planned and commissioned jointly.
8. The Children and Families Bill has now passed its second reading in the House of Commons and committee scrutiny of the Bill began on 5 March 2013. During this process, it was announced that the Bill will be amended to place a legal duty on CCGs to secure health services that are specified in EHC Plans. This provides important clarity and reassurance to families in addition to the duties already in the Bill in relation to co-operation and joint commissioning³.
9. Every Disabled Child Matters (EDCM) and the Children's Trust, Tadworth, have created a *Disabled Children's Charter for Health and Wellbeing Boards* as a tool to support Health and Wellbeing Boards to feel confident that they are meeting their responsibilities towards children and young people with disabilities, long term health conditions and SEN. The Charter is attached as **Appendix 1**; benefits and local evidence to support signing of the Charter is attached as **Appendix 2**. The Integrated Commissioning Group for Children and Young People with Disability and SEN will develop a plan to ensure compliance with the Charter.
10. A survey of over 1,000 families with disabled children in England in 2012 found that 76% of families do not visit their GP about their child's disability or condition. For those that did visit they found the quality of care inconsistent⁴. Contact a Family has produced *GP*

³ Department for Education (2013) Indicative Draft: The (0-25) Special Educational Needs Code of Practice <http://media.education.gov.uk/assets/files/pdf/s/sen%20code%20of%20practice%20indicative%20draft%20for%20committee.pdf>

⁴ Contact a Family (2012) Putting families with disabled children at the heart of the NHS reforms in England

Practice guide: supporting disabled children and young people and *Making GP practices more welcoming for families with disabled children* which are practical guides for GPs, other health professionals and commissioners in making sure health services are accessible for families who have children and young people with disabilities.

11. Improving the effectiveness of services for disabled children through joint planning and commissioning is a priority in the Health and Wellbeing Strategy and the Children, Young People and Families Plan 2011-14.
12. In Nottinghamshire, the Integrated Commissioning Group (ICG) for Children and Young People with Disability and SEN has been established for two years and is a core group of the Nottinghamshire Children's Trust Board. The ICG includes representatives from Nottinghamshire County Council (Children and Adult Services, Public Health), Nottingham North and East (NNE) and Bassetlaw CCGs as well as parents and a representative from the Special Schools Federation. Commissioning of healthcare services for disabled children became the responsibility of CCGs on 1 April 2013.

Needs Assessment for Children and Young People with Disabilities and/or Special Educational Needs in Nottinghamshire

13. The Nottinghamshire Children's Trust Board undertook a needs assessment of children with disabilities and SEN in Nottinghamshire in 2011/12, with work overseen by the ICG. The needs assessment informed the development of an Integrated Commissioning Strategy. The Strategy aims to ensure that partner agencies work together, align resources and deliver their services effectively, providing value for money and improving the experience and outcomes for people using these services.
14. The executive summary of the needs assessment is attached as **Appendix 3**, together with key findings and recommendations.

Key Messages from the Needs Assessment

15. The key messages are as follows:
 - there are between 7,000 – 12,000 children and young people who experience some form of disability or long term condition in Nottinghamshire. The estimate is wide because different sources of information suggest different actual numbers when applied to the Nottinghamshire population. There is no one recognised reliable national or local source of data and definitions of disability vary widely. The Report of the Children and Young People's Health Outcome Forum in 2012 found one of the biggest barriers to improving outcomes for this group of children is a paucity of robust and comprehensive data
 - the prevalence of severe disability amongst children and young people is increasing as a result of improved survival of children and babies with complex needs. Even if disability prevalence remains constant, the number of children with disabilities will continue to increase as the population of children and young people is forecast to grow in Nottinghamshire

- the number of children and young people with life limiting and life threatening conditions has doubled over the last decade
- there has been a 60% rise in young claimants (0-24 yrs) of Disability Living Allowance in Nottinghamshire over the last decade
- children who experience disability and SEN are more likely to live in poverty than the average. Nationally, 29% of disabled children live in poverty, compared with 21% of all children
- disabled children and young people have many of the universal needs of their non-disabled peers
- substantial inequalities persist between disabled children and young people and their peers in relation to fulfilling their health and educational potential
- for young people with disabilities or SEN, transition to adult services is often challenging
- locally, more children have choice and access to a wide range of short breaks and the number of children with disabilities accessing children's centres has increased
- the number of children and young people with disabilities receiving a direct payment has risen substantially since 2007/08
- over the last 10 years there has been a 72% increase in the number of accepted Universities and Colleges Admissions Service (UCAS) applications from disabled young people compared to a 16% rise in non-disabled peers
- there is a lack of data and performance information available on the services that disabled children and young people use
- consultation with local families in 2009 indicated that it is difficult to find out what services are available and that services on offer do not always help with the complex 'juggling act' required by families with a disabled child.

Why we need to do things differently: illustrative case studies

16. Below are brief summary notes from two case studies, one of a child with complex health, social care and education needs and one with additional but less complex needs. Families involved are keen to share this information in the hope that it can lead to improvements. The cases illustrate complexity in terms of interactions with services, highlighting that parents are not only parenting but are also carers, managers and coordinators of services. There is no description of the often significant impact this can have on marital and family life, economic activity and health and wellbeing of the wider family.

Case Studies

SEN and moderate health needs	SEND and complex care needs
<p>Emma* (born 1992) 13 years in education health & care</p> <p>Primarily neurological and developmental condition</p> <p>Used 6 statutory & 2 private services also 2 private funding sources for support to meet needs not met by statutory provision</p> <p>44 assessments completed and some of those are on-going</p> <p>19 Professionals involved</p> <p>10 organisations involved</p>	<p>Alice* (born 2003) 10 years health & social care support, 6 years in education (mainstream & special)</p> <p>Congenital, respiratory, neurological, ENT and orthopaedic conditions</p> <p>Used over 50 statutory services, 3 private services & 3 voluntary sector offering additional family support.</p> <p>Over 55 initial assessments. Completed. 34 services still active & assess/ review 6 monthly.</p> <p>Currently over 28 Professionals involved, this has varied over the years.</p> <p>55 organisations involved</p>

*names have been changed

17. In one single month Alice missed 12 school days through attending a variety of health, social care and education appointments. Her parent wanted to share the following thoughts:

"The services my daughter receives are generally excellent but when it comes to information, I do not know who holds what, where it is held and with whom it is shared."

"At times the volume of appointments and coordination of services can feel like a full time job."

"I often provide the same information to different services, which can be frustrating."

"I know about the services my daughter receives but I do not know what else might be available. Other parents are generally the best source of information for this."

"Professionals are often too busy to take on the role of key worker or lead professional which then places further pressure on parents to coordinate services."

"I should stress that the care received is good; it is the organisation that gets in the way!"

18. Emma's parent recorded part of her story:

"The most frustrating thing for me was that when she was around seven years old I knew something wasn't quite right for Emma and I knew it was associated with school. She was great during school holidays. I knew my child well: she has a strong character and was an intelligent articulate child capable of discussion, negotiation and reaching understanding and compromise. Over a period of time I noticed that she had become

impatient, easily frustrated and short tempered. She was, in plain language, unhappy but I couldn't find out from her what was troubling her. I spoke to her teacher at school about it on 3 occasions but felt fobbed off and not taken seriously. I later had the same experience with other teachers at Secondary School, the family GP and Practice Nurse. I am an intelligent, well educated professional, used to being listened to but found myself in a position where I was not been treated seriously and what I had to say was meaningless. I learned almost immediately that I had to fight to be listened to and heard. I became a warrior parent and Emma has learned to do the same and we haven't stopped fighting yet.'

19. Consultation has indicated that parents and carers are generally happy with services once they receive them, rating them very good or excellent. It is the process of accessing, the coordination and management that are not satisfactory.
20. Both young people and parents consulted as part of the needs assessment highlighted the need to improve the access to and coordination of services and the sharing of information.

Why children are different

21. Children generally have little direct control over factors that can affect their health, or the wide range of determinants of health. A child's problems may be a symptom of family dysfunction and so providing effective support for parents and families can have a profound impact on the health and well-being of their children. Thus, those planning and commissioning children's services must also consider the services provided to parents, particularly where parental factors, such as learning difficulties, mental health problems, substance abuse or experience of domestic violence, can have an adverse impact on their children.
22. For children, accessing the services they need can be more complex than for adults, largely as a result of their dependence on their family or carers. In addition, children's services are fragmented, smaller and geographic access may be more problematic.

The Nottinghamshire Response

23. The Children and Young People's Disability and SEN Integrated Commissioning Group identified the following priorities from the needs assessment:
 - develop robust, accurate information systems to enable commissioners to more effectively commission services to meet the needs of the local population
 - ensure co-ordinated planning at all levels, with roles and responsibilities of different agencies clarified and understood by frontline staff working with children, young people and their families
 - increase joint commissioning to reduce silo working across agencies working with the same children and families

- increase integration and joint delivery of services, to ensure that there is a consistent approach, reduced duplication, improved efficiencies and clearer pathways for children, young people and families
- use evidence based practice to shape local services and interventions, and help build the evidence base through robust evaluation of interventions and processes.

How these priorities are to be met through the Integrated Commissioning Strategy

24. Work on a number of areas is underway to improve services for disabled children, with two specific priorities identified for focused work because of their potential impact and the forthcoming legislation, namely:
- to implement Nottinghamshire's SEN and Disability (SEND) Pathfinder, known locally as the 'One Project', testing approaches to a single assessment and planning process. From September 2014 this process and the single Education, Health and Social Care (EHC) Plan will replace the statutory Statements of Special Education Needs (for under 16s) and Section 139a Learning Difficulty Assessments (for over 16s). The Pathfinder programme summary is attached as **Appendix 4** and the proposed integrated model as **Appendix 5**
 - to undertake the Integrated Community Children and Young People's Healthcare Programme (ICCYPH) which brings together providers of services, families, NHS Nottingham City CCG, NNE CCG, Nottinghamshire County Council (including Public Health) and Bassetlaw CCG to work together to improve access to and co-ordination of community healthcare services for children and young people. The programme summary and brief are attached as **Appendices 6 and 7** respectively.

SEND Pathfinder

25. The Nottinghamshire SEND Pathfinder (the 'One Project'), is one of 20 Pathfinders making up the Government's national SEND Pathfinder Programme and has been extended for 18 months, until September 2014. During this extension phase, the 20 Pathfinders will continue to test the planned reforms detailed in paragraph 6 of this report, to inform the Children and Families Bill, which contains the new SEN legislation and new SEN Code of Practice, as it progresses through Parliament.
26. Whilst it is expected that the new legislation will not be implemented in England until September 2014, a condition on all the Pathfinders is that they will introduce their new arrangements in advance of this date. In Nottinghamshire it is intended that there will be a phased roll-out starting from 1 September 2013 with arrangements fully operational by 1 January 2014.
27. A Pathfinder Project Board and Project Team have been established and will lead the changes required to deliver the new systems and processes, working with colleagues from education, health and social care services and with children, young people and their families.
28. To date 21 families have been recruited to the Nottinghamshire 'One Project' Pathfinder, with each involved in testing different elements of the new assessment and single plan

process, this is set to increase during the Pathfinder extension phase. A small number of these families are taking on personal budgets to help deliver the outcomes identified in their plan.

29. A key feature of the new assessment and single planning process is that, unlike the current process for Statements of Special Educational Needs (for under 16s) and Learning Difficulty Assessments (for over 16s), families and young people are able to express their views at an early stage, through the completion of an 'All About Me' personal profile. This profile looks at the whole day, not just the school day, and has a positive emphasis rather than offering a deficit model focused on what the child or young person is not able to do.
30. A number of other families not directly recruited to the Pathfinder are also involved, for example, in helping to shape the development of the local offer that will describe the support available.

The Integrated Community Children and Young People's Healthcare (ICCYPH) Programme

31. The vision of the programme is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their needs met wherever they are. Services will support the child's life choices rather than restrict them and will improve the quality of life for children and their families and carers. The aim of the programme is to develop a Nottinghamshire wide integrated model of children's healthcare, delivered via a network of community based services.
32. Scoping has been undertaken to identify local and national developments which may influence the outcomes of the programme. Consultation with children, families and professionals together with population and service data collection and analysis is underway.
33. Following completion of the above work, recommendations will be published, in relation to future commissioning of community health services for children and young people in Nottinghamshire County and Nottingham City.
34. The two areas of work detailed above require effective multi-agency work and there is considerable overlap between the projects. It is recommended that for children and young people with disability and SEN, the two work streams now integrate.

Integrated commissioning of services for children and young people with disability and SEN

35. In April 2013, the Nottinghamshire Children's Trust Board and the Health and Wellbeing Board approved the development of an Integrated Commissioning Hub, which will discharge commissioning responsibilities on behalf of CCGs to Nottinghamshire County Council for a range of children's health services. The function will include commissioning of services for children and young people with disabilities and SEN. Governance will be through the Nottinghamshire Children's Trust Board to the Health and Wellbeing Board and to Nottinghamshire CCGs. This will facilitate integrated planning, commissioning and

provision of services, to meet the health and well-being needs and improve outcomes for children and young people.

Other Options Considered

36. None.

Reason/s for Recommendation/s

37. The needs assessment has highlighted a number of recommendations that are being taken forward through the Integrated Commissioning Group for Children and Young People with Disability and SEN. As improving the effectiveness of services for disabled children through joint planning and commissioning is a priority in the Health and Wellbeing Strategy and the Children, Young People and Families Plan 2011-14, it is important the Health and Wellbeing Board are given the opportunity to review and comment on the progress of this work.

Statutory and Policy Implications

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

Equalities Implications

39. Due regard has been given to the Public Sector Equality Duty.

RECOMMENDATION/S

That the Health and Wellbeing Board:

- 1) is invited to comment on the current approach to improving health and wellbeing of children and young people with disabilities and/or special educational needs (SEN), as detailed in this report.
- 2) notes the on-going work in both the SEND Pathfinder and the Integrated Community Children and Young People's Healthcare (ICCYPH) Programme to move to an integrated model of commissioning and delivery for children and young people with disabilities and/or special educational needs.
- 3) signs up to the *Disabled Children's Charter for Health and Wellbeing Boards*.
- 4) receives an update on this area of work when the Children and Families Bill is published in 2014.

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Constitutional Comments (KK 24/05/13)

40. The proposals in this report are within the remit of the Health and Wellbeing Board.

Financial Comments (NDR 24/05/13)

41. There are no financial implications arising directly from this report.

Background Papers and Published Documents

NCC (2012) Web link for the Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN: Needs Assessment, Strategy and Terms of Reference.
www.nottinghamshire.gov.uk/improvetheeffectivenessofservicesfordisabledchildren

Department for Education (2012) Support and Aspiration: A new approach to special educational needs and disability

DH (2012) The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127193/mandate.pdf.pdf

Contact a Family (2013) GP practice guide: supporting disabled children and young people
Contact a family (2013) Making GP practices more welcoming
NCC (2012) Our Strategy for Health and Wellbeing in Nottinghamshire
NCC (2011) Nottinghamshire Children, Young People and Families Plan 2012-13 update

NCC (2011) The Early Intervention and Prevention Strategy
<http://www.nottinghamshire.gov.uk/caring/childrenstrust/pathway-to-provision/earlyinterventionpreventionstrategy/>

NCC (2012) The Pathway to Provision Multi-agency Thresholds Guidance
<http://www.nottinghamshire.gov.uk/caring/childrenstrust/pathway-to-provision/>

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

Electoral Division(s) and Member(s) Affected

All.

C0227

Why sign the Disabled Children's Charter for Health and Wellbeing Boards?

Benefits to Health and Wellbeing Boards of signing the Charter and meeting its commitments:

- Publicly articulate a vision for improving the quality of life and outcomes for disabled children, young people and their families
- Understand the true needs of disabled children, young people and their families in your local area and how to meet them
- Have greater confidence in targeting integrated commissioning on the needs of disabled children, young people and their families
- Support a local focus on cost-effective and child-centred interventions to deliver long-term impacts
- Build on local partnerships to deliver improvements to the quality of life and outcomes for disabled children, young people and their families
- Develop a shared local focus on measuring and improving the outcomes experienced by disabled children, young people and their families
- Demonstrate how your area will deliver the shared ambitions of the health system set out by the Government in 'Better Health Outcomes For Children and Young People: Our Pledge' for a key group of children and young people¹

Who are we talking about?

The Disabled Children's Charter for Health and Wellbeing Boards and this accompanying document have been developed to support Health and Wellbeing Boards (HWBs) meet the needs of all children and young people who have disabilities, special educational needs (SEN), health conditions, and their families. In this document, when we talk about disabled children and young people we are referring to all the children and young people in this group.

Page 77 of 140

¹ Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

Commitment 1: We have detailed and accurate information on the disabled children, young people and their families living in our area, and provide public information on how we plan to meet their needs

Statutory drivers

Health and Social Care Act 2012

Duty to prepare assessment of needs (JSNA) in relation to local authority area and have regard to guidance from Secretary of State

Information

The quality of data and information used to underpin the planning, commissioning and delivery of services for children and young people with very complex needs is often poor. The difficulty of developing accurate, robust data in a standard format about disabled children and young people is an enduring issue for local areas and for national agencies. Reliable performance information about the use and value of services is critical to commissioning decisions. The Children and Young People's Health Outcomes Forum identified the lack of accurate data as the single biggest challenge in relation to the development of outcomes for children with long-term health conditions, disabilities and life limiting conditions².

In March 2012, the CQC released a report entitled 'Healthcare for disabled children and young people'³. This report gave details of primary care trust (PCT) replies to a self assessment questionnaire on services for disabled children.

PCTs demonstrated an extremely worrying lack of awareness of the needs of local disabled children:

- **Five PCTs** claimed that **no disabled children and young people lived in their area**
- **Fifty five PCTs did not monitor whether services allocated as a result of Common Assessment Framework were delivered**
- **Sixty three PCTs didn't know how many children were referred for manual wheelchairs** and **nine said children were waiting over 51 weeks for wheelchairs**
- **Fifteen PCTs** said they **didn't provide short breaks services**

Due to the lack of reliable data on disabled children and young people, their strategic involvement and that of their parents is essential to gain a good understanding of the profile of this group

2 Children and Young People's Health Outcomes Forum (2012), Report of the long term conditions, disability and palliative care subgroup p.2

3 Care Quality Commission (2012), Healthcare for Disabled Children and Young People

and the particular challenges and experiences they face. Their views remain underrepresented in surveys and public and patient involvement in the health service.

Meeting Needs

One of the primary tools Health and Wellbeing Boards have to drive strategic commissioning in their areas is the Joint Strategic Needs Assessment (JSNA). The JSNA will assess the current and future health and care needs and assets of a local population and will underpin a Joint Health and Wellbeing Strategy (JHWS). It will interpret available data to develop an understanding of the causes of health inequalities and a narrative of the evidence.

The JSNA can only be an effective tool for evidence-based decision making if it is based on accurate and meaningful data. The bodies Health and Wellbeing Boards delegate collecting data to as part of the JSNA process, must focus on improving the quality and scope of information on disabled children and young people which they use, including: available national data sets; local information sources such as data from Common Assessment Frameworks; qualitative information from direct engagement with service users.

The JSNA process must develop an understanding of the local population which is sufficiently differentiated to understand the needs of all groups of children, particularly those who face the greatest inequalities or experience multiple disadvantages.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The full range of sources of information collected on disabled children, young people and their families which will be used to inform the JSNA process
- The quality assurance process used to ensure that information and data on disabled children, young people and their families used to inform commissioning is sufficiently detailed and accurate
- The way in which the JSNA will be used to assess the needs of local disabled children, young people and their families
- The way in which information on any hard to reach groups is sourced, and action taken to address any gaps of information with regard to local disabled children, young people and their families
- The way in which disabled children, young people and their families are strategically involved in identifying need, and evidence and feedback on their experiences is used to inform the JSNA process
- Public information on how the HWB will support partners to commission appropriately to meet the needs of local disabled children, young people and their families

Key resources for meeting this Charter commitment

Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Statutory guidance to support Health and Wellbeing Boards and their partners in understanding the duties and powers in relation to Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

NHS Confederation, Operating principles for Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies

Paper designed to support areas to develop successful Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies.

Child and Maternity Health Observatory: support for commissioners

Help to find the right tools, data and evidence to review, plan and improve services in your local area.

Child and Maternity Health Observatory: tools and data

ChiMat provides easy access to a wealth of data, information and intelligence through a range of online tools designed to support decision-making.

Rightcare (2012), NHS Atlas of Variation in Healthcare for Children and Young Adults

Variations across the breadth of child health services provided by NHS England are presented together to allow clinicians, commissioners and service users to identify priority areas for improving outcome, quality and productivity.

LGA (2011), Joint Strategic Needs Assessment: Data Inventory

Offers practical help to councils, clinical commissioning groups and other members of health and wellbeing boards.

Children and Young People's Health Outcomes Forum (2012), Making data and information work for children and young people

Factsheet on making data and information work for children and young people, including resources.

Contact A Family (2012), Health and Wellbeing Boards: making the case to target disabled children services

Briefing for Parent Carer Forums on the reasons why the Health and Wellbeing board in their area should target disabled children in their Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing strategy (JHWS).

Commitment 2: We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

Article 12 of the United Nations Convention on the Rights of the Child (UNCRC)

- The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

Article 7 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD)

- Children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realise that right.

Health and Wellbeing Boards should ensure that the voice of disabled children and young people is always heard when decisions are being made that affect them. Health and Wellbeing Board members should use their influence to embed engagement with disabled children and young people throughout the health and care system and in the context of a continuous and current partnership.

The benefits of embedding participation of disabled children and young people are huge: better services will be developed driven by feedback from the people who know and use them; resources are not wasted on services that are not taken up or valued; services will be more child and young person friendly and accessible; disabled children and young people will have insight into the diverse needs and barriers faced by marginalised and vulnerable groups; improved accountability to children and young people as stakeholders; and direct benefits to disabled children and young people themselves such as increased knowledge of services,

confidence, and skills⁴.

It should be recognised that many disabled children and young people may face significant barriers to their involvement, particularly in mainstream settings. Recent research from the VIPER project found that young disabled people's participation is still not embedded at a strategic, service level or individual decision-making. It found barriers to participation including a lack of understanding of what participation is and how you make it happen, lack of funding, inclusive practice, resources, time and training, and lack of consistent systems and structures⁵.

All disabled children and young people communicate and have a right to have their views heard and this may require targeted approaches and the involvement of Voluntary Sector Organisations (VSOs).

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with disabled children and young people in the preparation and delivery of the Joint Health and Wellbeing Strategy (JHWS), and next steps for JHWS engagement
- Evidence of partnership working with any local groups of disabled children and young people

Key resources for meeting this Charter commitment

[The NHS Confederation, Royal College of Paediatrics and Child Health and Office for Public Management \(2011\), Involving children and young people in health services](#)

This report highlights the key findings and recommendations from an event held in September 2011 to discuss the key priorities for child health.

[VIPER \(Voice.Inclusion.Participation.Empowerment.Research\)](#)

VIPER is a three-year project funded by the Big Lottery Fund, to research young disabled people's participation in decisions about services. It began in Summer 2010.

[VIPER \(2012\), The Viper project: what we found](#)

Findings and key messages arising from the research activities of the VIPER project.

[VIPER \(2012\), The Viper project: what we found from the survey](#)

Summary of the findings and key messages from the research activities. The research summarised in this report was carried out between 2010 and 2012.

4 Participation Works (2008), How to involve children and young people in commissioning, p.6.

5 VIPER (Voice, Inclusion, Participation, Empowerment and Research) (2013), Hear Us Out, p.23.

Participation Works

Enables organisations to effectively involve children and young people in the development, delivery and evaluation of services that affect their lives.

Participation Works (2008), How to involve children and young people in commissioning

An introduction to commissioning from a variety of perspectives. It describes the different parts of the process and ways to support children and young people to participate in all aspects of commissioning.

Participation Works (2008), How to build a culture of participation

Information and practical ideas about how to embed participation throughout your organisation in a way that brings about change.

Participation Works (2010), Listen and Change - a guide to children and young people's participation rights

Aims to increase understanding of children and young people's participation rights and how they can be realised in local authority and third sector settings.

Making Ourselves Heard (MOH)

MOH is a national project to ensure disabled children's right to be heard becomes a reality.

Council for Disabled Children (2009), Making Ourselves Heard

Based on a series of eight seminars with local authorities this book sets out the current policy context for disabled children and young people's participation, outlines the barriers and challenges to effective participation and highlights what is working well.

Franklin, A. and Sloper, P. (2009) Supporting the participation of disabled children and young people in decision-making

Presents research exploring factors to support good practice in participation and discusses policy and practice implications.

DfEs (2003), Building a culture of participation: research report

Many of the case studies in this research are attempting to make participation more integral to their organisation.

Commitment 3: We engage directly with parent carers and their participation is embedded in the work of our Health and Wellbeing Board

Statutory drivers

Health and Social Care Act 2012

Duty to involve third parties in preparation of the JSNA:

- Local Healthwatch
- people living or working in the area
- for County Councils – each relevant DC

Duty to involve third parties in preparation of the JHWS:

- Local Healthwatch
- people living or working in the area

The purpose of parent participation is to ensure that parents can influence service planning and decision making so that services meet the needs of families with disabled children. Effective parent participation happens when parents have conversations with and work alongside professionals, in order to design, develop and improve services⁶.

The benefits of effective parent participation are well established: resources are not wasted on services that are not taken up or valued; parent carers' insight can help develop cost-effective solutions to local problems; a shared view can be developed between parents and professionals of how to support families within funding limitations; more costly interventions can be avoided in the future; and complaints can be reduced by Parent Carer Forums monitoring services and alerting commissioners and managers if problems occur. The Contact A Family resources below contain a wealth of evidence and case studies into how effective parent participation has benefited the local areas where it has been implemented.

Health and Wellbeing Boards should ensure that parent carers are involved in decisions that affect them at a strategic and service level. Health and Wellbeing Board members should use their influence to embed engagement with parent carers throughout the health and care system and in the context of a continuous and current partnership.

It should be recognised that parent carers may face significant barriers to their participation in mainstream settings but that this should not prevent their involvement in decision-making.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the JSNA process, and next steps for JSNA engagement
- Evidence of the way in which the HWB or its sub groups have worked with parent carers of disabled children in the preparation and delivery of the JHWS, and next steps for JHWS engagement
- Evidence of partnership working with local parent groups, including the local Parent Carer Forum(s)

Key resources for meeting this Charter commitment

Together for Disabled Children (v2.0 2010), Parent carer participation: How to guide.

A guide to support parent carer forums, commissioners and managers to develop parent carer participation. It can be downloaded in the following separate sections:

[Section 1 - The Process](#)

[Section 2 - producing information](#)

[Section 3 - consultation](#)

[Section 5a - successful meetings Together for Disabled Children](#)

[Section 5b - how to reach and engage parents](#)

[Section 5c - supporting parent representatives](#)

[Section 6b- for strategic leaders](#)

[How parent participation and parent carer forums leads to better outcomes for disabled children, young people and their families 2011](#)

[Contact A Family \(2012\), Parent Carer Participation: An overview](#)

This short guide provides examples of successful parent carer participation

[Contact A Family, Improving Health Services](#)

Resources to support the commissioning and management of health services.

[Contact A Family, Resources](#)

Resources, case studies and information for professionals to help them improve how services are delivered, so they better meet families' needs.

[Contact A Family \(2013\), Parent carer forum involvement in shaping health services - second report](#)

Report into Parent Carer Forum involvement with the health service in the lead up to the new health system coming into effect.

Commitment 4: We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account

Statutory drivers

Health and Social Care Act 2012

Duty to prepare a JHWS for meeting needs included in JSNA in relation to LA area and to have regard to guidance from Secretary of State

Power of the HWB to give its opinion to the local authority which established it on whether the authority is discharging its duty to have regard to relevant JSNA and JHWS

CCG is under a duty to involve HWB in preparing or significantly revising the commissioning plan – including consulting it on whether the plan has taken proper account of the relevant JHWS

Duty to provide opinion on whether the CCG commissioning plan has taken proper account of the JHWS. Power to also write to NHS England (formerly the NHS Commissioning Board) with that opinion on the commissioning plan (copy must also be supplied to the relevant CCG). Duty to review how far the CCG has contributed to the delivery of any JHWS to which it was required to have regard and to consult HWB on this

Duty in conducting the performance assessment, to assess how well CCG has discharged duty to have regard to JSNA and JHWS and to consult HWB on its view on CCGs' contribution to delivery of any JHWS to which it was required to have regard (when conducting its annual performance assessment of the CCG)

In response to the report of the Children and Young People's Health Outcomes Forum, the Government set out its ambitions for improving health outcomes for children and young people by launching 'Better Health Outcomes For Children And Young People: Our Pledge'⁷. Health and Wellbeing Boards will play a key role in delivering on these ambitions.

Disabled children and young people will provide a crucial test of the effectiveness of the new health system and improving the outcomes they experience, including those in the NHS and Public Health Outcomes frameworks, will require concerted strategic leadership. However, if a Health and Wellbeing Board can improve integration for local disabled children and young people, who frequently test the interface between multiple services and agencies, it can deliver for all children and young people.

For the JSNA and JHWS process to make a positive impact on the outcomes faced by disabled children, young people and their families, it is essential that the evidence collected through the JSNA process reflects the outcomes that are most meaningful to them. Health and Wellbeing Boards should use the JSNA process to develop a shared understanding of the needs of disabled children, young people and their families, and the causes of the poor outcomes and inequalities

⁷ Department of Health (2013), Better Health Outcomes for Children and Young People: Our Pledge

they experience. They should set clear strategic outcomes for partners to meet and ensure that mechanisms are in place to measure and monitor progress towards achieving them.

The JHWS should address how the needs of disabled children, young people and their families should be met and make recommendations on cost-effective approaches to reducing the health inequalities they experience. However, if this group is not identified as a priority in the JHWS, the Health and Wellbeing Board should demonstrate how it is providing strategic direction for partners to meet the needs of disabled children and young people.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Public information on the status of outcomes for local disabled children and young people based on indicators such as the NHS Outcomes Framework, the Public Health Outcomes Framework, etc.
- Public information on the strategic direction the HWB has set to support key partners to improve outcomes for disabled children and young people. This may be encompassed by the JHWS, but would need to be sufficiently delineated to demonstrate specific objectives and action for disabled children and young people.

Key resources for meeting this Charter commitment

[NHS Confederation \(2012\), Children and young people's health and wellbeing in changing times](#)

The purpose of this report is to support implementation of the health reforms to improve children and young people's health and wellbeing.

[Report of the Children and Young People's Health Outcomes Forum \(2012\)](#)

The Children and Young People's Health Outcomes Forum was established by the Secretary of State for Health and tasked with responding to the challenges set out in Sir Ian Kennedy's report published in 2010 'Getting it right for children and young people'.

[Report of the Children and Young People's Health Outcomes Forum - report of the long-term conditions, disability and palliative care sub-group \(2012\)](#)

Report discussing the challenges around improving outcomes for this group of children.

[Report of the Children and Young People's Health Outcomes Forum - inequalities in health outcomes and how they might be addressed \(2012\)](#)

Report commissioned by the co-chairs of the Children and Young People's Health Outcomes Forum from Maggie Atkinson, Children's Commissioner for England.

[Children and Young People's Health Outcomes Forum \(2012\), Health and wellbeing boards and children, young people and families](#)

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Children and Young People's Health Outcomes Forum (2012), Commissioning in the new NHS for children, young people and their families

Poster setting out the Children and Young People's Health Outcomes Forum's vision for successful commissioning for children, young people and their families in the new NHS.

Department of Health (2013), Improving Children and Young People's Health Outcomes: a system wide response

The Children and Young People's Health Outcomes Forum report made recommendations, aimed at DH, DfE and a wide range of health system organisations, to improve health outcomes for children and young people. This document contains the system-wide response setting out the action already undertaken, in progress and planned in response to the recommendations.

Department of Health (2013), Better health outcomes for children and young people: Our Pledge

Government response to the report of the Children and Young People's Health Outcomes Forum, setting out shared ambitions across the NHS to improve outcomes and services for children and young people.

Contact A family and Strategic Network for Child Health and Wellbeing in the East of England (2012), Principles for commissioning and delivering better health outcomes and experiences for children and young people so that they are comparable with the best in the world

Poster showing 6 principles for commissioning and delivering better health outcomes and experiences for children and young people, developed by the Strategic Network for Child Health and Wellbeing in the East of England.

Department of Health (2010), The NHS Outcomes Framework 2011/12

The outcomes and indicators which make up the first NHS Outcomes Framework, following the consultation Transparency in outcomes – a framework for the NHS.

Commitment 5: We promote early intervention and support smooth transitions between children and adult services for disabled children and young people

The report of the Children and Young People's Health Outcomes Forum emphasised the importance of early intervention and transitions within a life-course approach to reducing health inequalities⁸. This is particularly significant for disabled children and young people and their families, who often struggle to obtain a diagnosis and access appropriate support at an early age and when transitioning to adult services, which affects their outcomes throughout their lives.

It should be emphasised that disabled children and young people may transition to adult services up to the age of 25. Health and Wellbeing Boards should consider the needs of disabled children and young people from 0-25 as well as ensuring smooth transitions to adult services.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- The way in which the activities of the HWB help local partners to understand the value of early intervention
- The way in which the activities of the HWB ensure integration between children and adult services, and prioritise ensuring a positive experience of transition for disabled young people

Key resources for meeting this Charter commitment

[Graham Allen MP \(2011\), Early Intervention: The Next Steps](#)

An independent report to Government, which argues that many of the costly and damaging social problems for individuals can be eliminated or reduced by giving children and parents the right type of evidence based programmes between 0-18 and especially in their earliest years.

[Graham Allen MP \(2011\), Early Intervention: Smart Investment, Massive Savings](#)

Graham Allen MP's second independent report to the Government sets out how early intervention programmes can be paid for within existing resources and by attracting new non-government money.

[Child and Maternity Health Observatory, Knowledge Hub: Transitions](#)

The transitions to adulthood hub brings together a range of resources and evidence relating to young people's transition process into the adult world. It is constantly updated with new resources.

Early Support

A way of working, underpinned by 10 principles that aim to improve the delivery of services for disabled children, young people and their families. It enables services to coordinate their activity better and provide families with a single point of contact and continuity through key working.

Early Support (2012), Key working: improving outcomes for all - Evidence, provision, systems and structures

A summary of the key evidence and consistent elements of a key working approach. It presents an analysis of the implications of key working that cuts across health, social care and education.

Ofsted (2013), Good practice resource - Early intervention through a multi-agency approach: Sheffield City Council

Sheffield City Council has developed a creative and innovative approach across the children's workforce by introducing a multi-agency perspective in providing preventative services to children and families.

C4EO, Improving the wellbeing of disabled children through early years interventions (age 0–8)

This section contains the following resources in support of improving the wellbeing of disabled children through early years interventions (age 0–8) priority: links to online tools; key online publications from C4EO partners and other organisations.

Institute of Public Care (2012), Early Intervention and Prevention with Children and Families: Getting the Most from Team around the Family Systems

Briefing paper arguing that effective local systems to identify families who would benefit from additional support and to coordinate support from a range of agencies is as important as delivering effective services.

Transition Information Network (TIN)

An alliance of organisations and individuals who come together to improve the experience of disabled young people's transition to adulthood. TIN is a source of information and good practice standards for disabled young people, families and professionals.

TIN Resource Library

You can use the search form to find a range of resources that can help you to improve your provision for disabled young people in transition to adulthood.

Preparing for Adulthood (PfA)

A 2 year programme funded by the Department for Education as part of the delivery support for 'Support and aspiration: A new approach to special educational needs and disability' green paper. It provides knowledge and support to all local authorities and their partners, including families and young people, so they can ensure young people with SEN and disabilities achieve paid work, independent living, good health and community inclusion as they move into adulthood.

Preparing for Adulthood (2012), PfA resource list

Created for the PfA 'How are you doing?' events which took place in June and July, 2012. Resources are listed under: Paid employment; Independent living; Good health; Community inclusion.

Sloper, P., Beecham, J., Clarke, S., Franklin, A., Moran, N. and Cusworth, L. (2011) Transition to adult services for disabled young people and those with complex health needs, Research Works, 2011-02, Social Policy Research Unit, University of York, York

This research aimed to provide evidence of what works well in developing and implementing multi-agency coordinated transition services for disabled children and those with complex health needs and their families. It also assessed the costs of the services.

Commitment 6: We work with key partners to strengthen integration between health, social care and education services, and with services provided by wider partners

Statutory drivers

Health and Social Care Act 2012

Duty to encourage integrated working:

- between commissioners of health services and commissioners of social care services
- in particular to provide advice, assistance or other support for the purpose of encouraging use of flexibilities under NHS Act 2006

Power to include in the JHWS a statement of views on how the commissioning of health and social care services, and wider health-related services, could be more closely integrated – i.e. the ability for the JHWS to look more broadly than health and social care in relation to closer integration of commissioning

Disabled children and young people access services across multiple agencies, and therefore are disproportionately affected by poor integration between health and social care services and a lack of coordinated commissioning. Health and Wellbeing Boards must work with key partners to meet the needs of disabled children and young people, including: education providers and schools; safeguarding boards, local children's trust arrangements; learning disability partnership boards; and others. Health and Wellbeing Boards should make recommendations to ensure that disabled children and young people experience seamless integration between the services they access.

In particular, Health and Wellbeing Boards should consider how they engage with education services, including schools and colleges, because of the significance of joined up-working between health, education and social care to disabled children and young people's outcomes.

To promote integrated commissioning Health and Wellbeing Boards will also need to consider how specialised health services commissioned by NHS England are joined up with locally commissioned services and ensure they are taken into account by their JSNA and JHWS.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Details of the way in which the HWB is informed by those with expertise in education, and children's health and social care
- Details of the way the HWB engages with wider partners such as housing, transport, safeguarding and the youth justice system
- Details of steps taken to encourage integrated working between health, social care, education and wider partners in order to improve the services accessed by disabled children, young people and their families

Key resources for meeting this Charter commitment

[Together for disabled children \(2009\), Facilitating integrated practice between children's services and health](#)

This report contains examples of innovative working practice where services are integrated with health.

[Council for Disabled Children \(2006\), Pathways to success: Good practice guide for children's services in the development of services for disabled children - evidence from the pathfinder children's trusts](#)

This project ran from April 2004 to March 2006 and set out to work alongside the pathfinder children's trusts in developing new ways of working and to capture the learning from their work. The work covered: strategic planning; commissioning services, pooling budgets; joint working and co-location; assessment process and information sharing.

[East Midlands, Everybody's learning \(2012\), Assured safeguarding: GP and Health Leader edition](#)

Resource to help commissioners and health providers reassure themselves they are doing everything possible to ensure that children within the services for which they are responsible are as safe as possible.

[Ofsted \(2012\), Improving outcomes for disabled children by integrating early support and prevention services: Luton Borough Council](#)

Luton's services for disabled children and their families bring together practice across health, social care and education services, alongside innovative short break and early support provision. The development of an extensive range of integrated early support and prevention services is improving outcomes for disabled children and preventing situations deteriorating so that child protection or looked after services become necessary.

Commitment 7: We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners

Statutory drivers

Health and Social Care Act 2012

Power to encourage close working (in relation to wider determinants of health):

- between itself and commissioners of health-related services
- between commissioners of health services or social care services and commissioners of health-related services

Power to appoint additional members to the board as deemed appropriate

Power for HWB to request information for the purposes of enabling or assisting its performance of functions from:

- the local authority
- certain members or those they represent with a duty to provide

Children Act 2004

Requirement for each local authority to have a children's trust board which must include representatives of the local authority and each of the children's trust 'relevant partners'

Local safeguarding children's boards put on statutory footing

Children and Families Bill 2012-13 (currently in Parliament)

(Clause 25) Local authorities must promote the integration of special education, health and care provision.

(Clause 26) Local authorities and their partner CCGs must make arrangements for the joint commissioning of education, health and care provision for children and young people with SEN.

(Clause 27) Local authorities must keep under review special education provision and social care provision for children and young people with SEN and consider the extent that it is sufficient to meet their needs.

(Clause 30) Local authorities must publish a Local Offer containing information about services available for children and young people with SEN, including education, health and care provision.

The role of the Health and Wellbeing Board must be understood in relation to new and existing partnerships, including: local children's trust arrangements; local safeguarding children's boards; learning disability partnership boards; and others. A clear local framework on how these partnerships interact needs to be established to avoid the duplication of effort or even

competing for resources.

The JSNAs and JHWS need to be aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block⁹; safeguarding arrangements; child poverty strategies; and children and young people's plans if they are still used.

Additionally, the Children and Families Bill currently in Parliament contains clauses for promoting integration between special educational provision, health and social care provision (25), making joint-commissioning arrangements (26), keeping education and care provision under review (27), and producing a local offer (30), for children and young people with SEN. These new duties on local authorities all have a clear relevance to the functions of the Health and Wellbeing Board to encourage integrated working, promote close working and undertake a JSNA and JHWS. This is particularly important as CCGs will be under a new duty to secure specific services in education, health and care plans for children and young people with SEN¹⁰. Indicative regulations also make clear that local authorities must consult Health and Wellbeing Boards when preparing and reviewing its Local Offer¹¹.

How to meet your Charter commitments

In order to fulfil this commitment, we would expect a HWB to be able to provide the following evidence:

- Information on links to other local integration forums which set strategic direction for disabled children's services, e.g. the local children's trust arrangements, the local safeguarding board, the learning disability partnership board, the school forum, etc.
- Evidence of how the JSNA and JHWS is aligned with other arrangements, such as: reviewing and commissioning of SEN services via the High Needs Block; safeguarding arrangements; child poverty strategies, etc.

Key resources for meeting this Charter commitment

NHS Confederation (2012), [Children and young people and health and wellbeing boards: putting policies into practice](#)

Developed by the health and wellbeing board learning set for children and young people, part of the National Learning Network for health and wellbeing boards, to give HWB members some ideas of how other boards are organising themselves to deliver coordinated services for children and young people.

9 See Department for Education (2012), [School funding reform 2013-14](#), pp. 16-20

10 See Department for Education website (2013), [Children and young people with special educational needs to benefit from new legal health duty](#)

11 The Special Educational Needs (Local Offer) (England) Regulations 2014: <http://media.education.gov.uk/assets/files/pdf/c/clause%2030%20draft%20regulations%20sen%20local%20offer.pdf>

Children and Young People's Health Outcomes Forum (2012), Health and wellbeing boards and children, young people and families

Poster produced in June 2012 by the health and wellbeing board learning set for children and young people.

Easton, C.; Hetherington, M., Smith, R., Wade, P., Aston, H. and Gee, G. (2012). Local Authorities' Approaches to Children's Trust Arrangements (LGA Research Report)

The Local Government Association commissioned the National Foundation for Educational Research (NFER) to investigate local authorities' approaches to their children's trust arrangements and how they are fulfilling their duty to promote cooperation with partners to improve children and young people's health and wellbeing.

General resources

[The Marmot Review \(February 2010\), Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010](#)

Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England.

[Kennedy, Prof Sir Ian \(September 2010\) Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs](#)

An independent review of services provided by the NHS to children and young people, concentrating on understanding the role of culture in the NHS. It focuses on areas where there are cultural barriers to change and improvement and makes recommendations.

[NHS Confederation - Resources for Health and Wellbeing Boards](#)

The NHS Confederation has been working with each health and wellbeing board learning set in collaboration with the NHS Institute for Innovation and Improvement, Department of Health and Local Government Association to produce publications which summarise their key points of learning and which will be shared with other shadow health and wellbeing boards.

[NHS Confederation \(2012\), Children and young people's health and wellbeing review of documents](#)

Briefing summarising the key policy documents on children and young people's health and wellbeing that have been published over the last two years."

[NHS Confederation \(2012\), Support and resources for health and wellbeing boards](#)

Summary of the support available to spread networking and learning opportunities for Health and Wellbeing Boards

[NHS Confederation \(2012\), National learning network for health and wellbeing board publications 2012](#)

A list of publications produced by The National Learning Network for health and wellbeing boards to share learning and support the establishment of well functioning boards.

[Local Government Association - Resources for Health and Wellbeing Boards focusing on children, young people and family issues](#)

The Health and Wellbeing Board learning set for children and young people looked at the issues important to the development of Health and Wellbeing Boards. The learning sets are a part of the Department of Health's development and support programme for Health and Wellbeing Boards which is supported by the LGA, NHS Confederation and NHS Institute. Nine learning sets focused on a number of themes including governance, resources and public engagement.

[Getting the Best Out of Your Health and Wellbeing Board Leadership Development Offer - Health and Wellbeing Board Information Resource](#)

This document brings together information about publications and websites which should be of value to Health and Wellbeing Boards.

Child and Maternity Health Observatory

ChiMat was established in 2008 as a national public health observatory to provide wide-ranging, authoritative data, evidence and practice related to children's, young people's and maternal health.

National Voices

The national coalition of health and social care charities in England. They work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

Regional Voices

Supports the voluntary sector to successfully influence local strategic decision making in health and social care. This group of pages links to a variety of resources to support you develop strategies to influence in your local area.

About Us



Every Disabled Child Matters is the national campaign to get rights and justice for every disabled child. It is run by four leading organisations working with disabled children and their families: Contact a Family, Council for Disabled Children, Mencap and the Special Educational Consortium.



The Children's Trust, Tadworth is the leading UK charity for children with acquired brain injury, multiple disabilities and complex health needs. The Trust's services include the UK's largest rehabilitation centre for children and young people with acquired brain injury, nursing care for technology-dependent children, and education for children and young people with profound and multiple learning difficulties and complex health needs.

Evidence to support the decision for the Health and Wellbeing Board to commit and sign the Disabled Children's Charter for Health and Well Being (May 2013)

The Charter asks that the Health and Wellbeing Board will provide evidence within one year. It is recommended that if the H&WBB agree to sign the Charter then the responsibility to collate the evidence will be through the Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN.

Below are seven statements that the H&WBB will need to provide evidence for to fulfil the Charter, under each statement is the current information to support fulfilling the Charter. Work is still required to fully meet the Charter, however, work is underway and plans in place to achieve the statements in one year's time.

1. We have detailed and accurate information on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs.

Data collection and quality remains problematic however, the work of the Integrated Commissioning Hub, the Integrated Community Children and Young People's Healthcare Programme and the SEND Pathfinder will significantly improve this. A Local Offer is being developed which will describe the support available in Nottinghamshire for children and young people with disabilities. Work is also underway to improve the uptake of children and young people who are on the Nottinghamshire Children and Young People's Disability Register which is currently quite low.

2. We engage directly with disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board.

Young People and families are fully involved in the Integrated Community Children and Young People's Healthcare Programme and the SEND Pathfinder. A participation group has been established for young people at APTCOO as the voluntary partner for the SEND Pathfinder.

3. We engage directly with parent carers of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board.

There are parents as members of the Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN.

Parents and carers are fully involved in the Integrated Community Children and Young People's Healthcare Programme and the SEND Pathfinder. Participation groups have been established for parents and carers at APTCOO as the voluntary partner for the SEND Pathfinder. Parents/carers are represented in both the Core Delivery Team and Programme Board. The development of the Local Offer is in partnership with parent and carers and plans are in place to engage with Healthwatch.

4. We set clear strategic outcomes for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account.

This is carried out through the Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN Joint Commissioning Strategy. This strategy is updated annually and performance monitored through the Children's Trust Board. Improving the effectiveness of services for disabled children through joint planning and commissioning is a priority in the Health & Wellbeing Strategy and the Children, Young People and Families Plan 2011-14.

5. We promote early intervention and support for smooth transitions between children and adult services for disabled children and young people.

The Early Intervention and Prevention Strategy (NCC, 2011) and The Pathway to Provision Multiagency Thresholds Guidance (NCC, 2012) promotes the importance of early intervention.

Review of the multi-agency transitions protocol to ensure it meets the needs of all children & young people transitioning into adult services is a priority in the Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN Joint Commissioning Strategy. Recent progress has been slow, however, the protocol is to be reviewed by September 2013, which will be undertaken through Transitions Operational Group.

6. We work with key partners to strengthen integration between health, social care, and education services, and with services provided by wider partners

The Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN has commissioning representation from parents, health, social care and education. Plans are in place to have a provider forum annually which will include health, social care, education and the third sector. The SEND Pathfinder is a joint programme of work led by Nottinghamshire County Council including partners from health and the third sector.

The Integrated Commissioning Hub that will be operational from September 2013 will facilitate integrated planning, commissioning and provision of services, to improve outcomes and meet the health and well-being needs of children and young people.

7. We provide cohesive governance and leadership across the disabled children and young people's agenda by linking effectively with key partners.

There is a clear Governance arrangement in place with the Integrated Commissioning Group (ICG) for Children & Young People with Disability and SEN being a core group of the Children's Trust Board which provides performance monitoring of this groups work. Leadership is distributed across partners and will be strengthened through the Integrated Commissioning Hub with having a dedicated team of commissioners for Children's health and wellbeing services. Involvement of the Health and Wellbeing Board through the signing of the Charter will help shape the overarching governance and leadership structures.

Children with Disabilities and/or Special Educational Needs - February 2012



A Needs Assessment for Nottinghamshire Executive Summary



"I am very grateful for the respite and play services my son receives and would feel far less anxious if I could be assured that planners were assessing needs for the growing population.....coming through the system and that provision, recruitment and training of staff should be happening now to meet their needs once they reach adulthood."

Local parent

Introduction

The Nottinghamshire Children's Trust has developed this needs assessment to identify the needs of children, and young people with disabilities and/or Special Educational Needs (SEN) and their families within the county. Findings from this needs assessment will be used to influence a local joint commissioning strategy, which will make sure that the partner agencies work together, align resources to deliver their services effectively, provide good value for money and improve the experience and outcomes for people who use these services.

Establishing joint commissioning arrangements and processes around key target groups such as disabled children and young people will help to improve co-ordinated packages of support, streamline processes, reduce duplication and costs, as well as improve outcomes.

We are working to achieve the following ambition:

We want Nottinghamshire to be a place for everyone to enjoy a good quality of life and realise their potential; and for our children to be safe and happy. In particular we want children with a disability and/or special needs to have the same access of opportunity as other children, to aspire, and be empowered to do so.

To achieve this ambition we are working with partners to identify the needs of children, young people and families with disabilities in Nottinghamshire, we will identify gaps in service provision, review what children and families tell us and ensure our interventions and services are based on evidence based practice to improve outcomes.

Every child deserves a fair start in life, with the very best opportunity to succeed. Currently, life chances for the approximately two million children and young people in England who are identified as having a special educational need, or who are disabled, are disproportionately poor¹.

"The assessment of children and families' needs and the development of services to meet those needs are vital steps towards well being. Having a complete picture of the numbers and circumstances of disabled children is part of this process, yet there is no current complete information in the UK to guide local areas."²

The data used in this needs assessment is based in the main on national and local estimates of needs, as well as data stemming from which groups access the services available locally. In addition, most children have more than one disability, with severely disabled children commonly having physical, sensory and learning disabilities. So planning which focuses on just one disability or the 'main' disability can be problematic.

It is also notoriously difficult to gather and analyse data on disability, as there is no comprehensive register of disabled

children in the county. Data is collected by numerous health and social care agencies, as well as education, and the different categories, definitions and thresholds used across the system add complexity to the process. For example, routine data is collected by local authorities on children with statements of special educational needs, but this does not reflect the spectrum of disability and is only a weak proxy measure for severity. Some agencies classify a 'young person' as being up to the age of 16, others up to 19, and others up to 25. In addition, information about individuals may be held in care records that are not linked, and even where data might be available, it is difficult to extrapolate and translate individual experiences into the population estimates needed for effective commissioning.

This needs assessment is therefore imperfect. It is a best effort, which contains incomplete data and gaps in information, synthetic estimates and 'educated guesses'. For example, data on school aged children is much more readily available than for children in the early years or post 16, so much more work needs to be done to 'drill down' into these areas. However, through the analysis of as much available intelligence as possible from a range of stakeholders, a picture of need has been formed, along with recommendations for more effective planning and commissioning.

There are a range of opportunities for joint work and joint commissioning for children and young people with SEN or disabilities. The development of this needs assessment is part of a phased approach and further information will be collected and analysed as the work is progressed and the strategy is developed and implemented.

Aims of Needs Assessment

- To identify the population of children who have a disability in Nottinghamshire
- To understand the current demand for services alongside the current levels of provision
- To provide an evidence base and understanding of need for the forthcoming joint commissioning strategy
- To identify improvements in relation to data collection, analysis and use.

Definitions

Nottinghamshire County Council and its partners have adopted the Disability Discrimination Act³ (DDA) 2005 definition of disability:

"A child or young person is disabled if they have a physical or mental impairment which has substantial and long term adverse effect on his/her ability to carry out normal day to day activities"

Methodology

This needs assessment was developed using information already available to a number of teams and organisations working in Nottinghamshire as well as national data and evidence. Researchers worked with members of the joint commissioning group to scope what information was required and then proceeded to work to answering a series of questions that commissioners and planners would find useful.

Researchers have also used qualitative information where available, including case studies and quotes from service users held by local organisations and teams.

Key Headlines

The needs assessment highlighted the following headlines:

Demography

- The national picture indicates that more children and young people with disabilities are living longer and surviving into adulthood.
- There are between 7,000 and 12,000 children and young people (0-19) experiencing some form of disability in Nottinghamshire. Indications are that this is slightly more prevalent among boys than girls.
- Nottinghamshire's overall 0-19 population is forecast to rise by 8.7% between 2011 and 2033, with the largest increase being in the 10-14 age group (20.2%).
- 20-24 year olds represent the highest proportion of young people with limiting long term illness (6.5%) in Nottinghamshire, followed by the 15-19 age group (5%). The lowest proportion is the 0-4 age group (2.7%).
- The highest number of young people (0-24) claiming Disability Living Allowance (DLA) live in Ashfield (1,380), followed by Mansfield and Newark & Sherwood (both 1,170 each). The lowest number live in Rushcliffe (640).
- There has been a 60% rise in young claimants (0-24) of DLA in Nottinghamshire over the last decade.
- One in five Nottinghamshire school pupils has some kind of special educational need (SEN). The highest rates are in Mansfield (24.1%), Ashfield (21.4%) and Bassetlaw (21.3%).
- Over the last five years, the percentage of SEN pupils in Nottinghamshire primary schools has decreased from 16.6% to 16.0%. However, in the county's secondary schools, the percentage has increased from 15.9% to 22.8%.
- Around 1,550 pupils in Nottinghamshire have been assessed as School Action Plus or Statemented, so have a primary need of behavioural, emotional or social difficulties (BESD) by schools, and 1,880 have some form of learning difficulty.

- National evidence indicates that black and minority ethnic families are less aware of, and make less use of, specialist disability services; and that asylum seeking families may not report their child's impairments for fear it might affect their immigration status.

Themes

Poverty

- National research shows that disabled children are more likely to live in poverty - the average income of families with disabled children is nearly a quarter less than the mean UK income.
- In Nottinghamshire, the rates for severe disability are greatest amongst children from 'semi-skilled manual' family backgrounds, with the lowest rates in the 'professional' and 'managerial' categories.
- A recent health needs assessment of Nottinghamshire (city & county) special schools also identified a strong relationship between level of need and deprivation. It is not certain if this is a reflection of actual prevalence of need, or ability to meet need due to resources available within the family.
- 13% of Nottinghamshire school pupils are eligible for free school meals. This figure more than doubles for pupils who are at School Action Plus or have a statement (28%).
- National evidence suggests that families with a disabled child are 50% more likely than other families to live in overcrowded accommodation, to rate their home as being in a poor state of repair and to report problems with wiring, draughts and damp in the child's bedroom.
- It is possible that those who are most in need of services are the least likely to access them due to the 'inverse care law', which suggests that those living in areas of deprivation find it more challenging to access services than their more affluent counterparts.
- National evidence suggests a lack of 'door to door' transport, either through school transport services or public transport, is a key barrier to participation in out of school opportunities and activities for many disabled children and young people.

Social Care

- There are just under 100 school pupils in the county who are both the subject of a child protection plan and have an SEN category. Just under half of these (47%) have BESD.
- There are on average 75 looked after children (LAC) in Nottinghamshire who have a disability, with the highest numbers in Mansfield and Ashfield.
- The number of children (aged 5-15) who have been looked after continuously for at least 12 months and who have an SEN category totals 180 (or 74.5%

of that cohort). As there are approximately 20% of Nottinghamshire pupils overall with SEN, this means LAC are three and a half times more likely to have SEN compared to all pupils.

- So far in 2011 there have been 177 referrals to the County Council's Disabled Children's Team (up to November), compared to 325 in all of 2010 and 279 in all of 2009.
- In 2010/11, 260 disabled children and young people in Nottinghamshire accessed direct payments, up from 95 in 2007/08.
- Nottinghamshire pupils who are in the School Action Plus category are around 25 times more likely to have a Common Assessment Framework than non-SEN pupils.
- National data indicates that children with SEN and/or disabilities are disproportionately at risk of bullying. However, the number of disability hate crime incidents reported in Nottinghamshire is low.

Early years and childcare

- The Disabled Children's Access to Childcare programme is currently supporting 168 children and young people (0-19). 96 of these are in the 0-4 age range.
- Children's centres in Nottinghamshire saw 410 disabled children (aged 0-4) between September 2010 and August 2011, compared to 216 in the previous twelve months.

School Education

- The achievement gap at Key Stage 2 between SEN and non-SEN pupils in Nottinghamshire has narrowed over the last four years, but is slightly worse than statistical neighbours and the national average.
- At Key Stage 4, the gap in Nottinghamshire is better than statistical neighbours and the national average, but is widening as non-SEN pupils improve at a faster rate than SEN pupils.
- Children with SEN in Nottinghamshire have higher than average absences from school and are four times more likely than the rest of the school population to be persistent absentees. This is broadly in line with other local authorities.
- SEN pupils in the county are ten times more likely than the rest of the school population to receive a fixed period exclusion from school and nearly 15 times more likely to be permanently excluded.
- Over a quarter (27%) of children who are electively home educated in Nottinghamshire have special educational needs.
- There are 11 special schools in the county, which currently accommodate 847 pupils. 84 pupils who live in the county attend special schools in other local authorities and 103 pupils who live outside the county attend Nottinghamshire special schools. Placements in independent or non-maintained special schools have increased from 58 in 2005/06 to 132 in 2011/12.

- The most common high level needs in Nottinghamshire (city & county) special schools are personal care, physiotherapy, continence, communication, occupational therapy, wheelchair and moving/handling.
- County Council provision for home to school transport for pupils attending special schools and other school provision will account for around £5.7m in 2011/12, up from £4.7m in 2005/06.
- Children and young people with SEN in Nottinghamshire schools consulted in 2009 said they did not feel sufficiently engaged in decision making processes that affect them; that they are often the victims of bullying; and that the level of personalised learning in schools does not always match the diversity of their needs.

Post-16 Education

- The biggest challenge commissioners face is to find suitable placements for a small number of young people with complex needs (mainly emotional/behavioural or Autistic Spectrum Disorder (ASD)), who have been engaged on alternative provision pre-16 (often one to one support) and therefore struggle to integrate into a mainstream or specialist post-16 placement.
- Young people in Nottinghamshire with learning difficulties and/or disabilities (LDD) are over-represented in NEET (not in education, employment or training), especially School Action Plus pupils.
- The proportion of Nottinghamshire residents aged 16-19 with LDD in further education and sixth form colleges is 22%, which is slightly above the regional average (19%).
- In the county in 2010/11, there were 49 residents aged 16-24 with placements in Independent Specialist Providers (ISPs), up from 38 in 2009/10. Nottinghamshire is one of six local authorities in the East Midlands with 50% or more of their residents in ISPs placed in residential rather than day provision.
- Between 2001/02 and 2010/11 there was a 72% increase in the number of accepted disabled UCAS applicants in Nottinghamshire (403 accepted in 2010/11), compared to a 16% increase in the non-disabled population.

Caring Responsibilities

- Parents with disabled children are at increased risk of stress compared to other parents, and stress levels are strongly linked to child behaviour and sleeping problems.
- The numbers of children and young people accessing short breaks has increased from 860 in 2007/08 to 2,190 in 2010/11.
- Siblings can feel pushed out, may be jealous of the attention their disabled sibling receives and are often carers themselves - which can in turn affect their achievement at school, their general well-being and their own friendships.

- A national study of families with children with profound and multiple difficulties found that 60% of parents spend more than 10 hours per day on basic physical care. These demands can deter parents and carers from accessing employment.
- A different national survey identified that over nine out of ten family and friends carers who responded were grandparents.
- Local intelligence from the voluntary sector indicates that parents/carers sometimes do not know what support is available to them to help with transitions and how to access it. All parents consulted found transition planning a very difficult process and commented about the uncertainty they felt.
- Consultation with local families in 2009 indicated that services on offer do not always help with the complex 'juggling act' of looking after a family with a disabled child and that it is also difficult to find out what services are available.
- Other consultation locally undertaken in 2009 found that parents reported access to social and leisure opportunities for children and young people with SEN to be uncoordinated and frequently unavailable.
- Future growth in demand for specialist equipment is expected to accelerate given the increasing numbers of children with disabilities.
- An audit of 200 referrals to the Community Paediatric Service during 2010/11 identified that the highest proportion (50%) were as a result of problems with behaviour, such as ASD, ADHD and social interaction.
- The Paediatric Occupational Therapy Service received 105 referrals from the county (excluding Bassetlaw) and 62 from the City between April 2010 and September 2010.

Conclusions

Improving the lives of disabled children and young people is a key priority for Nottinghamshire's Children's Trust. Representing a diverse group, disabled children often have highly complex needs requiring multi-agency support across health, social care and education services. Disabled children often require a vast and complex array of services, so they stand to benefit from joined up approaches to joint commissioning and planning.

The prevalence of severe disability is increasing because of higher survival rates of children and babies with some complex problems. Even if disability prevalence remains constant, the number of children with disabilities will continue to increase as the population of children and young people is forecast to grow. This needs assessment begins to identify some issues and encourages further work to forecast for increasing demands on services.

"Parents of children with disabilities experience vast variation in the kinds and levels of support they receive from a range of services, which appear to have little bearing on need."⁵ This is reflected in the case studies and quotes included within this needs assessment where parents and carers are confused about what services their children are entitled to, what services are available; and what to do when support needs (real or perceived) are not met and the reasons for this. We have identified that there is some unmet need, however without having access to all data and performance information it is a challenge to identify exactly where unmet need is.

Substantial inequalities persist between disabled children and young people and their peers. This is an issue nationally and locally reflected within this needs assessment e.g. education outcomes.

There is a lack of current local information on the numbers of children and young people with disabilities and long-term conditions and the needs of this group; this has been compounded by challenges around data and information sharing across organisations. This has also made it a challenge to assess full levels of unmet need for disabled children and their families.

Health

- It is difficult to identify the numbers of disabled children attending hospital due to the lack of a systematic way of recording status. However, one issue that has been identified is disabled children who spend prolonged periods in hospital with chest infections. A rapid response physiotherapy service is currently being piloted in the south of the county to treat this issue in the community - it is estimated that there are approximately 80-100 children and young people in the county (excluding Bassetlaw) who could benefit from the service.
- National data shows that children who have a limiting illness are more likely to be overweight or obese, particularly if they also have a learning disability. There is no local data on obesity and disability, as children unable to stand on scales are excluded from the National Child Measurement Programme.
- Children with physical or learning disabilities are identified nationally as at risk of not being fully immunised. There is, however, no local data on this.
- There are an estimated 1,800 children and young people (0-19) with ASD in the county. Diagnoses of ASD and demand on services are on the increase.
- NHS Continuing Healthcare in Nottinghamshire (excluding Bassetlaw) currently has 30 patients (aged 0-25) who receive fully funded continuing healthcare. In addition, during 2010/11, 27 items of equipment for patients (aged 0-25) were funded, with 17 items in the first six months of 2011/12.

Data is not always available but where it is we are not routinely sharing or analysing data for the benefit of service users. This results in children and families having to repeat their story too often and continued siloed working practices.

There are a substantial number of services which offer support and interventions to children and young people with varying levels of disabilities and/or SEN. There seems however often to be a lack of coordination of these services and interventions for families as services and teams often work very separately from each other.

This needs assessment is the tip of the iceberg as far more work is required to understand this subject appropriately to be able to influence service provision and working practices.

Key Recommendations for Planners and Commissioners

Top Six Priority Recommendations for members of the Joint Commissioning Group

1. The availability of relevant data would enable commissioners to more effectively commission services to meet the needs of this local population. Further work is required to further assess needs; in particular where data has not been made available for this needs assessment (further information is provided in later).
2. Ensure co-ordinated planning at all levels, with roles and responsibilities of different agencies clarified and understood by frontline staff working with young people.
3. Increase opportunities to integrate key services to ensure that there is a consistent approach, reduced duplication, improved efficiencies and clearer pathways for children, young people and families.
4. Increase joint commissioning opportunities to reduce silo working across agencies working with the same children and families.
5. Demand on services exceeds availability so budgets are tight, commissioners and services need to plan more together to be efficient and ensure needs led services and interventions developed and delivered jointly.
6. Use evidence based practice to shape local services and interventions, and help build the evidence base and invest time and resource into evaluation of interventions and processes.

Additional Recommendations

- **Information sharing** - Removing barriers that prevent the sharing of data will enable joint commissioning whilst minimising duplication for children and young people,

families and service providers. Without more effective data-sharing, delivering integrated services will remain challenging.

- There should be more cross referencing of data sets to combine and explore data held by Nottinghamshire County Council, PCTs and NHS providers, Nottinghamshire Futures etc.
- **Improved data collection** - during the development of this needs assessment it has become apparent that organisations do not collect data that commissioners and planners would find useful, in particular measuring the impact of interventions on outcomes for children and young people with Disabilities and/or SEN. In addition mainstream services lacked data regarding disability e.g. apprenticeship schemes, and specialist services do not routinely collect data for service users including ethnic origin.
- Commissioners should be explicit about what data is collected and shared within contracts for all commissioned services working with these groups.
- Services and commissioners should look to develop improved monitoring which captures categories of disability need rather than just looking at primary or secondary needs in most cases. The Health Needs Assessment carried out in Special Schools provides a useful categorisation system.
- Data should be used to systematically plan and resource for evaluating the impact of what has been commissioned
- **Forecasting** - this needs assessment has identified there will be higher demand on services in the future. Commissioners and planners will need to ensure that forecasts are planned and resources available to meet increasing demand. In light of budget restrictions, planners may be required to review thresholds for some service provision to ensure those with greatest need are prioritised e.g. transport.
- **Improve the Nottinghamshire register of children and young people with a disability or SEN** - The register of all disabled children should be maintained by the Local Authority as they hold comprehensive education and social care information, improved information sharing with health partners is also critical. A comprehensive, up to date, and well used register is central to ensure a safe and responsive transition through key stages including early years to school, school to FE College, children's to adult services. It will also allow permission for data sharing across partners.
- Consistent requests for consent to share data should be a routine element of all initial contacts with families. Promoting the use of the register among a range of practitioners including healthcare who have early contact with target groups is fundamental to ensure children and young people's needs are identified and addressed in order to improve their outcomes. Data collected and

analysed through the register should be shared with front line practitioners so they understand the rationale for data collection.

- **Use evidence based practice** - this needs assessment identified evidence based practice to help improve outcomes for children with disabilities and/or SEN. A number of key areas have been included within these recommendations.
- It is also important however to help build the evidence base and invest time and resource into evaluation of interventions and processes.
- **Identification of Pre School disabled children** - Numbers of children aged 0-4 with a disability or SEN are often not known by services such as Children Centres. Health partners will hold more data on this population and it would be advisable if information could be routinely shared using the register of disabled children so that services can be targeted appropriately.
- **Increasing Numbers of SEN Young People** - explore why there are increasing numbers of young people assessed as having SEN in secondary schools in Nottinghamshire, and not in primary schools.
- **Assessing levels of unmet need** - A recent health needs assessment of special schools identified a strong relationship between level of need and deprivation. It is not certain however if this is a reflection of actual prevalence of need, or ability to meet need due to resources available within the family. It is important to remember that those living in areas of deprivation find it more challenging to access services than their more affluent counterparts. It would be useful therefore to carry out some qualitative work with families from different socio-economic groups to fully assess levels of need and unmet need.
- **Challenging behaviour** - Looking at children and young people's behaviour has been a challenge within this needs assessment because behaviour is not always linked to a clinical assessment or diagnosis and could be linked to a wide range of factors including parenting. Commissioners and planners need to be mindful of this issue when developing their joint commissioning strategy.

Intervention Approaches

- **Targeted interventions** - the needs assessment has identified that further work is required to ensure those with the greatest needs are targeted. It is important therefore to target children and families from the poorest socio-economic groups and key BME communities who we know are less likely to engage with some services.
- **Early intervention and prevention** - Understanding the causes of disability is critical for all Children's Trust partners, so the wider partnership can invest time and resource to support early intervention and prevention approaches e.g. maternal health (smoking, alcohol and substance use, folic acid) and prevention of infectious

diseases during infancy and childhood.

- **Lead Professionals** - Establish lead link/co-ordination roles for families requiring a range of interventions from a range of services. Children and young people who undergo a CAF will have a lead professional; however it is advisable for a lead professional role to support a whole family where there is a disabled child/young person, in particular those with complex needs. Improved partnership working is a necessity.
- **Participation of Service Users** - Listening to parents/carers and children/young people to help improve and plan services is critical to ensure those services meet identified needs. Evaluation practices must also routinely engage service users and target groups.
- **Early Years interventions** - evidence suggests that high quality pre-school centres improve children's cognitive development and reduce the need for special education in primary care. It would be useful to therefore assess the quality of early year's provision for children with disabilities or additional needs.
- **Direct Payments** - Analysis of feedback of parents and young people in receipt of direct payments should be sought and used routinely to understand any concerns, anxieties, barriers and support needs e.g. support as employers of their own staff.
- **Service/Care Pathways** - A number of service pathways are available for specific disabilities including ADHD, ASD, and Palliative Care. It is advisable that the joint commissioning group review these collectively to ensure pathways are clear and there are clear interrelations with a range of services across Nottinghamshire.

Information and Communication

- **Information, Advice and Guidance** - ensure clear non biased information, advice and guidance for parents and carers to help them to understand their rights, their entitlements, local services and how to access services for their children as well as support for themselves.
- Evidence suggests that web based information is the most effective in dealing with specific issues or problems.
- **Improved communication** - this needs assessment identified that in some cases parents and carers have higher expectations for services above and beyond what they can offer. Services need to be explicit about what they offer and to whom and when, this should be included on service materials as well as Nottinghamshire wide websites that target parents, carers and young people. It is also important for all professional groups to understand any recent changes to services including thresholds.
- In addition some parents and some professional groups do not understand why there are layers of bureaucracy before being granted approval for some services and

interventions. A greater understanding of the procedures surrounding the access to some services e.g. why a school may require written proof of a diagnosis, the processes and thresholds is urgently required.

- It is also important to ensure that parents, carers, children and young people understand why processes take time to complete by explaining to them what is involved, this is important at the start of processes but also throughout any process of assessment. Nevertheless if assessment processes are taking too long as identified by some parents in this needs assessment, then this should be remedied as soon as possible.

Focusing on Outcomes

- **Measuring Outcomes** - many services have traditionally collected data on the numbers of service users seen and have not fully adopted service evaluation which captures the impact on the outcomes for children and young people. The forthcoming joint commissioning strategy should focus on improving outcomes and encourage improved evaluation and performance activity.
- **SEND Pathfinder** - It will be important for the Joint Commissioning group for children with disabilities and/or SEN to have a clear overview of the activity of the pathfinder to ensure learning influences practice e.g. the use of one assessment and one care plan shared by a range of organisations and professionals. This will also provide an opportunity to inform the evidence base of what works.

Education Outcomes

- **Educational attainment** - further work is required to improve the attainment of children and young people who have a SEN statement and therefore close the gap between SEN children and young people and their peers at all key stages in particular Key Stage 4.
- Ensure that children and young people with disabilities and/or SEN are a key target group within the imminent 'Closing the Gap' strategy, in order to narrow the attainment gap.
- **Pupil Premium** - schools are due to receive the Pupil Premium which should help them to improve the attainment of the schools most disadvantaged pupils. It would be useful to ensure schools have access to evidence based practice on how best to use the resource for children and young people who are eligible for free school meals and have a disability or SEN.
- **Post 16 Educational Placements** - Information indicates that there are a range of services and interventions available for young people aged 16+ however the biggest challenge for many is to find suitable placements for a small number of young people with very specific complex needs. Many of these young people struggle to integrate into a college environment, mainstream or specialist post 16 placement. It is important to further develop the market to ensure

placements are available for these specific needs, as well as a review of the 2011/12 pilot programme which is using on-going support from the alternative pre-16 provider for four young people to support them to transition post-16.

Health Outcomes

- **Occupational Therapy** - following on from the Joint Public Health and Social Care AHDC Occupational Therapy Pilot, there is still a need to develop a joint Occupational Therapy commissioning strategy with a clear pathway to provision in respect of equipment and other shared roles to ensure collaborative working and reduced confusion for families and therapists.
- **Improving access to specialist equipment** - Further discussions with health colleagues are required to agree a way forward to develop a fast track procedure/protocol for equipment (taking account of ICES criteria for provision).
- There need to be clear simple pathways for service users and professionals to help them understand roles and responsibilities for Occupational Therapy, Equipment Panels, ICES etc, this will also help ensure children and families know what to expect and who to contact.
- **Palliative care and Complex Health Needs** - a recent scoping report identified a number of recommendations that have yet to be implemented. These included the need for consistent provision of therapy services for this group of children and young people; the need for prompt referrals to community based services and increasing the availability of specialist family support and key working.
- There is also a requirement to develop flexible provision with a multi-skilled workforce that is county-wide, offering a range of services, including 24 hour on call, seven days a week support with the capability for home visiting for short breaks at end of life if required by families.

Approaches to Joint Commissioning

- **Costs and benefits** - to enable improved joint commissioning and agreement of shared priorities, it would be useful to look at the costs of all key services and interventions. Commissioners should look to share this data so that cost benefit analysis work can be achieved, and decisions for commissioning priorities should explore value for money.
- An investment based model of joint commissioning should be adopted so that commissioners can assess value for money and cost benefit analysis.

External Placements

- **Cross border working** - as has been identified in this needs assessment, Nottinghamshire pupils attend Special Schools outside of the Nottinghamshire County borders as other children attend Nottinghamshire schools from neighbouring areas. It would be worthwhile to assess how packages of support are agreed and funded for children and young people.

- **Out of Authority Placements** - Further work is required to understand who uses out of authority placements, why this placement was used rather than a more local service provision, why there are larger numbers being placed in these placements, feedback from children and young people, as well as cost implications. It would be useful to look at out of authority placements for children and young people using social care placements, special school placements and those in post 16 placements jointly.

Transition Processes

- **Transition support** - It would be useful to widen the scope of research into support on transitions for all children and young people with SEN, for example children with dyslexia or young people moving into further education, training or employment. However it would be useful to gather specific qualitative information from children and families about transition.
- Transition services require greater collaboration across all key agencies to meet the priorities of young disabled people with complex needs as they move into adulthood.

Equitable Access to Services and Interventions

- **Transport** - an urgent review of transport availability and use is required to ensure that those who need it most are able to access flexible transport, this however may mean that some universal transport provision will move to a needs assessed allocation in order to spread out already very thin resources.
- **Special School Nursing** - there seems to be currently some inequity in how Special School Nursing is delivered across Nottinghamshire Special Schools, further work would be required to ensure the service is equitable and based on need.
- **Short Breaks** - activity for children and young people to access short breaks seems to be responsive to need and the team is active in collecting and analysing information from service users. Work should continue to ensure those children and families most in need are prioritised for interventions.
- **Inclusive universal services** - All universal services need to be inclusive for children and young people with disabilities; this encourages children and young people to participate in activities with their peers and siblings and helps their understanding of peer culture. There should not be sole reliance on specialist activities. The use of access audits will help assess if services are inclusive.
- **Children Centres** - it is unclear if outreach targets for Children Centres in reaching disabled children are being met. It is known however that numbers seen at Children Centres are increasing; the interventions that took place in 2010/11 have had a positive impact on numbers seen by the centres. Further work should be implemented to ensure there is a continual increase in the numbers of disabled children accessing Children Centres. It would also be useful to identify the impact of Children Centre interventions on the outcomes of disabled children.

Further Needs Assessment Activity

- **Ethnicity** - further work is required to ensure ethnicity data is collected by services as well as the register of disabled children, so that services can be prepared to meet a range of varying needs linked to ethnicity. We know for example that asylum seeker families are less likely to request support so organisations may be required to implement outreach activities to engage them.
- **Gender** - this needs assessment identified that more boys than girls are being assessed as having a disability. Additional work is required to explore this further and to understand gender differences e.g. are more boys than girls being identified as having challenging behaviour which has impacted on the data or is this linked to increasing diagnoses of ASD?
- **Locality of residence** - this needs assessment struggled to identify the geographical location of where disabled children and young people reside. Those in special schools however are known and data is available in Appendix Three, however further work is required to identify needs based on locality. This data may be available through better implementation of the register of disabled children and young people.
- **Social care data** - this data was not fully made available for this needs assessment so we lack information about how well social care support disabled children and their families in Nottinghamshire.
- **Out of authority placements data** - no data was provided for use in this needs assessment. It would be worthwhile to explore the numbers of children and young people in a range of out of authority placements, why they are there, how their needs are being met, and performance of these placements as well as cost. It is recommended that a further needs assessment is developed to look at this issue and include qualitative data from service users and their families.
- **Transition assessments** - Analysis of a range of data collected during core transition assessments would be useful for those responsible providing and commissioning services for children and families. Further work would be beneficial to collect, analyse and share this data with the joint commissioning group to enable them to have a greater understanding of issues for children and young people during key transition stages.
- **Qualitative feedback from children and young people** - although pre existing qualitative data was requested for this needs assessment, more information seemed to be available from parents and carers rather than the children and young people themselves. Any further needs assessment work must make every effort to engage children and young people with disabilities and/or SEN to gather their views of services and the issues facing them which impact on a range of outcomes.

- **Uptake of direct payments** - full data regarding the use of direct payments by parents of disabled children or disabled 16-17 year olds who access in their own right was not available for this needs assessment. It would be useful to explore data from health and local authority service leads to help to identify who accesses Direct Payments and who requires additional support. It would also be useful to see details of claimants e.g. age, gender, postcode.
- **Palliative care for children and young people** - this data was not available for this needs assessment, although numbers are small, this data would be useful for commissioners to use in order to ensure services are available to meet needs.
- Additional work would be useful to understand the numbers of children and young people that may be considered suitable for palliative care because the proportion of deaths that occur in hospital is relatively high, suggesting that there is a considerable challenge to improve access to palliative care services for children.
- **Equipment needs** - specialist equipment has not been addressed adequately within this needs assessment. It is recommended that a separate needs assessment be carried out looking at equipment for children and young people, pulling information together from a range of partners including NHS, Local Authority, Special Schools, parents/carers and children/young people. Projection planning would also be useful in terms of equipment needs.
- **Emotional health and well being needs** - the Health Needs Assessment for pupils in Special Schools identified that emotional health was not recorded as being a particular need in complex needs pupils. It is not clear if this is truly the case or because it is perceived that physical need is more important. It is recommended that the emotional health and wellbeing needs of pupils are explored in this group of children and young people as this figure is surprisingly low.
- **Qualitative feedback from professionals working with children and families** - to further assess unmet need it would be useful to engage a range of practitioners working in the field of Children's disability and SEN. They will help to discuss any barriers within pathways for children and their families, and will be able to identify gaps in service provision. Special School head teachers for example would be able to make a worthwhile contribution discussing a range of services and interventions.
- **Health Service Performance Data** - More comprehensive data should be collected from all local health services including those serving Bassetlaw. Data should include current performance levels to further assess needs.
- **Planned and unplanned admissions to hospital including A&E** - Anecdotally we know that disabled children are more likely to have unplanned hospital admissions including visits to accident and emergency departments. This needs assessment however could not confirm this anecdotal information. It is difficult to identify disabled children attending hospital from routine data due to the lack of a systematic way of identifying and recording this status, so there may be unmet need if data is not available.
- **Undertake 'access audits'** - it may be worthwhile to consider the development of an access audit of activities including, youth, play and leisure services to ensure that these universal services are inclusive and changes are made where required. It would also be useful to undertake health equity audits to ensure universal health services are also inclusive and engage disabled children and their families.
- **Housing** - identify local data on families with disabled children and the conditions in which they live (e.g. overcrowding, state of repair etc.)
- **Transport** - numbers of disabled children requiring transport, geographic spread, projections, analysis of costs - and barriers to participation created by a lack of transport provision.
- **Bullying** - there is no local data on disabled children and their experiences of bullying and hate crime.
- **Parents/Carers** - intelligence on the demands which local parents and carers (including young carers) of children with profound and multiple difficulties are under is very limited.
- **Obesity** - there is no local data on obesity and disability, as children unable to stand on scales are excluded from the National Child Measurement Programme. The National Child Measurement Programme does not ask to identify if children accessing the programme have a disability.
- **Immunisations** - nationally, children with physical or learning disabilities are identified as at risk of not being fully immunised. There is currently no local data available to monitor this
- **Kinship Carers** - no local data was available for this needs assessment that would help to identify the proportion of carers who are members of the family (excluding parents). Further work to understand and meet the needs of kinship carers in Nottinghamshire is required.
- **Workforce development needs** - evidence based practice recommends that a skilled workforce is needed in particular in universal services to ensure that they are inclusive. No data was available regarding how inclusive the local workforce is. It would be worthwhile therefore to assess workforce development needs.

References

- ¹ Department for Education (2011) Support and aspiration: A new approach to special educational needs and disability - a consultation' www.education.gov.uk/publications/eOrderingDownload/Green-Paper-SEN.pdf
- ² Sloper T (2004) 'Meeting the needs of Disabled Children' Quality Protects Research Briefings (no 6) Research in Practice
- ³ For the purposes of the DDA Act, references to disabilities that are substantial and long term means that the effect of the impairment has lasted or is likely to last for at least 12 months and affects normal day-to-day activities including everyday things like eating, washing, walking and going shopping. A normal day-to-day activity must affect one of the 'capacities' listed in the Act which include mobility, manual dexterity, speech, hearing, seeing and memory.
- ⁴ Department for Education and Skills (2006) 'Health and Well-being: Physical Health' Research and Practice Briefings: Children and Young People



**Nottinghamshire
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Nottinghamshire's Special Educational Needs and Disabilities Pathfinder – the 'One Project'

The vision... to help support children and young people with special educational needs and disabilities aged 0 to 25 to lead an ordinary life with their families

Our mission... to provide a Nottinghamshire local offer of services and an integrated 0 to 25 multi-agency assessment leading to 'One Plan' for education, health and care, which is person centred and outcome focused, enabling the joint commissioning and provision of quality services which can be paid for using a personal budget

From fragmentation ...

Information and advice: Variety of duplicated access channels where information and advice is available but may require multiple contacts to resolve an enquiry.

Assessment: Multiple assessments to access and plan support arrangements across education, health and care, requiring children/young people and their families to repeat their stories and personal information.

Services: Separate appointments made with families appear un-coordinated and build in delay for children and young people receiving services.

Commissioning: Separate commissioning and block contract arrangements for services across education, health and care creates inflexibility and the ability to maximise value for money.

Phase 1 - Scoping

- The 'One Project' team and governance arrangements established (April 2013)
- Children, young people and their families engaged in developing the local offer (April 2013 then ongoing)
- Scope of education, health and care assessments and services agreed (May 2013)

Phase 2 - Development

- New 0 to 25 multi-agency assessment team structure and processes developed (May 2013)
- Information sharing and supporting systems developed (May 2013 then ongoing)
- Multi-agency training needs identified and planned (June 2013 then ongoing)
- Resource allocation system developed (June 2013 then ongoing)
- Updated local offer of services made available (September 2013)
- Recommendations from the Integrated Community Children and Young People's Healthcare Programme are aligned to the Pathfinder (September 2013)
- New 0 to 25 multi-agency service delivery team structure and processes developed (October 2013)

Phase 3 - Implementation

- Staged implementation of new 0 to 25 multi-agency assessment team across the county (May 2013 then ongoing)
- Personal budgets are increasingly available (June 2013 then ongoing)
- Final local offer of services made available (December 2013)
- Staged implementation of new 0 to 25 multi-agency service delivery team across the county (April 2014 then ongoing)

...to integration

Information and advice: A single point of access that filters enquiries using a single source of information (the 'local offer') as soon as contact is made, whether that's by dialling a single telephone number, accessing from a web site or visiting a person/team.

Assessment: Multi-agency thresholds into an integrated 'One Plan' team who with the support of an IT system co-ordinate the assessments and reduce duplication.

Services: An integrated service that is multi-agency and co-located with a single line of management, and which creates opportunities for a better relationship and lines of communication.

Commissioning: A Joint Commissioning Strategy Hub/Unit commissions internal and external services, and gives greater choice and control to parents and young people to commission services using a personal budget.

Our principles ...

Valued uniqueness – The uniqueness of children, young people and families is valued and provided for

Planning partnerships – An integrated assessment, planning and review process in partnership with children, young people and families

Key Working – Service delivery is holistic, co-ordinated, seamless and supported by key working

Birth to Adulthood – Continuity of care is maintained through different stages of a child's life and through preparation for adulthood

Learning and Development – Children and young people's learning and development is monitored and promoted

Informed Choices – Children, young people and families are able to make informed choices

Ordinary Lives – Wherever possible children, young people and their families can live 'ordinary lives'

Participation – Children, young people and families are involved in shaping, developing and evaluating the services they use

Working Together – Multi-agency working practices and systems are integrated

Workforce Development – Children, young people and families can be confident the people working with them have appropriate training, skills, knowledge and experience.

10 Key Principles of Early Support (2013), www.ncb.org.uk/earllysupport

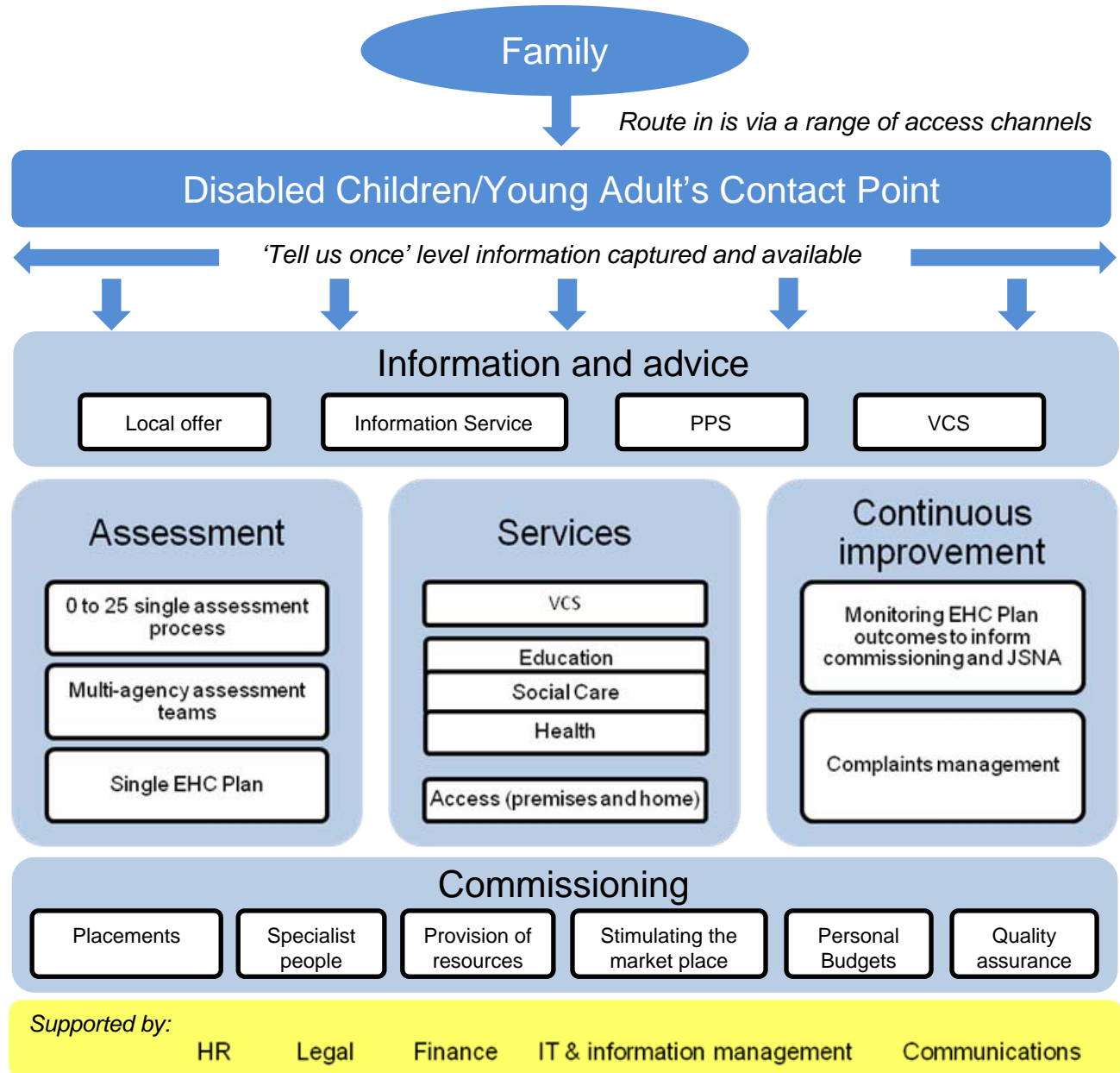
For further information please contact mark.evans@nottsc.org.uk

Drivers

- Children & Families Bill (SEN legislation)
- Health & Care Bill
- Health and Social Care Bill
- Health Outcomes Framework
- NHS Mandate
- Financial pressures
- Integrated services

The vision ... To help support children and young people with special educational needs and disabilities aged 0 to 25 to lead an ordinary life with their families.

Our mission ... To provide a Nottinghamshire local offer of services and an integrated 0 to 25 multi-agency assessment leading to 'One Plan' for education, health and care, which is person centred and outcome focused, and enables the joint commissioning and provision of quality services which can be paid for using a personal budget.





Joint Nottingham City / Nottinghamshire County Integrated Children and Young People's Healthcare Programme

The vision...to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families

From fragmentation...

Lack of co-ordinated support for children and young people with complex needs and disability and their families leading to inequity of access and potential safeguarding risks

Multiple providers/ teams working to different processes, policies and procedures leading to duplication and lack of efficiency/effectiveness, having a negative impact on children, young people and families

Too many acute and emergency attendances and admissions for conditions that could be treated at home or avoided

Children staying in hospital for too long

Phase 1 – ends 31st March 2013

Scoping, mapping and consulting:

- Childrens Community Services like Nursing, Occupational Therapy, Physiotherapy, Speech and Language Therapy, Paediatricians, Short Breaks
- Children and young people: aged 0-18 years with acute and short term illness, and long term conditions; aged 0-25 years with disability and complex needs, life limiting, life threatening conditions including palliative and end of life and neonates
- Consulting and engaging children, families and professionals
- Population and service data collection, analysis and mapping

Post March 2013 (to be confirmed):

Phase 2

- Developing
- Planning
- Specifying
- Commissioning

Phase 3

- Implementation
- Evaluation
- Consolidation
- Monitoring and continual improvement

Our mission...to commission and provide co-ordinated, integrated community healthcare services for children and young people and their families which improve their health and wellbeing and their life chances

...to integration

Single point of access and co-ordinated assessment, treatment and review so that families experience a seamless service that is centred around the child / young person and family promoting independence and quality of life

Improved safeguarding outcomes

Children and young people and their families are enabled to lead as normal a life as possible

Improved access and equity of service provision with genuine choice for children, young people and their families

High quality, cost and clinically effective services with consistent staffing

Satisfied and highly motivated teams ensuring the right skills in the right place at the right time, every time.



Nottingham
City Council



Nottinghamshire
County Council

**Nottinghamshire
Integrated Community Children and
Young People's Healthcare Programme**

Programme Brief

May 2013 (V2)

Note: NHS Bassetlaw PCT/CCG position to be determined

Glossary of acronyms and abbreviations used in this document	
ADHD	Attention deficit/hyperactivity disorder
APTCOO	A place to call our own
ASD	Autistic spectrum disorders
CAMHS	Child and adolescent mental health service
CAS	Clinical Assessment Service
CCG	Clinical Commissioning Group
DH	Department of Health
HNA	Health needs assessment
JSNA	Joint strategic needs assessment
LAC	Looked after children
NICE	National Institute of Health and Clinical Excellence
NNE	Nottingham North and East
OT	Occupational therapy
PPI	Patient and public involvement
SEBD	Social, emotional and behavioural difficulties
SEN	Special educational need
SLT	Speech and language therapy

Version control

The final version was produced in November 2012.

Logos only updated in May 2013 to reflect the changes in commissioning organisations from 1st April 2013.

Programme Brief

Integrated Community Children and Young People's Healthcare Programme

Introduction

The purpose of this programme is to develop a Nottinghamshire wide integrated and sustainable model of children's care delivery via a network of community based services. This will include in-reach and out-reach, for children and young people with acute or additional health needs including disability and complex needs. Key elements will be a single point of access and co-ordinated assessment, treatment and review processes implemented across integrated care pathways.

The vision is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families and carers.

Stakeholder engagement will be fundamental to informing the programme. Equality and quality impact assessments will be undertaken on developments.

Policy and drivers

National

There are many national policies and drivers relevant to the programme e.g.:

- NHS at Home: Community Children's Nursing Services (DH, ref 15106, 2011)
- Healthy lives, brighter futures: The strategy for children and young people's health (DH, ref 094397, 2009)
- Disability and Special Educational Needs green paper (2011)
- Framework for children and young people's continuing care (DH, ref 116469, 2010)
- ACT (2009) Right people, right time, right place: planning and developing an effective and responsive workforce for children and young people's palliative care
- NICE guidance for related paediatric conditions

Local

- NHS Nottingham City Transformational Change in Specialist Children's Nursing Services in the Community, GP Commissioning Executive Committee. June 2012
- Nottinghamshire County Joint Strategic Plan, Children's Trust Board. Feb 2012

Scope

This is a joint NHS Nottingham City and NHS Nottinghamshire County programme for children and young people with acute or additional health needs including disability and complex needs. These include the following four groups:

1. Children and young people with acute and short term conditions (0-18yrs)
2. Children and young people with long term conditions (0-18yrs)
3. Children and young people with disabilities and complex conditions including those requiring continuing care and neonates (0-25yrs)
4. Children and young people with life limiting and life threatening conditions and illness, including those requiring palliative and end of life care (0-25yrs)

During their development and/or the progression of their condition or illness individual children and young people may and often do move between and overlap these groups.

Needs

Nottingham City 0 to 18 years population – approx 57,900. There are approx 4,000 disabled children of which 900 are severe.

- Nottingham City JSNA, 2010 – refresh currently in progress.
- Disabled Children's Ofsted inspection 2012 (publication pending).

Nottinghamshire County 0 to 18 years population - approx 180,000. There are estimated between 7,000 to 12,000 disabled children of which more than 2,500 are severe.

- Nottinghamshire County JSNA for children and young people 2010.
- Nottinghamshire County HNA for children and young people with disability and SEN, including HNA for children and young people in special schools, 2011.

Issues

- There is a lack of co-ordinated support for children and young people with complex needs and disability and their families.
- There is an increase in demand and a need to demonstrate value for money as well as ensuring equity of access and service provision, whilst taking account of City/County differences e.g. population needs, geography, finances.
- More children with a severe disability and complex needs are living longer (Healthy Lives, Brighter Futures 2009), due to new interventions and technology.
- Disabled children and those with complex needs have higher safeguarding needs.
- There are multiple providers/teams working to different processes (e.g. assessments, care plans), policies and procedures and different IT systems resulting in duplication / lack of efficiency and effectiveness (negative impact on children, young people and families)
- There are too many acute and emergency attendances and admissions for conditions and illness that could be treated at home or avoided.
- There are too many children staying in hospital for too long, particularly those who are vulnerable to hospital acquired infections.

Current service provision

Current health providers and partners

- | | |
|--|---|
| • NHS County Health Partnerships | • Sherwood Forest NHS Hospital Foundation Trust |
| • NHS Nottingham University Hospital Trust | |
| • Nottingham City Council – Education, Social Care and Public Health (from April 2013) | • Nottinghamshire County Council – Education, Social Care and Public Health (from April 2013) |

Core services

- | | |
|---|-------------------|
| • General practice | • Education |
| • Hospital services | • Social services |
| • Universal community children's services | |

Supported by specialist community services (not an exhaustive list)

- | | |
|---|--|
| • Children's Community Nursing, including special school nursing, short breaks and training provision | • Looked after children health services |
| • Paediatricians | • Safeguarding |
| • Speech and language therapy | • Local Authority specialist services e.g. short breaks services, special educational needs team, disabled children team, looked after children services |
| • Physiotherapy | |
| • Occupational therapy | |

Interfaces and linkages with CAMHS will be considered within the programme, however they are not specifically included within the development scope.

Benefits

Benefits include:

Children young people and their families

- A single point of access and co-ordinated assessment, treatment and review will mean that parents and families experience a co-ordinated seamless service that is centred around and personalised to the individual child and family promoting independence and quality of life.
- Improved safeguarding outcomes due to improved co-ordination of services.
- Parents and carers are able to put being parents first and health care providers second and are enabled to do ordinary family activities.
- There is genuine choice of end of life care, acknowledging the preferences of the child or young person and their families.
- Children and young people are admitted to hospital or stay in hospital only when it is clinically inappropriate to care for them in the community.
- Children and young people who are vulnerable to infection are protected from health care-acquired infection.
- Children and young people are enabled to lead their vision of a normal a life as possible with minimum disruption to their every day lives.
- Improved access and equity of service provision.

Services

- High quality and cost effective services
- Consistent staffing from satisfied and highly motivated teams.
- A cohesive coordinated network model will ensure that there is utilisation of the right skills in the right place at the right time every time.

Commissioners

- Quality services and value for money would be achieved through re-focussing resources where the need is.
- Improved performance management of service delivery.

Risks

A detailed risk assessment and actions to mitigate risks will be undertaken by the Programme Steering Group, including clear communication and consultation with stakeholders. Some potential risks are identified below:

Potential risks of not implementing the programme may include:

- | | |
|---|--|
| • Insufficient service capacity to meet increasing demand | • Increased safeguarding risks |
| • Long waiting times | • Inconsistent and inequitable access to services |
| • Negative impact on quality and co-ordination of services | • Increased litigation and escalating compensation costs |
| • Deterioration of health and economic wellbeing of children, young people and their families | |

Potential risks of implementing the programme may include:

- | | |
|--|--|
| • Not having a clear implementation plan and phased/systematic approach | • Potential to destabilise and de-motivate staff delivering services |
| • Impact of organisational change and restructure on continuity and comprehensive support for implementation | • Inequities resulting from inconsistency of implementation across City and County |
| | • Increased costs |

Summary Timeline - phase 1

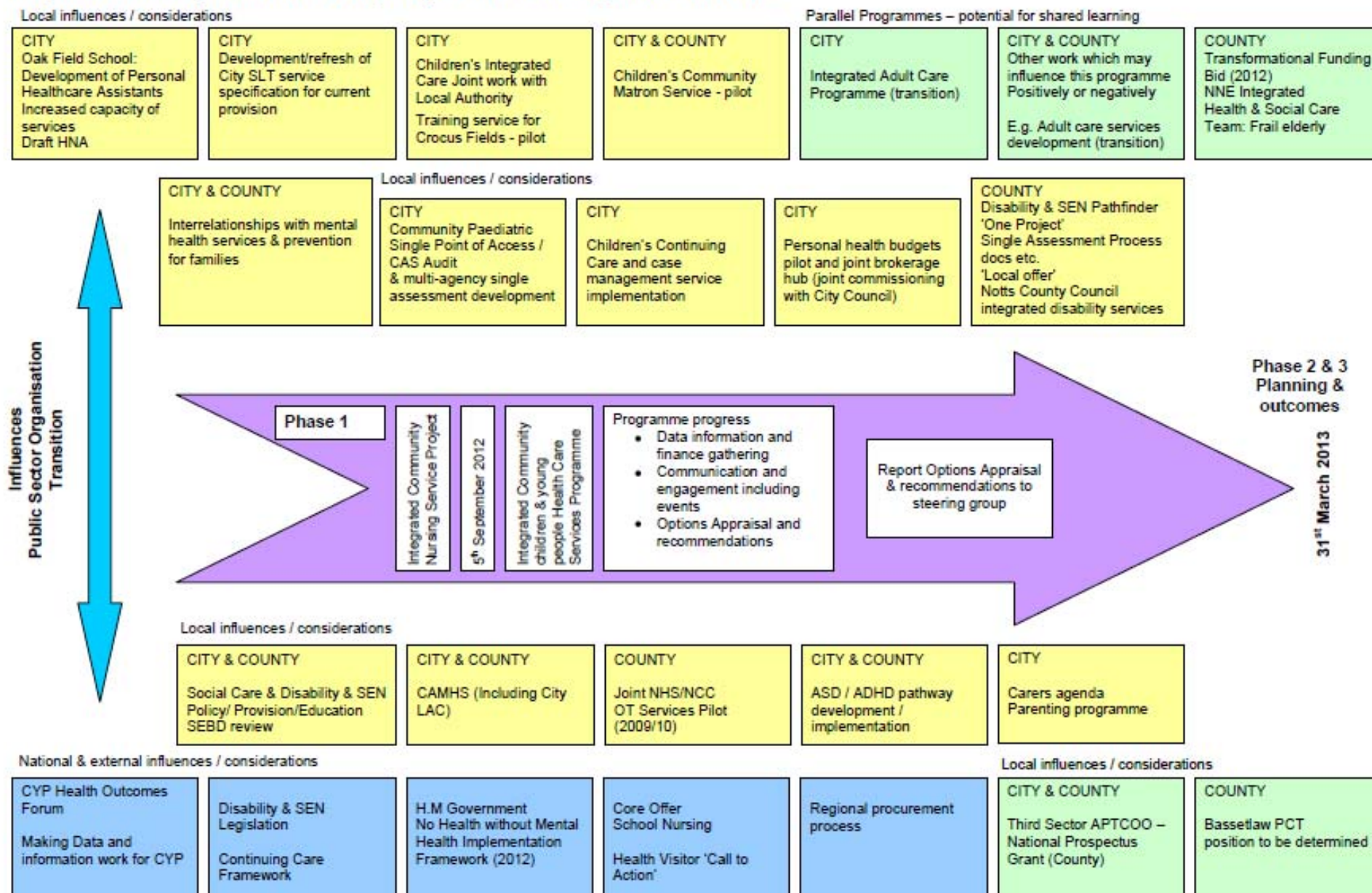
Integrated Community Children and Young People's Healthcare Programme

Date	Key milestone
August 2012	Establish steering group <ul style="list-style-type: none"> • Develop project controls
September 2012	Programme signoff <ul style="list-style-type: none"> • City CCG Clinical Council • County – Joint Commissioning Group Special Educational Needs and Disability • County Cross CCG Children Commissioning Group
September/October 2012	Initial set up of programme task and finish groups: <ul style="list-style-type: none"> • Communications and engagement <ul style="list-style-type: none"> ○ Development of communications plan ○ Involvement of provider PPI/Communications leads • Data, information and finance <ul style="list-style-type: none"> ○ Contract activity ○ Health needs
September – January 2013	Programme scoping: <ul style="list-style-type: none"> • Four Groups: <ul style="list-style-type: none"> ○ Children and young people with acute and short term conditions ○ Children and young people with long term conditions ○ Children and young people with disabilities and complex conditions including those requiring continuing care and neonates ○ Children and young people with life limiting and life threatening conditions and illness, including those requiring palliative and end of life care • Engagement on pathways with healthcare professionals and service users • Current contracts: <ul style="list-style-type: none"> ○ Activity ○ Cost ○ Outcomes • Health needs: <ul style="list-style-type: none"> ○ JSNA outcomes ○ Other health profiling ○ Population projections ○ Transition <p>Purpose – to outline the programme of work required to implement an integrated children's services.</p>
March 2013	Report with option appraisal and recommendations to be presented to CCGs

Overview diagram

The diagram below is an overview of the Integrated Children and Young People's Healthcare Programme showing local and national factors and current developments (as at time of writing) which may influence the outcomes of the programme.

Integrated Community Children and Young People's Healthcare Programme - Overview



5 June 2013**Agenda Item: 12****REPORT OF THE DIRECTOR OF PUBLIC HEALTH****HEALTH & WELLBEING STRATEGY CONSULTATION PLAN 2014/15****Purpose of the Report**

1. This report describes the work programme for the on-going development of the Health & Wellbeing Strategy. It summarises the discussion from the Health & Wellbeing Board workshop held on the 27th March 2013 which identified themed priorities, based on the work of the integrated commissioning groups. It also proposes a timeline for the forthcoming consultation to agree the Health & Wellbeing Strategy for 2014/15.

Information and Advice**Background**

2. The first Health & Wellbeing Strategy for Nottinghamshire was approved by the Health & Wellbeing Board in May 2012. The Board agreed that the strategy would take account of the priorities within the strategies from all key partners. These were reviewed and considered against agreed criteria to confirm that the chosen areas represented current local priorities.
3. The first strategy gave a good foundation on which to base the early work of the Board and communicate the Boards vision for Health & Wellbeing. The strategy included the following priorities:
 - **Prevention: Behaviour Change & Social attitudes** – smoking, obesity, drugs and alcohol.
 - **Children, Young People & Families** – health and wellbeing areas included in the Children Young Peoples and Families Plan.
 - **Adult and Health Inequality Priorities** – Learning disability, Autistic Spectrum Disorders, Physical Disability, Long Term Conditions and Sensory Impairment, Mental Health & Emotional Wellbeing, Dementia, Older People.
 - **The Wider Determinants Of Health & Wellbeing** - Education, Personal Attainment & Aspirations, Crime & Community Safety (inc domestic violence) Healthy environments in which to live, work and play (inc. Housing.)
 - **Carers**

Current Priorities

4. Given the board range of priorities within the strategy, Health & Wellbeing Board members asked that a smaller number of priorities be agreed that focused on areas of work where the Board could add greatest value. They also wished to realise benefit in the short term, whilst work continued on areas that would produce important benefits in the longer term.
5. In response, the Health & Wellbeing Implementation Group tasked each integrated commissioning group with agreeing up to three priorities for 2013/14, which reflected the group's views, and demonstrated what outcomes could be achieved. These are available in the background paper 'Proposed Health & Wellbeing Priorities for 2013/14'. The Health & Wellbeing Board considered these priorities during its workshop on 27th March to help gain a collective view on the role of the Board in delivering the priorities.
6. This work has been taken forward alongside the development of the Joint Strategic Needs Assessment (JSNA). Following the refresh of the adults sections of the JSNA in 2012, work has now been completed on the review of the Children and Young People's section. This section is currently awaiting final approval.
7. In addition to the refresh of the JSNA, work has been started to identify and address gaps in evidence. The work programme also includes review of the format, content and accessibility of the JSNA to make the information more available to a wider range of partners when planning and assessing health and wellbeing services.

Future Strategy

8. The Health & Wellbeing Implementation Group has developed a plan to perform a full review of the Health & Wellbeing Strategy for 2014 onwards, using the refreshed JSNA. This includes a comprehensive consultation and engagement programme to explore partners and public views. This work is due to be completed by September 2013 to feed into the commissioning cycles for 2014 onwards. The programme of activity is included in **Appendix One**.
9. Discussion at the March Health & Wellbeing Board workshop was wide and far reaching and comment was made that the priorities within the strategy were all important, and should not be reviewed to form a short list for 2013/14. It was therefore suggested that these feed into a full review of the Health & Wellbeing Strategy for 2014/15.
10. The following themes emerged from the workshop discussions which may be useful to frame the future consultation and or strategy:

I. Prevention and Early Intervention

There was a general theme around the need to reinvest earlier in pathways to help prevent future problems. This was supported by a number of examples in the discussions:

- a) Early identification of dementia
- b) Reducing the number of people starting to smoke, especially children and young people.
- c) Increasing healthier choices available for out of home food provision.

- d) Delivering brief intervention training to staff to make better use staff assets.

II. Supporting People

The Board recognised the need to support people to retain their independence, improve their own health and wellbeing, and reduce the need for traditional health and social care services.

- a) Supporting older people and people with long term conditions to live at home.
- b) Raising awareness of carers issues to identify and signpost people to available support, including target groups such as young carers.
- c) Promoting apprenticeships across partners to improve participation, attainment in learning and employability.
- d) Supporting the Winter Warmth programme to reduce winter deaths.

III. Improving collaboration and coordination across partners

The Board recognised the need to show strong leadership across partners and maintain a consistent message to the public on key issues.

- a) Use of social marketing and local media to deliver a coordinated substance misuse message across partners.
- b) Challenging stigma associated with mental health
- c) Supporting the Multiagency Safeguarding Hub to promote effective information sharing and coordination of services.
- d) Use of the new integrated commissioning model for children to produce clear and easy to follow pathways to children's services

NB: Whilst these areas have been split into 3 categories, there is clearly overlap across these areas.

- 11. Discussion within the workshop also recognised that there was further work required to fully consider priority actions for housing, healthy environment and domestic violence, as these were not reflected in the work to date.

Next Steps

- 12. Each discussion group noted that there needed to be a much stronger focus on outcomes in order to be confident that the proposed actions will deliver significant benefits. It was suggested that the integrated commissioning groups be asked to consider this further whilst developing their more detailed actions plans.
- 13. The Health & Wellbeing Implementation Group has an important role in assuring performance and identifying where resource is required to address problem areas. The Board will receive feedback on decisions required or action taken accordingly.
- 14. The Health & Wellbeing Board took on its statutory duties as the local system leader for Health & Wellbeing on 1 April 2013. Early attention on the full review of the current Health & Wellbeing Strategy will provide leadership on the priorities for the new Health & Wellbeing Board.

15. The Health & Wellbeing Board is asked to consider the content of the current Health & Wellbeing Strategy and agree themes on which to frame the forthcoming consultation questions.
16. The Board may also wish to propose a revised approach to the Health & Wellbeing Strategy to concentrate on areas where the Board provides added value in the new system. The discussion at the workshop highlights examples where a collective agreement can lead an integrated approach to address common priorities areas.

Statutory and Policy Implications

This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder and users. Where such implications are material, they have been brought out in the text of the report.

RECOMMENDATION/S

The Health & Wellbeing Board are asked to:

1. Note the plan to review the Health & Wellbeing Strategy for 2014 onwards.
2. Comment on the consultation process and propose themes for the consultation or future strategy.
3. Receive a further report in September on progress against these priorities and the full review of the strategy.

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact:

Cathy Quinn, Associate Director of Public Health.

Telephone extension 72882 or email. cathy.quinn@nottsccl.gov.uk

Constitutional Comments (SG 09/05/2013)

17. The Board is the appropriate body to decide the issues set out in this Report. The Board has responsibility for preparing and publishing a Health and Wellbeing Strategy based on the needs identified in the joint strategic needs assessment and to oversee the implementation of the Strategy by virtue of its Terms of Reference.

Financial Comments (ZKM 16.05.13)

There are no financial implications arising directly from this report.

Background Papers

Our Strategy for Health & Wellbeing in Nottinghamshire: Priorities for 2012-13

Proposed Health & Wellbeing Priorities for 2013/14

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

Electoral Division(s) and Member(s) Affected

All.

APPENDIX ONE - HEALTH & WELLBEING STRATEGY – PLAN TO REFRESH STRATEGY FOR 2013 ONWARDS

Background

1. The following report provides information on the work being undertaken around the implementation of the Health & Wellbeing Strategy and the proposed plan to undertake a formal refresh of the strategy for 2013 onwards.
2. The first Health & Wellbeing Strategy was developed during November 2011-March 2012. The strategy was approved by the Health & Wellbeing Board (HWB) in May 12 (and Nottinghamshire County Council in July 12). The Initial development involved review of existing strategies from all partners, many of which had been jointly produced and were still relevant. This produced a long list of priorities which were the subject of workshops with wider stakeholders and a public consultation to produce a short list for development into the Health & Wellbeing Strategy.
3. A rapid refresh of the Joint Strategic Needs Assessment (JSNA) took place at the same time and its findings (including consultation responses) were incorporated into the development of the strategy and on-going work programme.
4. During 2012 a new supporting structure was developed to support the delivery for the Board. This included a range of integrated commissioning groups to lead the development of health and wellbeing commissioning priorities. During this time, the groups were consulted on the priorities, JSNA and the development of a local outcomes framework, which would be used to monitor progress over time.

Plan to Review the Strategy

5. Discussions around the plan to refresh the strategy were built into HWB development workshops and meetings of the integrated commissioning groups and supporting groups. Early feedback suggested that there was general support for the priorities included in the strategy. However Board members and partners felt that there should be agreement of a small range of immediate priorities where the Board could concentrate its efforts.
6. The Health & Wellbeing Implementation Group tasked the Integrated Commissioning groups to identify three key actions for each priority within the strategy. This work commenced in October and is continuing as part of the implementation group work programme.
7. It is proposed that the Health & Wellbeing Board perform a formal review of its strategy once all groups have considered their action plans, aligned them to the work of the board and agreed their immediate priorities. This work will include consideration of short-term priorities for the individual groups where the HWB can bring added value to existing commissioning mechanisms.

Next Steps

8. The Health & Wellbeing Implementation Group agreed the following plan to support the consultation on the next version of the Health & Wellbeing Strategy for 2014 onwards.

Action	Lead	Timescale
Integrated Commissioning Group to present their three agreed priorities for consideration by the HWIG and HWB.	Chair of integrated commissioning groups	18 March 2013
HWB to consider priority areas for HWS for 2013 in workshop	Chair of HWB	27 March 2013
Communicate themes from March HWB workshop to integrated commissioning groups	Associate Director of PH	April 2013
Start implementation of communication plan by reviewing information on HWB website and building plan of engagement activities using existing processes	Associate Director of PH	April – May 2013
Integrated commissioning groups to review commissioning priorities for 2014 onwards in light of JSNA findings, HWB feedback and local outcomes framework performance.	Integrated Commissioning Group Chairs	April – June 2013
Hold workshop for integrated commissioning groups on role of HWB structure & function, including HWS consultation	Associate Director of PH	10 June 2013
Hold stakeholder network on HWS immediate priorities and gain views for future strategy	Associate Director of PH	June 2013
Define consultation questions and produce plain language text to support HWS consultation	Associate Director of PH	June 2013
Undertaken public consultation Health & Wellbeing Strategy priorities for 2014 onwards	Associate Director of PH	June - September 2013
Finalise content and scope of HWS	Associate Director of PH	September 2013
Present revised HWS to HWIG	Associate Director of PH	26 Sept 2013
HWB to agree HWS	Associate Director of PH	6 November 2013
Publish & Launch Health & Wellbeing Strategy for 2014 onwards	Associate Director of PH	January-March 2014

Written by: Cathy Quinn, Associate Director of Public Health

5 June 2013**Agenda Item: 13****REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND
CORPORATE SERVICES****WORK PROGRAMME****Purpose of the Report**

1. To consider the Board's work programme for 2013/14.

Information and Advice

2. The County Council requires each committee, including the Health and Wellbeing Board to maintain a work programme. The work programme will assist the management of the committee's agenda, the scheduling of the Board's business and forward planning. The work programme will be updated and reviewed at each pre-agenda meeting and Board meeting. Any member of the Board 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.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To assist the Board in preparing its work programme.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

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

Jayne Francis-Ward
Corporate Director, Policy, Planning and Corporate Services

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

Constitutional Comments (HD)

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

Financial Comments (PS)

2. There are no direct financial implications arising from the contents of this report. Any future reports to the Board will contain relevant financial information and comments.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Health and Wellbeing Board & Workshop Forward Plan

	Health & Wellbeing Board (HWB)	HWB Workshop (closed sessions)
5 June 2013	<p>Needs Assessment for Children and Young People with Disabilities and/or Special educational Needs (Anthony May / Sue Gill)</p> <p>Mid-Nottinghamshire Integrated Care Transformation Programme (Dr Mark Jefford /Lucy Dadge)</p> <p>Joint Working To Improve The Care Of Frail Older People (Dr Guy Mansford)</p> <p>Campaign to End Loneliness (Mary Corcoran)</p> <p>Health & Wellbeing Strategy – Consultation Planning for 2014 onwards (Chris Kenny)</p> <p>Integrated Care and Support Pioneer: Expressions of Interest (David Pearson)</p>	
3 July 2013		Sexual Health- Action Planning TBC
4 September 2013	<p>Homelessness (Barbara Brady)</p> <p>Mid-Nottinghamshire Integrated Care Transformation Programme (Dr Mark Jefford /Lucy Dadge)</p> <p>Young People Friendly services in Nottinghamshire (Derek Higon / Kate Allen / Irene Kakoulis)</p> <p>Winterbourne View Review (Jon Wilson)</p> <p>Health & Wellbeing Strategy 2014-17 (Cathy Quinn)</p> <p>HealthWatch (Joe Pidgeon) TBC</p>	

	CCG Commissioning Intentions (TBC) Publication of Public Health Annual Report (Chris Kenny) Health & Wellbeing Implementation Group report (David Pearson)	
2 October 2013		Vulnerable Children & Disability
6 November 2013	Health Checks (John Tomlinson) Public Health Nursing & Healthy Child Programme (Kate Allen) Mid-Nottinghamshire Integrated Care Transformation Programme (Dr Mark Jefford /Lucy Dadge) Health Protection Arrangements (Jonathan Gribbin / Vanessa McGregor) JSNA annual report (Chris Kenny) Nottinghamshire Safeguarding Children Board Annual Report 2012/13 (Steve Edwards) Nottinghamshire Child & Family Poverty Strategy annual performance update (Derek Higton)	
4 December 2013		Homelessness TBC
8 January 2014		
5 February 2014		
5 March 2014		
2 April 2014		

Proposed Future Items (& suggested date)

Public Meeting	Workshop
<ul style="list-style-type: none"> • Role of NHS England • CCG collaborative commissioning arrangements • CAMHS needs assessment (September TBC) • Health Inequalities • Role of Police & Crime Commissioner (September TBC) • Workplace Health • Dental public health • Accidental injury prevention • Campaigns to prevent cancer and long-term conditions • Interventions to reduce and prevent birth defects • Learning Disabilities • End of Life • Housing • Use of social media to portray health messages • MASH report 	<ul style="list-style-type: none"> • SHA review outcomes – scrutiny of QOF data / Quality of Primary Care services (May/July) • QIPP • Links with scrutiny

