Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 05 March 2014 at 14:00

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

AGENDA

NOTES:-

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

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

Customer Services Centre 0300 500 80 80

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

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

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

Notes

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Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 5 February 2014 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Joyce Bosnjak (Chair)
John Peck
A Martin Suthers OBE
Muriel Wiesz
Jacky Williams

DISTRICT COUNCILLORS

Jim Aspinall – Ashfield District Council
A Simon Greaves – Bassetlaw District Council
Jenny Hollingsworth – Gedling Borough Council
Pat Lally – Broxtowe Borough Council
A Debbie Mason – Rushcliffe Borough Council
A Tony Roberts MBE – Newark and Sherwood District Council
Phil Shields – Mansfield District Council

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

Dr Steve Kell	-	Bassetlaw Clinical Commissioning Group (Vice-Chairman)
Dr Judy Jones	-	Mansfield and Ashfield Clinical Commissioning Group
Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group

Dr Paul Oliver	-	Nottingham North & East Clinical Commissioning Group
Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group

LOCAL HEALTHWATCH

Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

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

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Vacancy

SUBSTITUTE MEMBERS IN ATTENDANCE

Councillor Griff Wynne	-	Bassetlaw District Council
David Mitchell	-	Gedling Borough Council
Councillor David Staples	-	Newark and Sherwood District Council
Derek Bray	-	NHS England
Kate Allen	-	Children, Families and Cultural Services
Cathy Quinn	-	Public Health

OFFICERS IN ATTENDANCE

Paul Davies	-	Democratic Services
Nicola Lane	-	Public Health

ALSO IN ATTENDANCE

Lucy Dadge	-	Director of Transformation, Mansfield and Ashfield CCG

MINUTES

The minutes of the last meeting held on 8 January 2014 having been previously circulated were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Simon Greaves, Dr Chris Kenny, Councillor Debbie Mason, Anthony May, Helen Pledger, Councillor Tony Roberts and Councillor Martin Suthers.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

BETTER CARE FUND

The Board considered the draft Better Care Fund plans for 2014/15 and 2015/16. A detailed progress report on the plans was presented to the previous meeting. Since then, the Better Care Fund Working Group had continued to meet and the draft plans approved by the six CCGs. The final meeting of the Working Group had been on 31 January 2014, when critical friend, Sir Neil McKay had suggested that some of the narrative in the plans could be strengthened. Timescales had not allowed this strengthened wording to be included in the drafts submitted to the Board. A revised recommendation was circulated which allowed the Chair and Vice-Chair to agree the final wording before submission on 14 February. There would be an assurance process, details of which were to be announced, with the deadline for submission of the final version of the plans being 4 April. It might be necessary to present the final version for approval by the Board at a special meeting on 2 April.

The Chair thanked everyone involved in the plans for their tireless work to prepare the plans. She believed that the plans were in the best interests of people in Nottinghamshire.

There was discussion about the plans' content and language, and arrangements for monitoring their implementation. The Working Group and area planning groups would continue, and the CCGs and Board would also have monitoring roles.

RESOLVED: 2014/011

1. That the draft Better Care Fund Plan for 2014/15 and 2015/16 be approved.

2. That the Chair and Vice-Chair agree the final version of the Plan for submission to NHS England Area Team by 14 February 2014

3. that any strengthening of the Plan be agreed with the local planning groups.

4. that if further changes are required as a result of the assurance process, a special meeting of the Board be called on 2 April 2014

The meeting closed at 3.00 pm.

CHAIR

Nottinghamshire County Council

Report to the Health and Wellbeing Board

5 March 2014

Agenda Item: 4

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

APPROVAL OF THE HEALTH AND WELLBEING STRATEGY

Purpose of the Report

1. This report asks the Health & Wellbeing Board to comment on and approve the draft Nottinghamshire Health & Wellbeing Strategy for the period 2014-2017.

Information and Advice

Background

2. The draft Health & Wellbeing Strategy underwent a three month public consultation between the 27 June and 26 September 2016. A previous report to the Health & Wellbeing Board outlined the consultation process and summary findings of the consultation.

3. A follow up workshop was held on 4th December with key health partners to consider the consultation feedback and make sure that competing pressures across the health and social care system are recognised in the aspirations of the Strategy.

4. The members of the Health & Wellbeing Board and partners re-affirmed support for the proposed principles and priority areas, taking consultation comments into account. **Appendix One** details the consultation feedback report.

5. Common themes in discussions were how to strengthen the children's focus in the strategy and the need to include the additional priorities: principally access to healthcare and health-checks.

6. In addition, comment was made on strengthening the message around evidence and value for money, as this theme should underpin the work of the Board.

7. Following the workshop, the Health & Wellbeing Strategy content and format has been reviewed, incorporating the feedback received.

8. The draft Health & Wellbeing Strategy is presented to the Board for comment and approval. Taking consultation comments on board, the strategy is presented in three forms to meet the needs of the different audiences:

a. A short strategy document outlining the four key ambitions (previously phrased as principles.) In addition to the three principles consulted a fourth ambition around giving children a good start in life has been added. The content and wording has been simplified to avoid jargon. A draft version is attached as **Appendix Two**.

b. The strategy will be supported by a short plain language document, briefly outlining the ambitions and priority areas.

c. A comprehensive delivery plan is being developed which details each action agreed through the integrated commissioning group to deliver against each priority. This document is supported by performance measures which will be monitored and reported back to the Health & Wellbeing Board on a regular basis following approval of by the Health and Wellbeing Implementation Group. A draft version of the delivery plan is attached as **Appendix Three.**

9. All comments have been reviewed and responses drafted to address each issue. These will be published on the Nottinghamshire County Council website and communicated through available networks.

10. Following approval, the final Nottinghamshire Health & Wellbeing Strategy will be launched at the Health & Wellbeing Board Stakeholder Network in June 2014. A follow up communication strategy will promote the vision of the Board and progress being made over time.

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 in relation to the NHS Constitution

1. Regard will be taken to the NHS Constitution together with all relevant guidance issued by the Secretary of State in any service changes relating to the implementation of the Health & Wellbeing Strategy.

Public Sector Equality Duty implications

2. The Public consultation included people with protected characteristics and from seldom heard groups. Equality impact assessments will carried out for any changes to services relating to the implementation of the Health & Wellbeing Strategy.

Implications for Service Users

3. The implementation of the Health & Wellbeing Strategy aims to improve general health and wellbeing for the people of Nottinghamshire, and in particular for those in greatest need.

RECOMMENDATION/S

The Health & Wellbeing Board are asked to:

1. Comment on the final document and approve the Nottinghamshire Health & Wellbeing Strategy for 2014-2017.

Chris Kenny
Corporate Director, Public Health

For any enquiries about this report please contact:

Cathy Quinn, Associate Director of PH
Tel: 0115 977 2130
Cathy.Quinn@nottscc.gov.uk

Nicola Lane, Public Health Manager
Tel: 0115 977 2130
Nicola.Lane@nottscc.gov.uk

Constitutional Comments ()

12. To follow

Financial Comments ()

13. To follow

Background Papers

Our strategy for Health and Wellbeing in Nottinghamshire. Consultation document - priorities 2014 – 2016.

Summary Results of the Health & Wellbeing Strategy Consultation. Report to Health & Wellbeing Board November 2013.

Electoral Division(s) and Member(s) Affected

All

Appendix One: Health and Wellbeing Strategy Consultation Summary December 13

Background

Following the consultation around the Health and Wellbeing Strategy a paper was presented to the Health and Wellbeing Board with initial findings on 6 November 2013.

Further work has been done to analyse the responses received during the consultation through the survey, responses obtained via NAVO and the consultation events. This paper outlines the results of this review.

Initial findings from the Health and Wellbeing Strategy consultation

- There is general support for the 3 principles which are seen to be reasonable.
- There is broad agreement with all priorities, but there is some concern over deliverability.
- There needs to be more focus on health inequalities
- Some comment has also been made that there are too many priorities, but there was no agreement on which should come out of the strategy
- The level of detail about how the strategy is delivered is important and further information of desired outcomes is required.
- The need for measurable objectives and measuring success is required.
- There is a need to include cost effectiveness models to be able to prioritise further in the current financial climate.
- People think that there is a need to use available resources better and join things up to avoid duplication.
- Mapping of services in the community & voluntary sector to identify gaps & duplication.
- Comments were made that pooled budgets are required to make integration work.

Method

Questionnaire responses, notes from the consultation events and associated emails and letters have been reviewed using NVIVO software. This package can be used to identify themes within the responses through the use of keywords. Absolute values cannot be given though given the quality of the data. This was mainly resulting from variations in spelling and phrasing within the responses.

The findings within this paper are intended to compliment those within the initial paper to the Health and Wellbeing Board on 6 November 2013 which can be accessed via the Nottinghamshire County Council website.

Illustrative comments have been included in the report. Additional comments taken directly from the consultation responses are included in Appendix 1 to add clarity. This is not a complete list of all of the consultation responses as many themes were duplicated. However the report provides representative comments around the principles and priorities.

Principles

Generally there was support for the Health and Wellbeing Board's principles within the consultation. 90% of online questionnaires supported the principles and this was echoed within the discussions at the consultation events. There were a number of themes which emerged from the consultation responses, some of which refer to the priorities within the Strategy.

Prevention and early intervention

The main themes were:

- Smoking, alcohol & substance misuse
- Healthy eating
- Mental health
- Educating children, young people and families
- Physical activity/exercise

Responses around healthy eating were largely linked to education of young people and families.

> Educating to fight obesity – sensible but graphic to young people in particular so that they may put pressure on adults to stop contributing to their early deaths

There were also a number of responses which suggested personal responsibility for health and wellbeing although many respondents highlight the issues with vulnerable groups who may not be able to achieve this.

> Making individuals aware of their own responsibility for managing their health and wellbeing and that of their families. If this priority is focused upon from early years onwards, this will have an impact on service usage.

The principle of supporting independence caused some discussion at the consultation events and this is also reflected in the questionnaire responses. This may have been as a result of the wording of this principle. Responses indicate that supporting independence may imply a withdrawal of services which is not the intention. Wording suggesting appropriate services to help individuals to develop or maintain their independence and live at home may be more appropriate.

> Older People suffer from social isolation as do people with mental health problems

> Explicit statement (required) that supporting independence does not mean relinquishing accountability

There was a strong theme within the responses around social isolation and abandonment. Again amending the wording around this principle may improve understanding of the aims of this principle.

Supporting independence

Themes within the responses around supporting independence also included:

- Self care – in particular associated with Long Term Conditions
- Carers
- Staying at home
- Buildings and adaptations
- Fitness to work & rehabilitation
- Transport

The promotion of "self care" and the "expert patient" programme does not receive sufficient actions under the "supporting people" principle, particularly in the strategy's priority area of "Adult and Health Inequality priorities".

Support the carer and the person at home properly

Comments around carers highlight the need for support and their involvement in developing care plans. The comments around buildings and adaptations relate to supporting older people to remain in their homes and also to domestic violence.

Under domestic violence, supporting independence there needs to be a priority to support victims in the home via services such as sanctuary and women's aid

Supporting and developing the significant work done in delivering Disabled Facilities Grants to ensure that clients can stay in their own home and not require other provision

There were a number of references to transport in maintaining independence, related to wider public transport as well as services related to health and social care.

Pathways through services – need to be right into the community – transport and social activities are key to reducing isolation/promoting recovery and are often provided by the voluntary sector - need to integrate these services – small, low-cost local action can make a huge difference – need to ensure that people in clinical settings know about these and signpost to them

There were also a number of comments around fitness to work and supporting people to get into and maintain employment. Specific reference is made to those with mental health problems, those with issues around drugs and alcohol, stroke survivors and those with long term conditions.

Promoting Integration

There was general support for the principle of Promoting Integration across partners. There were repeated comments around ensuring that community and voluntary organisations are included within an integrated approach.

The actions listed are ok but we would like to see specific goals for integration as currently services are fragmented between agencies with apparently little communication. There must be clarity about the interface between services

The other main themes were around communication between elements of health and social care and also the need for consistent messages from professionals and the 'volunteers'.

There were also requests for specific actions and implementation plans on how integration will be achieved and specific goals.

The actions listed are ok but we would like to see specific goals for integration as currently services are fragmented between agencies with apparently little communication.

A number of responses also related to integration and coordination with neighbouring Health and Wellbeing Boards, particularly with the City and where people are resident in one area but registered with a GP in another.

Priorities

Whilst a number of consultation responses commented that there were too many priorities, none of the responses received identified any which should be removed.

Top priorities

Considering all of the priorities, those most frequently raised within consultation responses were:

- Mental health & emotional wellbeing
- Obesity & weight management
- Older people
- Drugs and alcohol
- Community safety & violence, including domestic violence

Responses around mental health and emotional wellbeing include suggestions regarding children, young adults and adults.

Ensure mental health has parity with physical health - emotional wellbeing is equally important and has a major impact on physical wellbeing.

Prevention for mental health problems – particularly children & families. Mitigating against knock on effects of mental health problems of other family members.

However, support across the priorities was broad and there was no priority which attracted significantly more support than any other.

Missing priorities

The questionnaire asked whether there were any missed priorities and there were 73 responses to this question covering a wide range of issues.

The majority of these issues were only raised once across all of the responses. Those missed priorities which were highlighted by two or more respondents were:

- Access and Advice provision (where to go)
- Physical Activity
- Cancer
- Health checks
- Black, Minority Ethnic \Lesbian, Gay, Bisexual and Transgender Groups
- Oral Health\Dentists
- Accident Prevention for Under 5s
- Access to GPS and Hospital Care
- Promotion of self-care\expert patient
- Children's mental health
- Early Health Education
- Active Transport

Some of these issues however were raised by the same group within multiple consultation responses. None of these issues were raised more than 5 times. Also some were also included in the draft Strategy.

Physical activity however, was one of the main themes within the prevention and early intervention principle responses. Promotion of self-care, the expert patient programme and transport were also themes within the responses around the supporting independence principle.

Involvement of community and voluntary groups to deliver outcomes

Within each principle the consultation questionnaire asked about how to engage with community and voluntary groups to deliver the Strategy.

The main theme of the responses was around communication between service commissioners, service providers and the community and voluntary groups. There were several requests for mapping of services to identify duplication, overlap and gaps and also to provide a directory of services to health and social care staff.

There were also calls for formal links between community and voluntary organisations and the Health and Wellbeing Board.

VCS Health and Wellbeing Network to feed into and get information from the HW Board facilitated by a non-service delivery organisation to maintain independence and equity

Conclusions

The consultation attracted a good response from a variety of organisations and individuals. The broad nature of the Strategy resulted in a similarly broad range of responses.

There was broad support for the supporting principles of the Health and Wellbeing Board although there were some suggestions around clarity of wording.

The priorities within the Strategy also received broad support. The responses received did not conclusively identify any area which should be prioritised above any others. There were some suggestions around the actions to support each of the priority areas.

There are some suggestions regarding missed priorities but these are largely received from isolated individuals and not by multiple respondents.

Nicola Lane
December 2013

Health and Wellbeing Strategy 2014 – 17

Introduction

Welcome to the Health and Wellbeing Strategy for Nottinghamshire for 2014 to 2017 and thank you to everyone who has contributed to its development.

The Strategy sets out the priorities for the Health and Wellbeing Board for Nottinghamshire, which is clearly to improve the health and wellbeing of its residents. We have considered both the evidence which identifies the main local issues, and your feedback on the draft document in developing this final version. Responses to the consultation told us that you would like to see a short and clear Health and Wellbeing Strategy so we have prepared a concise Strategy document which will be supported by a more detailed Delivery Plan with clear actions and outcomes.

This document sets out our vision for improving health and wellbeing for everyone and at its heart is the belief that if we all work together to achieve our ambitions we *can* make a real difference. The members of the Health and Wellbeing Board know we have to make the best use of our valuable resources and this Strategy aims to focus efforts on the areas where we can have the biggest impact.

The response to the consultation was wonderful and the input from those people who took the time to contribute is much appreciated. We would like health and wellbeing to be everyone's business and as a Board we hope to continue the conversation the consultation began. We will continue to involve residents and partners as we implement and monitor the delivery of the Strategy.

The Board is committed to leading on the delivery of better health and wellbeing across Nottinghamshire and this Strategy sets the direction for everyone.

Councillor Joyce Bosnjak
Chair of the Health and Wellbeing Board for Nottinghamshire

Dr Steve Kell
Vice Chair

Our vision:

We want to work together to enable the people of Nottinghamshire to live longer, be healthier and have a better quality of life, especially in the communities with the poorest health.

We will do this by providing the most efficient and effective services.

Who are 'we'?

'We' are the Health and Wellbeing Board for Nottinghamshire.

The Health and Social Care Act 2012 changed the way that health and social care leadership in England was organised. The Act allowed us to set up a Health and Wellbeing Board to bring together politicians, doctors, councils and a representative of the local

people through Healthwatch. All of these people have the shared aim of working together to improve health and wellbeing.

A Board was set up in Nottinghamshire in May 2011, in shadow form to begin with but it took on its full responsibilities from April 2013 and its main focus is to improve the health and wellbeing of the people of Nottinghamshire.

The Board cannot achieve this alone so it is supported by working groups which bring together partners from health and social care, district and borough councils, representatives of service users, carers and the public, service providers and the community and voluntary sector.

Partners include:

Health & Wellbeing Board	Health service providers
Health & Wellbeing Implementation Group	Social care providers
Partnership Commissioning Groups	Carers
Clinical Commissioning Groups	Service users
Community & Voluntary organisations	Healthwatch
NHS England	Public Health England

A Stakeholder Network also meets three times each year to ensure that everyone has an opportunity to tell the Board what matters to them. This involves community and voluntary organisations, service providers and the public. Details of the Network are available on the Nottinghamshire County Council website.

What is health & wellbeing?

Health is often considered as being an absence of illness or disability. Health and wellbeing is much wider though and is a combination of physical, mental and social factors. In developing this Strategy we have looked beyond health and social care services to bring together other issues like housing and workplace health.

Why do we need a Strategy?

The main responsibility of the Health and Wellbeing Board is to identify current and future health and wellbeing needs and to develop a Health and Wellbeing Strategy which sets out how to deal with those issues.

The Strategy for Nottinghamshire has been developed to get the most from the whole system locally by focussing on the areas of highest need and where the Health and Wellbeing Board can have the biggest impact. With the Delivery Plan it also provides a framework to measure progress against our key ambitions.

The Health and Wellbeing Board in Nottinghamshire cannot deliver this Strategy alone – health and wellbeing has to be everyone's business. The Strategy gives partners and the public a clear idea about where they can help to improve health and wellbeing.

The Strategy sits alongside other plans and strategies to provide a focus on health and wellbeing and improve coordination. Partners reflect the Health and Wellbeing Strategy within their own plans to help join up everyone's efforts to improve outcomes.

How was the Strategy developed?

A draft Strategy was developed using information and evidence from the Joint Strategic Needs Assessment about current and future health and wellbeing needs in Nottinghamshire.

In 2013 we held a public consultation on the draft Strategy and responses were received from the public, partners, service providers, carers and community and voluntary organisations.

While there were a wide range of comments received about the priorities within the Strategy the core principles of the Strategy were well supported.

As a result we have developed this high level strategy document which sets out the vision of the Board, its key ambitions and the priorities to achieve the ambitions. Specific actions and plans are outlined in the Delivery Plan document.

What will the Strategy achieve?

The Board have identified four key ambitions for the people of Nottinghamshire:

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

All of these ambitions support our overall vision to improve health and wellbeing in Nottinghamshire. Getting the best value for money in delivering this vision is fundamental to the Board and all of its partners. During these difficult times we must get the very best from the resources we have available.

At the heart of the Strategy for Nottinghamshire is the desire to reduce health inequalities. It is vital to the Board that unfair and avoidable differences in health which result from where people are born, live, work and age should be reduced and removed. We will work to identify where there are inequalities across the county and to help address them.

How will we do it?

To achieve the ambitions the Board has identified a number of priorities which represent important local needs described in the Joint Strategic Needs Assessment. We believe that these priorities are the areas where the Board can have the biggest impact to achieve its ambitions.

These priorities have actions which are shared by the Health and Wellbeing Board members and partner organisations, to support all four ambitions. In brief these priorities are:

A GOOD START

Work together to keep children and young people safe
Improve children and young people's health outcomes through the integrated commissioning of services
Close the gap in educational attainment
Provide children and young people with the early help support that they need
Deliver integrated services for children and young people with complex needs or disabilities

LIVING WELL

Reduce the number of people who smoke
Reduce the number of people who are overweight & obese.
Improve services to reduce drug & alcohol misuse
Reduce sexually transmitted disease & unplanned pregnancies
Increase the number of eligible people who have a Healthcheck
Improve the quality of life for carers by providing appropriate support for carers and the cared for.

COPING WELL

Supporting people with learning disabilities & Autistic Spectrum Conditions
Support people with long term conditions
Supporting older people to be independent, safe & well
Providing services which work together to support individuals with dementia & their carers.
Improving services to support victims of domestic abuse
Provide coordinated services for people with mental ill

WORKING TOGETHER

Ensuring we have sufficient & suitable housing , particularly for vulnerable people
Improving workplace health & wellbeing
Improving access to primary care doctors & nurses

More detail about actions to support these priorities are available in the Health and Wellbeing Strategy Delivery Plan.

How are we going to do it?

The Health and Wellbeing Strategy Delivery Plan sets out the actions which the Board agrees will achieve its ambitions for everyone in Nottinghamshire. The Board is supported by partnerships which will deliver these actions. All of the partners will work to achieve these actions and their plans and strategies will reflect their role in the delivery of the ambitions of the Health and Wellbeing Strategy.

How will we know if it's working?

The Health and Wellbeing Delivery Plan will monitor progress against the specific actions to deliver the Boards priorities. The Strategy and the Delivery Plan will be public documents which will be published by the Health and Wellbeing Board on the Nottinghamshire County Council website: www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board

Annual reports against the Delivery Plan will be made to the Board showing how we are achieving our actions and these reports will be published on the County Council's website.

We will also make the reports available to the Stakeholder Network and will continue our work to engage and consult through the working groups and networks which support the Board and via Healthwatch Nottinghamshire.

Useful websites:

JSNA
http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/

Nottinghamshire Stakeholder Network
http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/stakeholdernetwork/

NHS England - Call to Action
http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/

Health & Wellbeing Board
http://www.nottinghamshire.gov.uk/caring/yourhealth/developing-health-services/health-and-wellbeing-board/

Healthwatch Nottinghamshire
http://www.healthwatchnottinghamshire.co.uk/

The Department of Health – The new Health and Care System Explained
https://www.gov.uk/government/publications/the-health-and-care-system-explained/the-health-and-care-system-explained

What you said about the Strategy:

- I think that the core ambitions are spot on.
- Independence of the elderly who wish to remain at home is of prime importance.
- I am very pleased at the focus on joined-up working and the aspiration to connect at community level.
- The Strategy is good & sets out important ambitions – addressing health inequalities is vital.
- Early health education should be part of the school's curriculum and included targeted work with children and parents.
- We need to build self-esteem & resilience especially in young people.
- Working in partnership to maximise use of resources.
- Prevention, prevention, prevention.
- Helping people to take responsibility for their own health…

Health & Wellbeing Strategy – Delivery Plan

This Delivery Plan has been prepared to support the Health and Wellbeing Strategy for Nottinghamshire 2014-17.

The Strategy document gives an overview of what we want to achieve, this plan gives more detail about how we will do it and the outcomes we want to achieve.

Our vision:

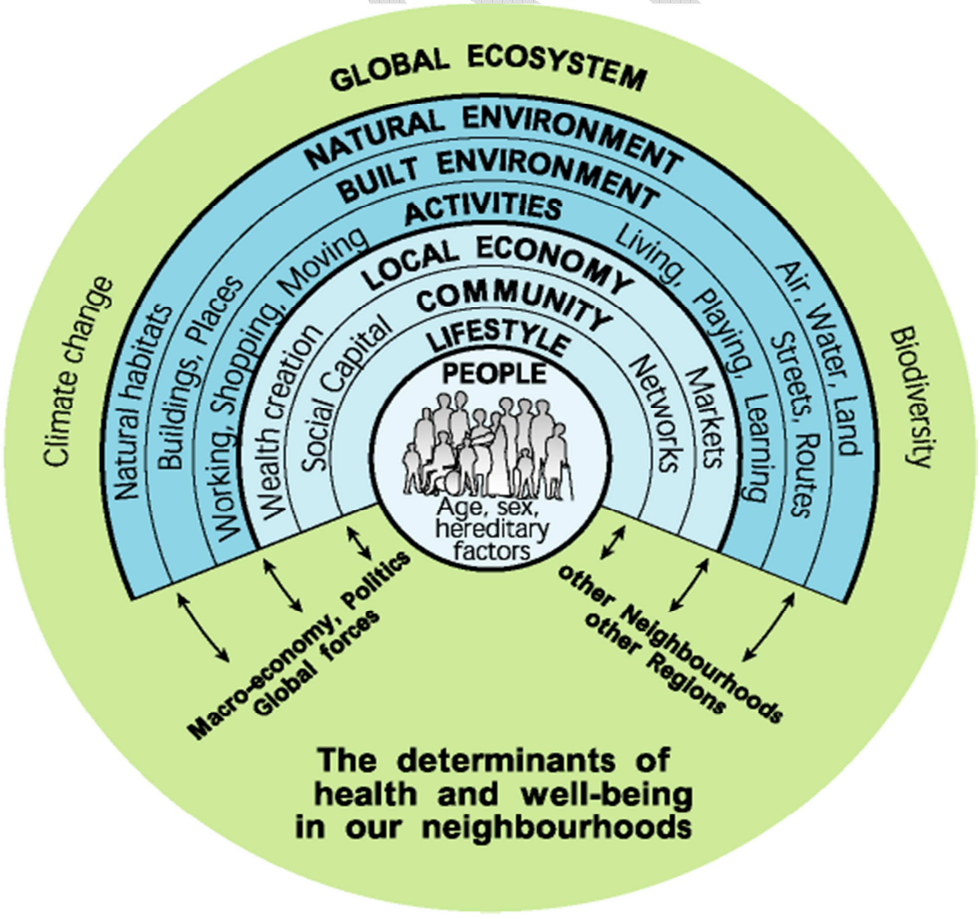
We want to work together to enable the people of Nottinghamshire to live longer, be healthier and have a better quality of life, especially in the communities with the poorest health.

We will do this by providing the most efficient and effective services.

What do we mean by health and wellbeing?

Health is often considered as being an absence of illness or disability. Health and wellbeing is much wider though and is a combination of physical, mental and social factors. In developing this Strategy we have looked beyond health and social care services to bring together other issues like housing and workplace health.

Figure one illustrates the layers of influence that determine health and wellbeing in our communities or neighbourhoods.



The Health and Wellbeing Board and its Partners

The Nottinghamshire Health and Wellbeing Board is a partnership committee, which is chaired by the Deputy Leader of Nottinghamshire County Council.

Partner organisations that are members of the Health and Wellbeing Board are:

Local Authorities: Nottinghamshire County Council, Gedling Borough Council, Newark and Sherwood District Council, Ashfield District Council, Bassetlaw District Council, Broxtowe Borough Council, Mansfield District Council, and Rushcliffe Borough Council.

The NHS: NHS Bassetlaw Clinical Commissioning Group (CCG), NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG, NHS England Area Team.

Healthwatch: Healthwatch Nottinghamshire.

Other Partners: In addition, there is a wide network of important partners which work together to influence health and wellbeing, these include:

Nottinghamshire Police, Nottinghamshire Fire and Rescue, Nottinghamshire Probation Trust, Public Health England, Jobcentre Plus, as well as the education and business sectors.

Partnership boards include the Safer Nottinghamshire Board (SNB), Adult and Children's Safeguarding Boards, the Children's Trust and district level health partnerships groups and Community Safety Partnerships.

Providers of services for health and wellbeing: The largest health providers within Nottinghamshire include Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust and East Midlands Ambulance Service NHS Trust. Across health and social care, there are a wide range of providers including private, independent and voluntary sector providers.

Our strategy has been published by Nottinghamshire County Council, as the lead partner with legal responsibility for the Health and Wellbeing Boards function.

A Picture of Nottinghamshire

In 2011, the resident population of Nottinghamshire was 785,802 (Census 2011), an increase of 5% since 2001. 18% were aged 65 and over (compared with 16% in England) and 18% were aged under 16 years (compared with 19% in England). The proportion of younger people (aged under 20 years) was highest in Ashfield and Mansfield. The proportion of older people (aged 65+) was highest in Newark and Sherwood, Gedling and Bassetlaw.

General health and wellbeing:

9.7% of people across Nottinghamshire identified themselves as having a long-term condition that limited daily activities a lot, compared with 8.7% in the East Midlands (Census 2011). 79% of residents felt they had good or very good health (Census 2011) though this varied across the County with only 76% in Mansfield but 85% in Rushcliffe.

Health and Wellbeing Inequalities in Nottinghamshire

Health is improving but not at the same rate for everyone. Some health differences are to be expected, for example, older people are more likely to become ill, and so can be expected to consume more health and social care resources.

Some groups have a higher presence of disease, worse health outcomes, or worse access to health care that cannot be explained by differences in need. These represent the true meaning of health inequities - unfair and avoidable differences in health that are a consequence of where people are born, grow, live, work and age. Those born into disadvantaged groups are likely to die at a younger age and live more of their lives in ill health than average. The districts of Nottinghamshire have a similar range of general health needs, however inequalities exist across the County

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Health and Wellbeing in Nottinghamshire: A Summary of Local Need

Smoking is still the leading cause of ill health and preventable death. 19.4% of adults in Nottinghamshire smoke. This is comparable with the national average for England, which is 19.5% (PHE Tobacco Control Profiles Feb. 2014 update). A significantly higher proportion of women smoked in pregnancy in Nottinghamshire compared with England (PHE Tobacco Control Profiles Feb. 2014 update).

Drug and alcohol misuse have a negative effect on the health, wellbeing and quality of life for those directly or indirectly affected. It also places demand on public resources and the links between alcohol and violent crime are evident. It is estimated that there are 16,327 people in Nottinghamshire dependent on illicit drugs, of which most (12,000) are dependent upon cannabis (PANSI). In Nottinghamshire the prevalence of drug misuse is significantly higher than the England average (PHE Health Profile 2013). It is also estimated that there are 28,800 people dependent upon alcohol in Nottinghamshire (PANSI). In addition alcohol related hospital stays increased year on year (Local Alcohol Profiles). The north of the County experiences more drug or alcohol-related harm compared to the south of the County. Those in treatment for drug or alcohol misuse often report issues with both drugs and alcohol (Nottinghamshire JSNA).

Obesity in adults and children leads to an increase in the likelihood of chronic long-term disability and life shortening conditions. Over a quarter of adults (26%) are estimated to be obese. Positively, there has been a significant decrease in obesity prevalence at Reception (age 4-5) across Nottinghamshire County between 2006/7 and 2012/13, in line with Regional and National trends. Although there has been no difference in levels of obesity by year 6 over the same 6 year period this is set against a regional and national picture showing a significant increase over the same period (PHE NCMP LA Profile Feb. 2014).

Sexual health is an important issue for Nottinghamshire County as many sexually transmitted infections have long-term effects on health including: increasing risk of cancer, infertility, cardiovascular, neurological, and suppression of the immune system. Young adults (age 15-24) make up only 25% of the sexually active population but represent almost 50% of all new acquired sexually transmitted diseases. The numbers of people accessing HIV services have increased year-on-year and in 2012 301 patients were using services. Nottinghamshire has a continuous downward trend in teenage pregnancies. However, some wards do still have higher rates than the national average. (Report on Sexual Health to Health and Wellbeing Board, March 2013)

Children, Young People & Families

In Nottinghamshire, the population aged 0-19 is increasing, although not quite as much as nationally. As in the rest of the country, there are increasing numbers of children and young people with complex health needs and disabilities. Although in many ways, children and young people across Nottinghamshire have outcomes in line with national averages, children from vulnerable groups do less well. Children and young people in some localities have poorer outcomes, as do those who are living in poverty, who are looked after by the local authority or who are disabled. Those communities where children do less well are usually those with higher levels of child poverty. They often have poorer health outcomes, including higher levels of child obesity.

Overall, the educational attainment of children and young people in Nottinghamshire is better than the national average (at ages 11 and 16), but there is an attainment gap between those who are eligible for free school meals and their peers. Children are affected by issues within families, such as domestic violence, or drug and alcohol use by parents and carers, as well as by issues in their communities, such as crime levels. Homelessness is now increasing, having reduced significantly in recent years, affecting both families with children and young people who are living independently.

Adult and Health Inequality

Mental ill health is widespread; at least one in four people will experience a mental health problem at some point in their life. Mental health problems have complex causes and effects, involving social and economic circumstances, and having a mental health problem also increases the risk of physical ill health. 83,215 people age 16-64 years in Nottinghamshire are estimated to have a mental health disorder, of which 93% are common mental health disorders (PANSI). There is significant variation in the prevalence of mental illness, rates of suicide, rates of self-harm and proportion of benefits claimants between districts in Nottinghamshire, broadly reflecting the variation in levels of deprivation.

Levels of disability in Nottinghamshire (20%) are higher than both the East Midlands (19%) and England (18%) and patterns of disability reflect variations in deprivation. (Levels are highest in Mansfield, 24% and lowest in Rushcliffe at 16%). It is estimated that in 2012 there were 38,891 people with moderate and 11,717 with severe physical disabilities. People with disability have more difficulty accessing services and are at increased risk of other physical health problems (PANSI)

It is estimated that there are around 13,656 people with moderate or severe visual impairment in Nottinghamshire of which 64% are aged 75 or over (PANSI, POPPI) and that there are 87,757 people with moderate or severe hearing impairment of which 75% are aged 75 or over. Sensory impairment can impact on every daily living skill and can be extremely isolating with access to services presenting particular difficulties. Acquired deafness with age is expected to increase across Nottinghamshire.

People with learning disabilities die younger and have poorer health than the general population. These differences are, to some extent, avoidable and therefore represent health inequalities. It is estimated that about 3,079 people over the age of 18 in Nottinghamshire have a moderate or severe learning disability (PANSI). In Nottinghamshire a higher proportion of people with learning disabilities than the national average live in their own homes (25%) and the percentage in paid employment (10%) is in line with the national average. A Nottinghamshire survey suggested around a third of people with learning disabilities would like to move, or would need to move (e.g. due to ageing family carers), in the next five years. There are concerns locally about levels of hate crime experienced by people with a learning disability.

Autistic Spectrum Disorder (ASD) is defined as a lifelong developmental disability that affects how a person communicates with, and relates to, other people. An estimated 4,804people aged between 18 and 64 have ASD in Nottinghamshire (PANSI). Around 50% of people with ASD also have a learning disability. People with ASD are much more likely to have mental health problems than the general population and a number of other conditions occur at a higher rate in people with ASD, including epilepsy and attention deficit hyperactivity disorder.

Long Term Conditions In general, the prevalence of many long-term conditions in Nottinghamshire is similar to the national average. The most common long-term conditions are hypertension, common mental health disorders, asthma, chronic kidney disease, diabetes, chronic back pain and coronary heart disease. Most long-term conditions are more prevalent in more deprived communities. The estimated number of hypertension sufferers in the county is 209,000, well above the next most common long-term condition (mental health with 83,215 sufferers). A relatively high proportion of people with some long-term conditions remain undiagnosed and therefore untreated, this includes those with hypertension, diabetes, COPD (Chronic Obstructive Pulmonary Disease), dementia and chronic kidney disease.

Older People: Census figures showed that the population living in Nottinghamshire aged 65+ has increased from 16.5% in 2001 to 18% in 2011. It is estimated that by 2020 21% of the total population will be aged 65+ (POPPI). The highest number of older people live in Newark and Sherwood, Gedling and Bassetlaw. Health and wellbeing needs of both an ageing and diverse population will need to be addressed.

Dementia is one of the main causes of disability in later life and the number of people with dementia is rising as the population ages. The prevalence of dementia is expected to rise across Nottinghamshire by

19% over 6 years from 11,022 in 2015 to 13,137 in 2021. Currently it is estimated that only about 54% of people with dementia are diagnosed and treated by their GP.

Carers In 2011 90,698 people were providing unpaid care in Nottinghamshire which is an increase of 7,517 since the 2001 Census. In addition, 2% of the 0-15 population in Nottinghamshire have caring responsibilities for another person (Census 2001). Of those adults providing unpaid care, 24% provided 50 or more hours per week, compared with 21% in the 2001 Census. A small survey of 19 of the county's young carers found that the average number of hours worked per day was 3.9 (weekdays), and 11.1 hours per weekend. Provision of unpaid care is highest in the north of the County.

The Wider Determinants Of Health & Wellbeing

Benefit claimant rates were lower in Nottinghamshire (2.6%) in October 2013 compared with the East Midlands (2.9%) or UK (3.0). Employment within industry sector shows that a higher proportion are employed within manufacturing within Nottinghamshire (12%) compared with England (9%), particularly in Ashfield (16%) (Census 2011).

Dwelling burglaries represented 5% of notifiable offences in Nottinghamshire in 2012/13 however this varied across Nottinghamshire with 8% in Rushcliffe and 3% in Mansfield. The number of reported incidents for violence crime were highest in Ashfield (1596) and Mansfield (1882) and lowest in Rushcliffe (580) and Broxtowe (942) in 2012/13.

Domestic violence has physical, psychological and further consequences on health and wellbeing for the victim and children who are exposed to domestic violence in the home. The majority of domestic violence incidents are not disclosed to the authorities but findings from the British Crime Survey 2011/12 show that around 30% of women will experience domestic violence at some point in their lives, equating to around 70,000 women in Nottinghamshire. Reported incidents of domestic violence have increased across Nottinghamshire between 2007-2012 and were highest in Ashfield and Mansfield (Report on Domestic Violence to Health and Wellbeing Board, Jan 2013).

Housing The relationship between health and housing is well documented: fuel poverty, the condition of homes, suitable sustainable accommodation (given the ageing population), and affordable homes have been identified as key factors affecting physical and mental health. In Nottinghamshire 1.4% of homes had no central heating (Census 2011) which is lower than England (2.7%). Within Nottinghamshire, Broxtowe (1.8%) and Gedling (1.7%) had the highest percentage of homes without central heating. In 2011 13% of households in Nottinghamshire were socially rented compared with England 18% (Census 2011).

Road traffic collisions (RTCs) are the single largest cause of premature death and serious injury in the country and they are largely preventable if the right resources, strategies and interventions are in place. In Nottinghamshire, around 70 people are killed and seriously injured every week on the County's roads. The rate of road injuries and deaths is significantly higher than the England average (APHO Health Profile 2012); however the rate has been falling year on year. Young people under the age of 25 years, road type (rural) and driver behaviours (speeding, using mobile homes, drink driving, not wearing a seatbelt) all contribute to increase an increased risk of a road traffic collisions.

Our Joint Strategic Needs Assessment (JSNA) is available at:
http://www.nottinghamshireinsight.org.uk/insight/jsna/county-jsna-home.aspx

Public Health England health profiles available at:
http://www.apho.org.uk/resource/view.aspx?RID=116449

Our ambitions

The Nottinghamshire Health and Wellbeing Board agreed four ambitions to achieve its vision to improve health and wellbeing across Nottinghamshire:

A GOOD START
We want to give children, young people and their families in Nottinghamshire a good start in life, to be healthy, safe and to reach their full potential.

LIVING WELL
We would like for people to lead healthier lives and to make healthier choices to prevent problems. We also want to make sure that we have services in place to address any problems early before they need more complex treatment.

COPING WELL
We want to help people cope well and to help and support people to improve and maintain their own health and wellbeing, to be independent and reduce their need for traditional health and social care services where we can.

WORKING TOGETHER
We would like services to work together to improve health and wellbeing. The Health and Wellbeing Board will provide the leadership to join up services and make sure that health and wellbeing services work together, sharing information to deliver consistent care or advice, wherever people live and whatever service they use. All of the priority areas include an element of integration.

These are our ambitions to improve the health and wellbeing of the people of Nottinghamshire. Underpinning all of these principles is a drive to ensure that we reduce and remove health inequalities. We recognise that health is improving but not at the same rate for everyone. Some groups have a higher presence of disease, worse health outcomes or worse access to health care that cannot be explained by differences in need.

We recognise that there are inequalities within districts in Nottinghamshire. The Health and Wellbeing Strategy provides an over arching vision for the County which partners should reflect in their own plans which may be on a geographical or condition specific basis.

Across the Nottinghamshire health and local government community, there is a need to save approximately £600 million from an expenditure of £1.8 billion over the next 3 years. A large amount of this money will be reinvested in health and local government services to meet the needs of an ageing population and increasing costs from medical advances and rising service costs.

The Health and Wellbeing Board is committed to improving health and wellbeing for local people. To do this, it must prioritise areas of greater need and greater potential to make improvements, so that it can make the best use of available finances.

The Board will take advantage of new structures and strengthened relationships to transform health and wellbeing services. It will lead the development of integrated approaches to achieve benefits that cannot be realised by any single organisation alone. This will require health, social care, housing, planning and other partners to work together and behave differently; building positive outcomes that further develop trust and confidence within partnerships.

How will we achieve our ambitions?

We have identified a number of actions which will support the delivery of our ambitions. The actions will deliver the biggest impact within areas of greatest need locally. The Health and Wellbeing Board is supported by a number of partnership boards which will work to deliver these actions. All partners will work to help to achieve the ambitions and will reflect their role in the deliver of the Strategy within their own plans.

Measuring Success: Nottinghamshire Local Outcomes Framework

It is important to make sure that real health and wellbeing improvements are delivered through the implementation of the Strategy. In addition to citizen feedback, the best way to achieve this at a service level, is to use recognised measures to monitor the benefits arising from agreed priority actions.
There are currently three national outcomes frameworks that are particularly relevant to local authority health and wellbeing strategies (June 2013). These are:

- The Adult Social Care Outcomes Framework (ASCOF)
- The NHS Outcomes Framework (NHSOF) and
- The Public Health Outcomes Framework (PHOF).

A Children and Young People's Health Outcomes Framework is also planned following a national strategy report in January 2013.

Each of these sets out a range of indicators that attempt to cover health and wellbeing priorities. The Outcomes Frameworks are all structured differently; together they embrace several hundred separate indicators.

The Local Outcomes Framework is a tool developed in Nottinghamshire to assess the success of the Health and Wellbeing Strategy. The indicators in the Local Outcomes Framework are derived from the national documents listed above, but also reflect agreed national and local measures that complement the national outcomes frameworks.

Actions

STARTING WELL

Work together to keep children and young people safe

Why is this important?

All children and young people need to be safe and feel safe so that they can achieve their full potential. All partner organisations have a role in safeguarding children, with Children's Social Care leading on the protection of the most vulnerable and we will continue to work together through the Children's Trust and the Nottinghamshire Safeguarding Children Board (NSCB).

Recently, there has been a substantial increase in the numbers of children who are referred to Children's Social Care, and in the numbers who are looked after by the local authority. This is a national trend which is reflected in Nottinghamshire. It creates increasing demand for services, while financial resources are decreasing. We are responding to this by developing innovative ways to work together, including the County Council's new operating model for children's services and the next stage of a transformation programme for Children's Social Care.

Actions
We will further improve our partnership arrangements to identify and support children and young people who are affected by parental mental health issues, substance misuse or domestic violence We will develop improved partnership arrangements to identify and support young carers We will deliver the next stage of a partnership strategy to ensure that children and young people are protected from sexual exploitation We will promote children and young people's awareness of safeguarding by developing a programme of engagement and participation in schools or other universal settings We will identify ways to promote safeguarding in the wider community, including through businesses and workplaces
We will deliver the next stage of a comprehensive improvement programme for Children's Social Care that will focus on: • Looked After Children • Disabled Children's Services, • Family and Placement Support • Workforce Development. We will continue to improve our arrangements for engaging children and young people in decision-making about their lives, including in child protection planning
We will review and further develop partnership arrangements for safeguarding children, as set out in the national guidance 'Working Together 2013' We will simplify and improve access to children's services by implementing a new operating model for services We will work together to support the effective operation of the County Council's Multi-Agency Safeguarding Hub (MASH), by bringing together the MASH and the Early Help Unit developing more effective information-sharing between partners promoting a shared understanding of thresholds for access to services

Outcome measures to be developed for each of these actions

Provide children and young people with the early help support that they need

Why is this important?

Providing early help when families need it is key to improving outcomes for children and young people. It also reduces the likelihood that families will need more costly specialist or statutory services, such as support from Children's Social Care. Early help may involve providing help early in a child's life. It may also be help that is provided early on when an issue emerges, whatever the age of a child or young person. Early Help Services are provided to children and young people across Nottinghamshire by a range of partner agencies. To provide effective early help, these organisations need to work together and provide clear pathways of support.

In Nottinghamshire, outcomes for children and young people vary across localities and there is an association between poorer health and wellbeing and higher levels of social or economic deprivation. The localities where there are higher numbers of families on low incomes are often those where children have more health and wellbeing issues. These can be inter-linked, with many children and young people facing difficulties in several areas of their lives. To respond to this, our partner organisations will work together to provide integrated early help services to those who need them most.

Actions
We will align early help and social care services in localities so that families receive a joined up service We will improve the multi-agency early help offer to children, young people and families simplifying and improving access to services and developing clear pathways into support We will undertake a rolling programme of needs assessments of key groups of vulnerable children and young people and use this information to inform commissioning priorities We will review and refresh our family support offer, to establish a consistent approach across the children's workforce
We will work together to align the services that are commissioned by the Integrated Commissioning Hub with the County Council's early help offer We will implement a multi-agency workforce development plan to ensure that we recruit and retain staff who have the necessary skills, knowledge and capacity to meet the needs of vulnerable children or young people and their families We will review and refresh our common assessment approach for individual children, young people or families who need integrated early help support

Outcome measures to be developed for each of these actions

Improve health outcomes through the integrated commissioning of children's health services

Why is this important?

Investing in children's health is an investment in the future. Healthy children and young people are able to enjoy life and achieve their full potential. They are more likely to go on to become healthy adults and parents who in turn promote better health in future generations. Early intervention and prevention to improve children's health and wellbeing can produce longer-term financial savings in higher-cost medical services.
Poorer health is associated with economic deprivation, both nationally and locally. Integrated working across health, social care and education services is more likely to provide disadvantaged children and young people with the right support. The Integrated Commissioning Hub acts as a single point of coordination for children's health and wellbeing integrated commissioning, on behalf of Clinical Commissioning Groups, the County Council, including Public Health and (from October 2015) NHS England Area Teams.

Actions
We will review unplanned admissions and avoidable emergency department attendances by children and young people by completing a needs assessment to be included in the JSNA and to inform future commissioning, linking to the Integrated Community Children and Young People's Healthcare priority on reducing hospital admissions We will work with key stakeholders to improve the quality of and access to Maternity Services by undertaking reviews in the Sherwood Forest Hospitals NHS Foundation Trust and the Nottingham University Hospitals NHS Trust, and implementing recommendations from the reviews.
We will further improve ways to actively engage children, young people and families in developing and reviewing services and use feedback to inform future commissioning We will review the Child and Adolescent Mental Health (CAMHS) pathway, establish if there is a need for a new operating plan and then, if needed, implement any new operating plan We will review elements of the Community Paediatric Services provided by the Sherwood Forest Hospitals NHS Foundation Trust and the Nottingham University Hospitals NHS Trust, and ensure that outcome based service specifications and robust quality and performance monitoring processes are in place for: • Medical Advisors to Adoption Service • Medical Services for Looked after Children Child Death Review Process (including rapid response to an unexpected death of a child)
We will embed integrated commissioning arrangements for children's health services and interventions across the local NHS and local authority organisations. We will work with NHS England to commission the Healthy Child Programme. This will include: A new contract and service specification for the School Nursing service in place from April 2015. Completion of the Healthy Schools review and implementation of key recommendations by July 2014 Successful transfer of commissioning responsibility for Health Visiting from NHS England to the Local Authority (ICH) from October 2015. Successful transfer of commissioning responsibility for Family Nurse Partnership from NHS England to the Local Authority (ICH) from October 2015. We will champion Children and Young People issues through public health life course areas.

Outcome measures to be developed for each of these actions

Close the gap in educational attainment

Why is this important?

Educational attainment gives young people greater opportunities for employment or further or higher education. It enables them to participate in society, achieving their full potential and contributing to their community and to the economy. Some children and young people may need more support to enable them to achieve. Both nationally and in Nottinghamshire, there is a gap between the achievements of disadvantaged children and young people and their peers.
In Nottinghamshire, overall educational attainment continues to improve each year at a higher rate than nationally. Attainment by those from disadvantaged groups is also increasing, but there is still a significant gap between these learners' attainment and that of their peers. We need to work to reduce this gap, while continuing to promote achievement for all.

Actions
We will deliver on the commitment to devolve funding for the support of pupils with emotional and behavioural difficulties to local School Behaviour and Attendance Partnerships We will work in partnership with schools and other organisations to close the gap in educational attainment between disadvantaged children and young people and their peers, delivering actions within our Closing the Gap Strategy
We will raise the educational achievements and aspirations of looked after children and young people, by providing support and monitoring to the schools that they attend We will raise the educational achievements of children and young people with disabilities and special educational needs, by developing more coordinated support and early help services
We will identify how partner organisations can contribute to closing the gap in educational attainment, by improving the health and wellbeing of children and young people so that they are able to fulfil their educational potential

Outcome measures to be developed for each of these actions

LIVING WELL
Tobacco Control

Why is this a priority? In England around 79,100 deaths (18% of all deaths of adults aged 35 and over) are estimated to be caused by smoking. In Nottinghamshire around 20% of adults smoke. Despite services to help people quit, smoking continues to highlight significant health inequalities and is the leading cause of preventable ill health and death.

Actions
Work with the 22 key contacts identified in the Children Families & Cultural Services directorate to integrate elements of tobacco control in to programmes and services for young people to include; Supporting the Children, Families and Cultural Services Department to establish a refreshed Tobacco policy (including secondhand smoke) for service users and staff by 2016 Increase the availability of smoking cessation resources by 20% to all youth service and children centre settings by 2016 Establishing and evaluating the secondhand smoke DVD's and resources in the 285 primary schools & other educational settings by 2016. Working with the 7 district councils to reduce the harms of secondhand smoke by exploring extending smokefree environments to play parks and schools.
We will support people to quit smoking through delivering quality universal stop smoking services. We will extend tailored and targeted stop smoking services to meet the needs of local population from April 2015 especially in; • Routine and Manual workers • Young People • Pregnant women • Other specific populations of need including; people with mental health problems We will deliver appropriate brief intervention training to prioritised frontline health, social and voluntary sector staff in Nottinghamshire in order to give them the skills to raise the issue of smoking and signpost people who want to quit to their local service. We will explore how to implement harm reduction strategies across Nottinghamshire based on the evolving evidence by 2015.
We will work with partners to embed Steps to Go Smokefree into services in order to achieve a 10% increase in the number of pledges received for the Steps to Go smokefree initiative *(baseline 2013-2014).* We will actively promote the use of the Smokefree Notts website to achieve a 10% increase in the usage of the smokefree website *(baseline 2013-2014).* We will work with Trading Standards, HM Revenue & Customs (HMRC), police and border force agencies to raise awareness and increase intelligence received in order to reduce demand and supply of illicit tobacco (including under age sales) *(baseline 2013-2014)).* We will achieve high level sign up of the Tobacco Control declaration across partners.

Outcome measures to be developed for each of these actions

Obesity and Maintaining Healthy Weight:

Why is this a priority? Obesity increases the risk of Type 2 diabetes, cancer and heart disease. It shortens life expectancy by 9 years. In Nottinghamshire, 8.5% of children aged 4/5 are obese and at the age of 10/11 this doubles to 17.4%.

There is a need to tackle elements of the environment that are 'obesity promoting' as well as providing people with the support and motivation to improve their diet and physical activity levels.

Actions
Increase the number of healthier choices available in out of home food provision such as fast food outlets. Increase the number of workplaces that are promoting and supporting physical activity, healthy eating initiatives and weight management support.
Establish obesity prevention and weight management services in each district • Decommission current services and commission countywide integrated obesity prevention and weight management services for children and adults. Develop access to personalised advice and support for both children and adults with excess weight to meet the needs of the local population.
Ensure workplace strategies are in place which promote healthy eating and physical activity.

Outcome measures to be developed for each of these actions

Drugs and Alcohol:

Why is this a priority? Nottinghamshire experiences a wide range of drug and alcohol misuse (substance misuse) related issues, with the north of the county experiencing the greatest level of harm in terms of problematic drug and alcohol use.

Intelligence continues to suggest that all drugs appear to be readily available, drug use patterns are changing and new synthetic drugs ('legal highs') being used. Nottinghamshire has approx. 111,000 (20%) people drinking at levels that are increasing their risk of health problems.

Actions
Improve the way in which we identify and support the needs of the individual, children and young people and parents in relation to their substance misuse needs by intervening earlier (Nottinghamshire Substance Misuse Strategy priority) • Increase awareness of the impacts of drugs and alcohol through appropriate channels/media to all ages. • Implement Alcohol Diversion Scheme • Implement Young Person's Substance Misuse Diversion Scheme. • Implement intensive Youth Support Project in Manton and Coxmoor.
Commission locality based substance misuse services, in partnership plus areas that support the needs of the individual, their families and carers to enhance their recovery potential - (Nottinghamshire Substance Misuse Strategy priority) • Ensure Alcohol Identification and Brief Advice is offered routinely by primary care. Ensure accessible substance misuse services are in place across the county to meet the needs of the local population.
Ensure Alcohol Identification and Brief Advice is offered routinely by partners. Ensure workplace substance misuse strategies are in place.

Outcome measures to be developed for each of these actions

Sexual Health:

Why is this a priority? There continues to be an increase in risky sexual behaviour, with continued ignorance about the possible consequences. Furthermore, there is a clear relationship between sexual ill health, poverty and social exclusion in Nottinghamshire.

15% of young adults between the age of 18 and 26 have had a sexually transmitted disease in the last year. Between 10 and 20% Chlamydia cases result in infertility. The proportion of heterosexuals who acquire their HIV infection in the UK continues to increase.

Actions
Renegotiating sexual health contracts to ensure equity of access and cost effectiveness across the county – new contracts to be in place by April 2014 Achieve the National rate for the uptake of Long Acting Reversible contraception by April 2015 Increase the number of new providers offering Emergency Hormonal contraception for women of all ages by 5% by April 2015 See also Children, Young People and Families priorities
All contracts for contraception and sexual health services will specify that Chlamydia testing is offered routinely to all 15-24 year olds by April 2014.
Targeted testing for HIV will be offered to high risk groups at the point of access in community settings from July 2014 Complete a comprehensive sexual health needs assessment for Nottinghamshire with recommendations for future actions by July 2014

Outcome measures to be developed for each of these actions

Community Safety and Violence Prevention – Domestic and Sexual Violence

Why is this a priority?

One in four women experience domestic violence across their life time and one in ten in any given year. The estimated number of female (16-59 years) victims of domestic violence in Nottinghamshire is between 66,000 and 73,000 across their lifetime and between 16,000 and 25,000 in any one year. Domestic violence in men is less common, but still represents an important element of this priority.

One in five women (19.6%) and 2.7% of men have suffered a sexual assault since the age of 16. Three percent of women and 0.3% of men report an actual or attempted sexual assault in any one year, equating to around half a million adult victims. Young women are at greatest risk of sexual assault, with prevalence of past year victimisation rising to 7.9% in 16-19 year old females.

The impact of domestic and sexual violence on physical and mental health can be very serious. This can be mitigated by interventions to improve safety and repair damaged self-esteem and confidence.

Domestic and sexual violence and abuse is under reported to the authorities. We are committed to establishing an infrastructure that improves the identification of those experiencing or have experience domestic and sexual abuse and to enable them to receive the support they need sooner. Developments across the Health Service include a greater emphasis on training, identification and referral to General Practice and hospital based staff. Developing a greater awareness of domestic and sexual abuse and healthy relationships is taking place in schools and the community through prevention programmes. Use contractual levers to ensure that midwifery services routinely ask about, record disclosure and refer pregnant women experiencing domestic abuse.	**Outcomes** All Clinical Commissioning Groups to implement IRIS Increased reporting of domestic and sexual abuse but reduced severity of that abuse as measured by repeat victimisation and risk level analysis
Currently specialist domestic and sexual violence and abuse services are commissioned to support people through a range of interventions including advocacy, refuge, outreach, floating support and sanctuary schemes. This includes specialist services for children and young people affected by domestic abuse. Repeat victims of domestic violence and abuse who are deemed to be at medium risk and who have complex needs are now offered a support service tailored to their needs. A consistent key worker who can remain involved long enough to gain the trust required before real changes can be made to their safety is in place. The City and County Councils are committed to	

maintaining the free 24 Hour Domestic and Sexual Violence Helpline which supports individuals and professionals with advice and information at any time of day or night. Three key agencies are responsible for managing the behaviour and welfare of offenders and potential perpetrators of domestic and sexual abuse. These are Notts Police, Notts Probation and Notts Healthcare Trust. Their activities are co-ordinated through the MASH, MAPPA and MARAC processes where intelligence and activity is shared to protect the public and support individuals to rebuild their lives and access mental health and substance misuse services as required.	
A review of the provision of domestic violence and abuse services will be complete in spring 2014. The Domestic and Sexual Abuse Executive Group will oversee the implementation of the review recommendations Clinical Commissioning Groups support improved information sharing between General Practice and MARAC. Learning from recent developments in primary and secondary care and medium risk work will take place following robust evaluations if these interventions. MARAC arrangements are currently being reviewed and improved to ensure best practice and common procedures across City and County to support High Risk victims The MASH (Multi-Agency Safeguarding Hub) is revising its procedures to include alerts to schools where a child has been affected by a serious DV incident	**Outcomes** All Clinical Commissioning Groups to implement GP practice information sharing with MARAC The Domestic Abuse Review and Joint Strategic Needs Assessment will inform the re-commissioning of domestic abuse services in 2015

Healthy environments in which to live, work and play - Housing

Why is this a priority? The Place where we live, work and play needs to include quality and affordable housing meeting all of the current 'green' requirements, as well as having access to employment, travel (affordable transport links), leisure (parks and green space) and other essential requirements such as health care and schooling. All these elements contribute to improved wellbeing.

Specific needs around housing are being highlighted in joint work across Nottinghamshire. Action will be required to improve health and wellbeing for communities.

- Fuel Poverty and Affordable Warmth **-** Around 20% of excess winter deaths can be attributed to cold housing.
- General Housing Stock Condition and Adaptations **-** cardiovascular disease, respiratory diseases, rheumatoid arthritis, depression and anxiety, nausea and diarrhoea, infections, allergic symptoms, hypothermia, physical injury from accidents, and food poisoning are all associated with poor housing. Tackling these conditions requires improvements in the condition and available adaptations to housing.

Actions
Work with partners to further develop strategies for ensuring the future housing supply meets the needs of our ageing population, as well as people with mental ill-health, physical, sensory and learning disabilities.
Increase appropriate housing, maintain quality and support solutions to enable people to stay in ordinary housing settings for longer, such as affordable warmth, accreditation schemes for landlords and local adaptation funding.
Promote joint working across health and local authorities to improve planning processes to promote the quality of housing, the environment and access to facilities.

Outcome measures to be developed for each of these actions

Workplace Health

Why is this a priority? Evidence suggests the better people feel at work the greater their contribution, the higher their personal performance and the performance of their organisation. Addressing workplace health and wellbeing effectively will improve health outcomes for staff, reducing sickness absence, staff turnover, presenteeism (attending work when unwell) and improving performance. In 2011/12, 27 million work days were lost through long term sickness (over 20 weeks), of which 22.7 million were linked to work related ill health. In Nottinghamshire, there is an older workforce, which is associated with greater health implications.

Actions
Establish & implement a workplace health and wellbeing programme across the County
Establish an integrated and inclusive workplace wellbeing programme within the County, commencing with Nottinghamshire County Council and sharing learning across partners.

Outcome measures to be developed for each of these actions

Carers: Priorities for 2014 - 2106

Why is this priority? The 2011 Census identified an increase in the number of carers in the last decade by 7,517 across Nottinghamshire County. There are now an estimated 57,426 carers providing between 1-19 hours of care per week, and the number of carers now providing over 50 hours of care per week has reached 21,680.

The challenges posed by an ageing society are relevant to health, Local Authorities, District and Borough Councils and the third sector. It is therefore essential that the needs and services required by carers are considered jointly

Actions
We will evaluate the temporary Carers' Triage Project (based in the Customer Services Centre, where specialist staff take calls from carers, offering them on-the-spot information, advice, assessments, etc) and consider options for future implementation. We will improve information and advice for carers with a focus on consistent and accurate advice, and ways of enabling carers to access information themselves e.g. using the 'Choose My Support' website. We will implement and evaluate the Carers' Crisis Prevention Service (formerly "Carers' Emergency Respite"), as part of the Home Based Services contract. This 24-hour service is free for carers who are unable to provide care in the short term. It is delivered to the person cared-for in their own home. *Continue to develop a whole family approach to identifying and supporting young carers.*
We will create specialist 'Compass Workers' within each Intensive Recovery Intervention Service (IRIS), to support carers looking after a person with dementia, to ensure they are supported in their crucial role through practical help, information and emotional support. We will make it easier for carers to access breaks, with a focus on alternatives for the 'cared for' person to have breaks / respite outside of residential care, either in the home, or in more community based and 'homely' environments. This may be through the use of Direct Payments for carers.
We will work with our partners in the NHS, across the voluntary and community sector and with carers themselves, to plan, implement and evaluate the Carers' Strategy. We will oversee the joint NHS and Local Authority funding for Carers in partnership with the Carers' Implementation Group. This will involve consideration of the national planning guidance for the Better Care Fund.

Outcome measures to be developed for each of these actions

Mental Health and Emotional Wellbeing

Why is this a priority? Mental health and wellbeing are fundamental to the quality of life and productivity of individuals, families, communities and nations. One in four people will experience mental health problems during their lives and one in ten children between 5 and 16 has a mental health problem. 23% of all ill health is mental ill health with an estimated cost of £105 billion

Service developments will be directed by the national strategy "No Health Without Mental Health" (DH National MH Strategy 2010) and the local No Health Without Mental Health, Nottinghamshire Strategy 2013. The impact of worklessness is a key factor leading to stigma and discrimination.

Actions
We will work with our partners in NHS, providers, and the voluntary and community sector to develop and implement an integrated model for preventing self-harm and suicide for known high risk groups as part of the local joint mental health strategy. We will undertake public consultation and engagement to develop an action plan. We will complete service mapping and modelling on pathways and services to ensure families and carers get access to appropriate evidence based community services that prevent admissions during a mental health crisis. We will work with our partners in developing a model of and funding for a low level crisis intervention and prevention service that will reduce and prevent admissions to hospital, use of S136 Suites, and inappropriate contact with criminal justice system.
We will continue the work of the mental health utilisation review project to identify additional housing and support alternatives that will enable people who no longer require inpatient treatment to be supported in the community, at the right time, in accommodation and support that promotes community inclusion, choice, independence and a safe place to live. We will ensure all programmes that support people to find and retain employment include people with mental health problems We will work with partner organisations to develop synchronised discharge pathways that support people moving out of hospital, rehabilitation services and acute admission wards.
We will work with partner organisations to implement the No Health Without Mental Health Strategy Nottinghamshire (2013), identifying commissioning priorities for 2014 – 2015 that support evidenced based interventions and outcomes. We will work towards integration to ensure that Health and Social Care commissioned services work together and are delivered in the most efficient and cost effective way, providing best value and quality. This will include working with with other area e.g. Carers and Physical Health We will continue to improve access to physical health services for people with long term mental health conditions, including, how best to build physical health needs into the Care Programme Approach. We will work with partner agencies to strengthen links between Social Care, Mental Health Services and Criminal Justice System including Police Forces to ensure that people receive the appropriate support, reducing inappropriate contact with the Criminal Justice System.

Outcome measures to be developed for each of these actions

Physical Disability and Sensory Impairment (Long Term Conditions)

Why is this a priority? Disability impacts on the length and quality of an individual's life, and can affect access to services. Disabled people generally fare less well than non-disabled people across a wide range of indicators and opportunities. The lack of inclusion in routine data recording makes it difficult to measure equity of access and outcomes for disabled people.

Actions
We will ensure that there are the right range and amount of early intervention and prevention services available. We will do this by: • Researching and reviewing evidence base and available data • Developing a strategy to improve outcomes for people with a physical disability, sensory impairment and Long Term Neurological Conditions. We will support people with a physical disability and sensory impairment by: • improving equity of access to services including people with HIV/AIDS, Long Term Neurological Conditions and Sensory Impairment • Improving ways to help people self manage their conditions including increasing the range of self management and self help programmes and implementing the Nottinghamshire County Self Care Strategy. • Ensure people have better access to information and advice including in other formats i.e. signing, audio CD, Braille etc. • Increasing the use of Assistive Technology to support independence • Assess best models for self help solutions such as, reablement and Time Banking.
We will work with health, social care, housing and other agencies to identify solutions and support to enable people to stay in ordinary housing settings for longer - See also Housing section. We will support people to stay in ordinary housing for longer by: • Developing service models to support young adults to live in the community including options for alternatives to residential care • Working together to ensure accommodation is designed to meet specific needs of people with a Physical Disability and Sensory Impairment e.g. Homes for Life • Identify appropriate community based services for people with sensory impairments who have complex needs • Develop community focused rehabilitation services for people with Long Term Neurological Conditions across Nottinghamshire. We will develop and implement pathways supporting people with Traumatic Brain Injury ensuring equity of access to services across Nottinghamshire and support independence. We will implement the Action Plan for Stroke and Physical Disability including Long Term Neurological Conditions. We will work with Health partners to identify opportunities to jointly commission community based stroke services. This will include identifying and securing funding for voluntary sector based services
We will explore greater integration between the Long Term Neurological Conditions Network and other Networks, including how clinicians and practitioners work together and links to other areas e.g. Carers and Mental Health We will continue to explore options for a joint model of delivery on Personal Health Budgets and Social Care Personal Budgets, to ensure they offer choice to patients and improve outcomes for reduced relapse rates, recovery rates, avoiding acute NHS stays and demand for residential care.

Outcome measures to be developed for each of these actions

Older People

Why is this a priority? Nottinghamshire has a higher proportion of older people than the national average with 18.1% of the population being over 65. By 2020, the numbers of older people in the county are predicted to increase by 31% among those aged 65 and over. The over 85 age group will increase by 39% in the same period.
Falls are a significant health issue for older people both nationally and locally. They are a major cause of disability, impairment and loss of function.

Actions
We will promote healthy ageing and tackle preventable ill-health by: • Continuing to address fuel poverty through targeted work e.g. Winter Warmth, Handy Persons Adaptation Scheme • Investigating new ways of promoting exercise and falls awareness • Developing a joint strategy to reduce falls and promote bone health; specifically working to reduce number of fallers taken to hospital • Reducing loneliness through a campaign to raise awareness and by ensuring current and new services can identify and respond to the needs of isolated people. We will design a new service model and consider procuring services which will directly address isolation and loneliness by 2015.
We will support older people to live at home safely for longer by: • Developing a minimum of an additional 160 Extra Care places across the County by 2017/18 • Create more flexible home based care services by April 2014, which will include carers' crisis prevention services and a 24 hour response service. • Support more people to self- manage their health and social care needs with help from community health and social care teams • Developing a joint strategy on sustainable housing for older people.
We will actively work towards the integration of services across health, social care, housing and other agencies to ensure that services support people to remain independent and are delivered in the most efficient and cost effective way. We will achieve this through the 3 local transformation groups; SIGNS, Mid Notts and Bassetlaw which are working to: • avoid admission to hospital or residential care and following a health crisis, support people to (re)gain their independence • integrate services where appropriate across homecare re-ablement, intermediate care and other discharge services • develop pathways/alternatives to enable people who are able to transfer out of hospital as soon as they are medically well into services that will support them to re(gain) their maximum independence • implement Comprehensive Geriatric Assessment (CGA) and case management We will review the range of existing early intervention and prevention services to ensure that they are joined up, cost effective and deliver good outcomes for individuals. We will continue to improve the quality of care in care homes by implementing any recommendations arising from the 'Strategic Review of Care Homes'.

Outcome measures to be developed for each of these actions

Dementia

Why is this a priority? The prevalence of dementia is expected to rise across Nottinghamshire by 88% between 2010 and 2030 from 9,800

to 18,400 because of the ageing population. Currently it is estimated that only about 45% of people with dementia are diagnosed and treated by their GP. Carer breakdown is a major cause of people moving into residential care.

Actions
We will continue to raise awareness, understanding and knowledge about dementia by making 'Dementia Friends' sessions available to all local authority and health care employees. • We will improve advice and support to people in the early stages of dementia through ; • Improving access to information about dementia and local services for people with dementia and their carers (internet and paper-based information) • Increasing referrals to the Dementia Advice and Support Service in all areas across the County We will increase the rates of dementia diagnosis to two thirds of prevalence by 2015 in line with the 'Prime Ministers Challenge' through; • Implementation of updated GP guidelines for the Prevention, Early Identification and Management of Dementia • Ensuring the full implementation of the Memory Assessment Service (MAS) county-wide.
We will continue the implementation of enhanced community services and services that support people to remain in their own home through; • enhancing the Intensive Recovery Intervention Service in Rushcliffe and Broxtowe, • continuing to promote the use of specialist assistive technology • the introduction and evaluation of an assessment bed service for people with dementia and/or mental health problems in the south of the county • the development of 10 specialist bungalows at the Extra Care development in Mansfield by 2015 • creating specialist 'Compass Workers' to support carers by April 2014.
We will improve the quality of dementia care in care homes through a joint improvement plan that includes; • continuing the specialist training programme for care home staff • recognition of high quality and excellent care through the dementia quality mark (DQM) • continued specialist support to care homes from the Dementia Outreach Team. • The plan will also take account of any findings and/or recommendations from the 'Strategic Review of Care Homes'.

Outcome measures to be developed for each of these actions

Learning Disability and Autistic Spectrum Conditions (ASC)

Why is this a priority?

The social exclusion task force identified people with moderate and severe learning disabilities as one of the most excluded groups of people within our society. There are an estimated 14,715 people in Nottinghamshire with a learning disability, approximately 247 of whom have profound and multiple disabilities.

The National Autistic Society estimate two-thirds of adults with Autism do not have enough support for their needs and one in three people experience mental health difficulties due to this.

Although not high volume, the current cost of services for people with learning disabilities and/or Autism and profound and/or complex needs tends to be extremely high.

Actions
We will develop a comprehensive training plan across health and social care to ensure a greater understanding of Autism and other neurological development disorders.
We will develop appropriate local community based health, housing, care and support services to help reduce the amount of people with a learning disability and/or Autism in secure hospitals and assessment and treatment units or in out of county placements. We will map the needs of young people transitioning from children's services and use this information to ensure appropriate health, support, housing and education services are available in Nottinghamshire.
We will develop a pooled budget between health and social care to support people with the most complex and challenging needs. We will develop a model to ensure effective diagnosis and post diagnostic support is available for people with Autism and other neurological development disorders such as Attention Deficit Hyperactivity Disorder (ADHD). We will improve data collection and sharing around people with Autistic Spectrum Conditions in order to better plan future services.

Outcome measures to be developed for each of these actions

Nottinghamshire County Council

Report to Health and Wellbeing Board

5 March 2014

Agenda Item: 5

REPORT OF THE CLINICAL LEAD, NHS NOTTINGHAM NORTH AND EAST CLINICAL COMMISSIONING GROUP

CLINICAL COMMISSIONING GROUP FIVE YEAR PLANS 2014-19

Purpose of the Report

1. To introduce a presentation at the Health and Wellbeing Board meeting on preparation of the Clinical Commissioning Groups' five year strategies.

Information and Advice

2. NHS England has mandated that NHS commissioners and providers must work together to co-design and deliver a five year strategy and plan to transform services over the next five years.

3. CCGs have formed three Units of Planning across Nottinghamshire. These are:

   - South Nottinghamshire: Nottingham City CCG, Rushcliffe CCG, Nottingham West CCG and Nottingham North and East CCG
   - Mid Nottinghamshire: Mansfield and Ashfield CCG and Newark and Sherwood CCG
   - Bassetlaw CCG

4. Each Unit of Planning will prepare a five year strategy and two year operational plan. These are currently under development, and the most up-to-date version of each plan will be presented at the meeting, based on a standard template called 'a plan on a page'.

5. Initial draft plans and draft two year operational plans were submitted to NHS England on 14 February 2014. Final two year operational plans and a second draft of the five year plan will be submitted on 4 April 2014. Final five year strategic plans are due on 20 June 2014.

6. The submission of these summary plans to the Health & Wellbeing Board forms part of the engagement process being undertaken by the organisations, and is an important step in the development of the final CCG plans

7. The Health & Wellbeing Board is asked to consider the information and raise questions about the individual plans or general process being followed.

Statutory and Policy Implications

8. 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) The Health & Wellbeing Board is asked to consider and comment on the content of the plans that will be presented at the meeting

Dr Paul Oliver
Clinical Lead,
NHS Nottingham North and East CCG

For any enquiries about this report please contact: Jane Laughton, Transformation Associate, South Notts Transformation Board. Jane.laughton@nottinghamcity.nhs.uk

Constitutional Comments

9. To follow

Financial Comments

10. To follow

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.

None

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Health and Wellbeing Board

05 March 2014

Agenda Item: 6

REPORT OF THE CORPORATE DIRECTOR FOR CHILDREN, FAMILIES AND CULTURAL SERVICES AND THE DIRECTOR OF PUBLIC HEALTH

INTEGRATED COMMISSIONING ARRANGEMENTS FOR CHILDREN'S HEALTH SERVICES: PROGRESS AND PROPOSED PRIORITIES 2014-2016

Purpose of the Report

1. To provide information on the development of the integrated commissioning arrangements for children's health services in Nottinghamshire.

2. To seek approval for the proposed work priorities of the Children's Integrated Commissioning Hub for the two years, April 2014 - March 2016.

Information and Advice

3. Commissioning high quality, effective, integrated children's and maternity services is a national and local priority, with recognition that commissioning processes for these services are different from those for adults.

4. Approval and funding for the development of an integrated commissioning function for children's health services was given by the six Nottinghamshire Clinical Commissioning Groups (CCGs) in 2013. The Health and Wellbeing Board, the Children and Young People's Committee and the Public Health Committee have also approved the development of a Children's Integrated Commissioning Hub (ICH). The ICH commissions or supports commissioning of a range of services on behalf of the CCGs and Nottinghamshire County Council (NCC).

5. The ICH is now fully operational with all posts filled and a Memorandum of Understanding (MoU) developed and in the process of being adopted by CCGs, Nottinghamshire County Council (NCC) Children, Families and Cultural Services (CFCS) and Public Health (PH) Departments. Where appropriate, the use of a Section 75 agreement will be developed to pool resources.

6. Robust governance arrangements are in place through the Council and the NHS (Appendix 1). A Commissioners Forum has been established, with representation from NCC, all six CCGs and NHS England Area Teams. Establishing good relationships and networks across the complex systems is progressing well and is essential to the success of the ICH.

7. The scope of the services covered by the Children's ICH is detailed in Table 1. Further areas for consideration include: general paediatrics (planned and unplanned care), continuing care for children and young people and joint commissioning on behalf of

NCC, for example the joint commissioning of disability services across health, education and social care. Commissioning responsibility for the Health Visiting Service and the Family Nurse Partnership Programme transfers to Public Health in NCC from October 2015.

Table 1: Services within the scope of the Integrated Commissioning Hub

1.	Public health services for children aged 0-5 (breast feeding support, Healthy Start Programme)
2.	Public health services for children and young people aged 5-19 (school nursing, Healthy Schools)
3.	Child and Adolescent Mental Health Services (CAMHS) Tiers 1/2/3
4.	Health services for Looked After Children (LAC)
5.	Services for children with disabilities and Special Educational Needs (SEN) (community services)
6.	Elements of community paediatrics (where these relate to wider medical safeguarding, LAC and adoption roles, support to schools, disability and SEN services)
7.	Teenage pregnancy
8.	Substance use services for young people
9.	Health services for young offenders in the community
10.	Elements of Maternity Services commissioning

8. In order to identify the commissioning priorities for the ICH, a range of considerations have been taken into account: services in scope; data from the Nottinghamshire children and young people's Joint Strategic Needs Assessment (JSNA); specific needs assessments and benchmarking data; results of consultations with children, young people and families; the Health and Wellbeing Strategy; the Children, Young People and Families Plan; national policy and the current financial climate. The Children's ICH proposes nine priorities to be delivered between April 2014 and March 2016. These are listed in Table 2 and described in more detail in Appendix 2. These priorities will form part of NCC's, CCGs' and NHS England's planning cycles.

Table 2: ICH Priorities April 2014 to March 2016

1.	**Embed integrated commissioning arrangements** for children's health services and interventions across the local NHS and local authority organisations.
2.	**Actively engage children, young people and families** in service developments and reviews, to inform commissioning and subsequently improve outcomes.
3.	**Review the CAMHS pathway** and develop commissioning plans to be implemented
4.	**Commission integrated pathways and services for children and young people with complex needs or disabilities**.
5.	**Work effectively with NHS England to commission the Healthy Child Programmes 0-5 and 5-19,** ensuring safe transfer of commissioning responsibilities in 2015
6.	**Complete and implement findings of the Maternity Services review**s
7.	**Review unplanned admissions and avoidable emergency department attendances by children and young people.**
8.	**Review elements of Community Paediatric Services provided in Nottinghamshire.**

9.	**Champion children and young people's issues through public health life course areas.**

9. The performance and success of the ICH will be evaluated bi-annually. Specific performance measures and evaluation methods are currently being developed.

Conclusion

10. The development of the Integrated Commissioning Hub (ICH) for children's health services represents an important opportunity to bring together the commissioning of children's services, an approach which is well established in other areas. Progress to date includes establishing the ICH, successfully recruiting to all posts, establishing governance arrangements, building relationships and networks across complex systems and developing priorities for work until March 2016. If approved, the ICH will spend the next two years delivering the priorities, ensuring that the services commissioned are of high quality, evidence based, provide value for money and deliver improved health outcomes for the children and young people of Nottinghamshire.

Statutory and Policy Implications

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

RECOMMENDATIONS

The Health and Wellbeing Board:

12. Notes the content of the report.

13. Acknowledges the progress of the integrated commissioning arrangements for children's health services in Nottinghamshire.

14. Approves the proposed work priorities for the Children's Integrated Commissioning Hub for the two years, April 2014 - March 2016.

Anthony May
Corporate Director for Children, Families and Cultural Services

Chris Kenny
Director of in Public Health

For any enquiries about this report please contact:
Dr Kate Allen, Consultant in Public Health
Kate.allen@nottscc.gov.uk

Constitutional Comments ([initials and date xx/xx/xx])

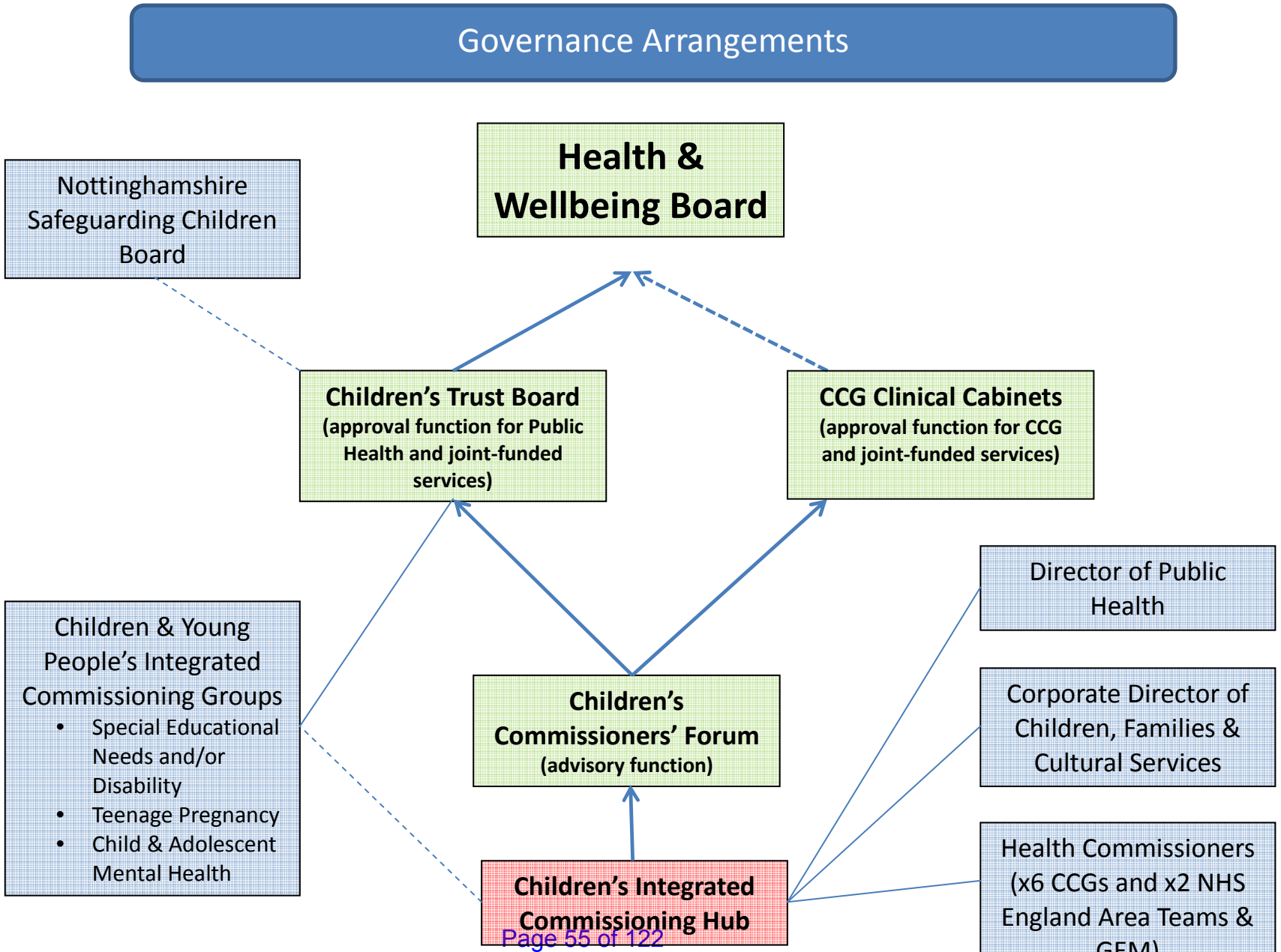
15.

Financial Comments (KAS 14/2/14)

16. There are no financial implications contained within the report

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

Appendix 1


Governance Arrangements
Health & Wellbeing Board
Nottinghamshire Safeguarding Children Board
Children's Trust Board (approval function for Public Health and joint-funded services)
CCG Clinical Cabinets (approval function for CCG and joint-funded services)
Children & Young People's Integrated Commissioning Groups
• Special Educational Needs and/or Disability
• Teenage Pregnancy
• Child & Adolescent Mental Health
Children's Commissioners' Forum (advisory function)
Children's Integrated Commissioning Hub
Director of Public Health
Corporate Director of Children, Families & Cultural Services
Health Commissioners (x6 CCGs and x2 NHS England Area Teams & GEM)

Appendix Two

(DRAFT) Priorities for the Children's Integrated Commissioning Hub: April 2014 - March 2016

1. **Embed integrated commissioning arrangements** for children's health services and interventions across the local NHS and local authority organisations.
   - Develop outcome based service specifications
   - Agree and develop quality and performance schedules and monitoring processes across all children's health services and contracts
   - Establish clear governance arrangements for decision making by April 2014, to be reviewed by December 2014

2. **Actively engage children, young people and families** in service developments and reviews, to inform commissioning and subsequently improve outcomes.
   - Commission, complete and evaluate a Mystery Shopper programme by October 2014
   - Engage with parents/carers and children and young people with disabilities through the Nottinghamshire Participation Hub (NPH)
   - Involve children, young people and families in the review of Child and Adolescent Mental Health Services (CAMHS) and the implementation of changes resulting from the pathway review, by December 2014
   - Involve families in the review of maternity services provided by Nottingham University Hospitals and Sherwood Forest Hospitals, by July 2014
   - Develop and roll out a primary school and secondary school annual online questionnaire with children and young people to assess health and wellbeing needs and inform service developments

3. **Review the CAMHS pathway** by April 2014 and establish if there is a need for a new operating plan and delivery model by June 2014; implementation of the new model from July 2014 onwards as appropriate.

4. **Commission integrated pathways and services for children and young people with complex needs or disabilities**.
   - Implementation of the Education Health and Care (EHC) Plan Pathway by September 2014
   - Implement the recommendations and priorities in the Integrated Community Children and Young People's Healthcare Programme including:
     - Integration and networking of services across health e.g. Children's Community Nursing and Special School Nursing Services through de/re-commissioning by April 2016.
     - Develop a single point of access for information and referral into services; to be delivered through a multi-disciplinary hub with coordinated assessments and plan, including key working by April 2016.
     - Integrate and network provision across health, social care and education by 2016

5. **Work effectively with NHS England to commission the Healthy Child Programmes 0-5 and 5-19.**
   - Complete review of School Health Services (school nursing) and working with providers, use findings of the review to develop and update the service during 2014-2015.

- Complete the Healthy Schools Service review and implement recommendations from July 2014
- Ensure successful transfer of commissioning responsibility for the Health Visiting Service from NHS England to the ICH from October 2015.
- Ensure successful transfer of commissioning responsibility for Family Nurse Partnership Programme from NHS England to the ICH from October 2015.
- Working with stakeholders, develop plans for the future commissioning of the Healthy Child Programme.

6. **Ensure effective implementation of the Maternity Services Review**s, working with key stakeholders.
   - Complete the Nottingham University Hospitals (NUH) Trust Maternity Service review by March 2014 and implement key recommendations from April 2014
   - Complete the Sherwood Forest Hospitals Foundation Trust (SFHFT) Maternity Service review by April 2014 and implement key recommendations from May 2014
   - Support Bassetlaw CCG in relation to Maternity Services as agreed (service review previously completed for Doncaster and Bassetlaw Hospitals Foundation Trust).
   - Develop Maternity Service Specifications for inclusion in contracts during 2014-15.

7. **Review unplanned admissions and avoidable emergency department attendances** by children and young people, completing analysis and a health needs assessment as part of the JSNA, to inform future commissioning intentions.
   - Needs assessment to be completed by December 2014

8. **Review elements of Community Paediatric Services** provided by NUH, SFHFT and DBHFT to determine whether services are fit for purpose and represent value for money. Ensure outcome based service specifications, including robust quality and performance monitoring processes, are in place. A rolling programme of review, identifying recommendations for future commissioning commenced in January 2014 in relation to:
   - Medical Advisors to Adoption Service
   - Medical Services for Looked after Children
   - Child Death Review Process (including rapid response to an unexpected death of a child)
   - Designated Doctor for SEN

9. **Champion children and young people issues through public health life course areas.**
   - Achieve outcomes and targets related to children through delivery of Nottinghamshire's Obesity Strategy, to be measured annually.
   - Achieve the improved sexual health outcomes for children and young people detailed in Nottinghamshire's Sexual Health Strategy, to be measured annually.
   - Ensure priorities relating to children and young people are achieved through Nottinghamshire's strategic tobacco alliance plans, to be measured annually.
   - Ensure priorities relating to children and young people are achieved through Nottinghamshire's substance misuse strategy, to be measured annually.

Nottinghamshire County Council

Report to Health & Wellbeing Board

5 March 2014

Agenda Item: 7

REPORT OF THE CORPORATE DIRECTOR, CHILDREN, FAMILIES & CULTURAL SERVICES AND THE DIRECTOR OF PUBLIC HEALTH

CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING: LOCAL IMPLICATIONS OF THE CHIEF MEDICAL OFFICER'S ANNUAL REPORT

Purpose of the Report

1. To consider the Chief Medical Officer's (CMO) annual report alongside a selection of current health performance indicators for children and young people and explore the implications for children's services locally.

Information and Advice

Chief Medical Officer's Annual Report

2. The focus of the CMO annual report for 2012 (published in October 2013) was children and young people, in particular whether we are giving them a good start and building their resilience. The report analyses the challenges to children's health and wellbeing and looks especially at those with neurodevelopmental disabilities, mental health problems, looked after children and young people in the youth justice system.

3. In essence the report concludes that: early interventions and preventative measures do make a difference to outcomes and also make sound economic sense; 'proportionate universalism' is the correct approach - improving the lives of all, with proportionately greater resources targeted at the more disadvantaged groups; and the importance of listening to children and young people in order to develop effective strategies and reduce their future burden of disease.

4. The CMO's key findings are as follows:

   a. England has poor outcomes for children and young people with respect to mortality, morbidity and inequality compared to other similar countries.
   b. 'Early action' is crucial and there is a need to move from reactive to proactive care.
   c. There is a need to raise the profile of children and young people's health and wellbeing with private, public and voluntary institutions and with the public itself (an annual children's week is proposed), as well as encouraging all sectors to work more closely together.
   d. Efforts to improve outcomes should be underpinned by improving the lives of all, with more resources targeted at the most disadvantaged.

e. The evidence base should be developed further around both how to nurture resilience in young people and the link between health and wellbeing and educational attainment.
f. There is a strong association between a sense of belonging in school ('connectedness') and well-being.
g. Evidence suggests that resilience and feeling connected have a positive effect in reducing risky behaviours, as too does strong communication between parents and young people.
h. A new 'health deal' to outline the compact between children and health providers will give an opportunity for organisations to show how children-focused they are.
i. The workforce must receive training on age appropriate care and develop skills to guide young people around the healthcare system, including understanding the role of school nurses.
j. Young people with a long term condition should have a named GP to coordinate their care.
k. Better data is needed around the health and wellbeing of children and young people, in particular mental health problem prevalence and neurodevelopmental disability.
l. Addressing socio-economic determinants is a primary prevention strategy that may reduce the number of children entering public care.
m. Young people in contact with the youth justice system are more likely to have multiple health problems, yet many of their needs go unrecognised and unmet.
n. Public health intervention strategies must have twin foci on early childhood and on adolescence, as both are critical periods of rapid development.

5. In addition, the CMO identifies the following challenges for the future, which will have significant implications both socially and economically over the coming decades:

a. **Child obesity** – this continues to rise steadily and is persisting most strongly among those of low socio-economic status. The CMO argues that the primary prevention of obesity should begin in infancy, with the delivery of interventions aimed at improving the eating and activity patterns of young children.
b. **Mental health** – it is increasingly clear that the foundations of good mental health are formed in childhood and adolescence, but the challenge is providing interventions in an economical manner. In addition, optimising maternal mental health during pregnancy needs to be given equal prominence to optimising maternal physical health, as it is a major influence on future child development and outcomes.
c. **Infection/immunisation** – how to ensure that messages about the advantages of vaccination reach those who need to hear them and that the health and care system responds to altered delivery needs, such as the expansion of vaccination programmes.
d. **Rare diseases** – ensuring speedier diagnosis by providing sufficient training for those working in healthcare and support with technology, both to identify disease and to assist families in navigating the system.
e. **Transition** – a core challenge in adolescence is the transition from child to adult services and, for many, moving away from home.
f. **Technology** – both harnessing the increased potential of new technologies and protecting against threats, such as data security and extra burdens on healthcare professionals.

g. **Cyber-bullying/pornography** - how to balance the potential of social media to enhance connectedness and wellbeing with the risk of exploitation of vulnerable young people.
h. **Workforce** – ensuring the workforce meets core standards and is adequately trained.
i. **Determinants of disease** – not losing sight of what is happening to inequalities, child poverty and the most vulnerable is vital in promoting health for all children.

Local Needs and Outcomes

6. Evidence from Public Health England[1] (PHE) confirms that health outcomes for children and young people vary considerably across Nottinghamshire, mostly in line with deprivation. Although deprivation locally is lower than the national average, around 24,500 children (aged 0-16 years) still live in poverty. Child poverty is concentrated in the north and west of the County, with Ashfield and Mansfield suffering higher levels than those nationally.

7. The links between deprivation and poor health outcomes are well-documented and evidenced in Nottinghamshire by a difference in life expectancy (9.0 years lower for men and 7.6 years lower for women in the most deprived areas than in the least deprived). Educational attainment, also influenced at least in part by deprivation, is connected to this since health obviously plays a major role in allowing children and young people to meet their academic potential.

8. Most recent data suggests that obesity in primary school age children across the County is generally in line with, or lower than, national levels, with Gedling and Rushcliffe displaying the lowest levels. In Year 6, 17.5% of children are classified as obese, compared to the national figure of 18.9%. The proposed new system model for obesity prevention and weight management services to be commissioned in Nottinghamshire[2] should support sustained behaviour change and improved outcomes in the coming years. In terms of tooth decay in children aged five years, Nottinghamshire has the lowest levels in the East Midlands and all districts are in line with or lower than the national average.

9. The number of women smoking in pregnancy is significantly higher than the national average across both the former Nottinghamshire Primary Care Trust (PCT) and Bassetlaw PCT areas, while numbers starting breastfeeding are significantly lower[3]. In comparison with local authority statistical neighbours, Nottinghamshire comes ninth out of eleven in terms of smoking in pregnancy and sixth out of eleven for breastfeeding (where first is best). However, virtually all statistical neighbours also under-perform compared to the national average for these two indicators. The County's percentage of term babies with a low birth weight is in line with the percentage nationally, but levels are much higher in the more deprived areas of the County, and there is a clear correlation between smoking at time of delivery and low birth weight.

[1] Evidence in this section is taken from the PHE Health Profiles 2013 (www.healthprofiles.info) and the PHE Health Outcomes Framework data tool (http://www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/pat/6/ati/102/page/0/par/E12000004/are/E10000024).
[2] Report to Children's Trust Board on 5 December 2013 (http://www.nottinghamshire.gov.uk/caring/childrenstrust/about-the-childrens-trust/childrenstrustboard/?entryid217=363549&p=1)
[3] PHE data for breastfeeding and smoking in pregnancy is only available by former PCT areas, not by local authority district. Other evidence, such as data from clinical commissioning groups, suggests that breastfeeding and smoking in pregnancy performance varies considerably across the County, generally relating to deprivation.

10. While teenage pregnancy has declined in recent years locally, rates in Ashfield and Mansfield are significantly higher than the national average, whereas rates in Broxtowe and Rushcliffe are significantly lower. Overall, Nottinghamshire levels of chlamydia diagnosis in the 15-24 years age range are also significantly lower than the national average, but rates in Ashfield, Bassetlaw, Gedling and Mansfield are significantly higher.

11. The rate of under-18s admitted to hospital due to alcohol-specific conditions is lower than the regional and national average. The conurbation areas of Broxtowe, Gedling and Rushcliffe have the lowest levels and, in comparison with statistical neighbours, the County's admission rate is also low. In addition, admissions caused by unintentional and deliberate injuries (aged 0-14 years) are lower than England and much of the region, with levels significantly lower than those nationally in all districts except Bassetlaw, which is similar to the England average.

12. Infant deaths under one year of age are generally in line with national and regional levels and Nottinghamshire is average among its statistical neighbours. However, the number of (all-age) road injuries and deaths is significantly higher than that nationally and above all but two statistical neighbours. Bassetlaw, Newark & Sherwood and Rushcliffe exhibit the highest rates. As children and young people are passengers, pedestrians and cyclists, this is a safeguarding issue which requires careful monitoring.

Local Delivery

13. The CMO's annual report is an endorsement of the direction of travel of the Children's Trust and the County Council's Children, Families and Cultural Services (CFCS) Department. The key themes of early intervention, proportionate universalism and participation of children and young people are reflected in the overall approach of the partnership locally and the purpose, principles and outcomes of the CFCS Department.

14. The re-modelling of Children's Social Care and the Early Help offer, including the establishment of the Multi-Agency Safeguarding Hub (MASH) and the Early Help Unit, have laid foundations for further improving the outcomes of vulnerable children and young people. This has been augmented by an enhanced children's centre core offer and new arrangements for a single Education, Health and Social Care Plan for children with special educational needs. The new local operating model in children's services will aid integration to improve a range of outcomes.

15. A number of key components describe the direction of travel for children's services and align with the some of the key CMO findings:

    a. Easier access to services by streamlining the "front door" for children's services, building on work to align the MASH and the Early Help Unit.
    b. Better triage and assessment of need through developments such as the MASH, Early Help Unit and the arrangements for Education, Health and Care Plans.
    c. Joining up services locally through integrated, multi-disciplinary, co-located teams based in the three geographical localities (Mansfield and Ashfield; Newark & Sherwood and Bassetlaw; Rushcliffe, Gedling and Broxtowe).
    d. Focused support on children and families with the greatest need and those geographical areas where services are needed most.

e. Helping children and families as early as possible, to deliver better outcomes for them.
f. Delivering a refreshed children's workforce development strategy to ensure staff keep pace with changes to services.

16. The CMO's challenges for the future broadly encompass much of the Children's Trust's work. Priorities for action in the previous Children, Young People and Families (CYPF) Plan (2011-14) that directly related to these challenges included emotional wellbeing, safeguarding, disability and child poverty. Obesity levels were also monitored under the Plan's performance framework, alongside a suite of other relevant indicators. The new CYPF Plan (2014-16) goes 'live' shortly, subject to approval by Policy Committee on 5 March 2014, and the Children's Trust Board has also considered how best to ensure the CMO's challenges remain effectively addressed over the coming years. There are a number of areas in the Health and Wellbeing Strategy that take a life course approach (for example tobacco, obesity, sexual health and substance use) which include a children's element. These are tackled across the whole age spectrum and therefore are not specifically detailed in the CYPF Plan.

17. Positive trends in educational results over the last few years, based on successful partnerships with schools, and work to narrow the gaps in attainment should gradually increase 'school connectedness' and boost resilience among children and young people. However, there is still much to be done to obtain better data for disability and mental health locally, and workforce development around the provision of age-appropriate care is an issue which needs careful monitoring in commissioned services. Influencing wider socio-economic determinants of health is also becoming increasingly difficult at a time of rising demand for services and reductions in budgets. The recent establishment of the dedicated Integrated Commissioning Hub (ICH) for children's health services will enable public agencies to work more closely together to streamline complex health-related commissioning activities and effectively evaluate the impact on outcomes.

Local Implications

18. The findings of the CMO's report present a backdrop against which the Health and Wellbeing Board can examine its effectiveness in improving outcomes for children and young people's health and wellbeing and test its preparedness for future risks. They provide a benchmark for the Board to measure itself against and assess whether it is 'on the right track' as it finalises its new Strategy for 2014-17. Eight implications are outlined in the table below, alongside what has been done locally and what still needs to be done.

Implication of CMO Report	Local Response	Next Steps
1. Regulators to review annually the extent to which they evaluate the contribution of statutory partners, local safeguarding boards and health and wellbeing boards to the health and protection needs of children and young people.	• The Health & Wellbeing Board holds all partners to account for their contributions to the Health and Wellbeing Strategy.	• Await national guidance from regulators such as the Care Quality Commission (CQC) and Ofsted.

Implication of CMO Report	Local Response	Next Steps
2. PHE should work with local authorities and schools to build on current efforts to increase participation in physical activity and promote innovative solutions that lead to improved access to existing sports facilities.	• The commissioning of weight management services will include an element for children and young people. • Ideas are currently being consulted upon with stakeholders, including young people. Consultation includes questions regarding physical activity. • A new service will be in place from April 2015.	• Ensure ICH representatives are active members of local obesity commissioning panels to champion the needs and views of children, young people and families. • Await national PHE guidance for local authorities and schools.
3. PHE should work with local government to identify how the health needs of families are met through Troubled Families Programme.	• The Nottinghamshire Supporting Families Programme offers a holistic support package. • Further work may be required to specifically identify and respond to health needs.	• Await national guidance.
4. Local authorities to examine if they are enacting the Healthy Child Programme in full and are prepared for the change in commissioning that is due shortly.	• A paper focusing on the Healthy Child Programme was presented at the January 2014 Health and Wellbeing Board. • The ICH is working with both NHS England area teams to aid the transition of health visiting and Family Nurse Partnership (FNP) to the Local Authority in October 2015.	• Determine the commissioning plan for school nursing. • ICH to continue to work with both NHS England area teams.
5. An annual National Children's Week should be held to provide a focal point for highlighting to stakeholders and the public current work to improve health and wellbeing.	• The ICH and Public Health disseminate all key national health and wellbeing campaigns e.g. Change4Life. • The ICH has a communications plan which includes support for national campaigns such as Sexual Health Awareness Week.	• Await information about a National Children's Week. • The ICH and Public Health will continue to work with communications teams to support national campaigns and communication regarding local activity.

Implication of CMO Report	Local Response	Next Steps
6. There is a renewed call for professionals to think about the whole family, not just the child, and the CMO has asked professional bodies to develop tools to support this.	• The County Council's Corporate Leadership Team approved a Think Family position statement in October 2013. • An Ofsted thematic inspection in May 2013 identified a number of recommendations and a Think Family Group was established to implement these.	• Ensure that the Health and Wellbeing Board can demonstrate an effective Think Family approach. • Await national tools for local use.
7. There is a need to prioritise pre- and post-natal interventions that reduce adverse outcomes in pregnancy and infancy (e.g. relating to smoking, breastfeeding and mental health). The CMO notes that this would require investment in research and expansion of services for pregnancy and the early years.	• Completion and implementation of the maternity services reviews at Nottingham University Hospital Trust, Sherwood Forest Hospitals Foundation Trust and Doncaster & Bassetlaw Hospitals Foundation Trust.	• Nottinghamshire County Council commissions children centres, so performance management information that is gathered could be used in the Joint Strategic Needs Assessment (JSNA) to inform priorities and commissioning plans. • Continue to work closely with NHS England to embed the FNP and support the transition of FNP and health visiting commissioning to the Local Authority from October 2015.
8. A discrete adolescent public health strategy is proposed, which would be horizontal across substance use, sexual health, mental health and long-term conditions.	• Nottinghamshire currently has separate strategies and plans for young people's substance use, teenage pregnancy, child/adolescent mental health and disability. • In addition there are life course strategies for obesity, smoking and sexual health.	• The Health and Wellbeing Board may wish to consider the development of a local adolescent public health strategy to pull together all key areas of work for this age group.

19. It seems likely that Ofsted, CQC and other inspectorates will seek to strengthen their evaluation processes relating to the health and protection needs of children and young people in due course. The renewed call for a 'Think Family' approach will no doubt be developed further as professional bodies are encouraged to promote and practise it, and more joined-up working between PHE and local authorities across a range of

programmes will present an opportunity to create more innovative ways to improve health and wellbeing outcomes further.

Other Options Considered

20. The report is presented for consideration and discussion by the Board. No other options have been considered.

Reason for Recommendations

21. To ensure that this major national policy document is taken into account in the Health and Wellbeing Board's strategic planning.

Statutory and Policy Implications

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

RECOMMENDATIONS

That the Board:

1) considers the findings and implications of the CMO's annual report (paragraphs 4 & 18) in relation to local efforts to improve health and wellbeing outcomes for children, young people and families.

2) discusses the challenges for the future that the CMO highlights (paragraph 5) and how these will be addressed through the new Health and Wellbeing Strategy and the wider work of the Health and Wellbeing Board.

Anthony May
Corporate Director, Children, Families and Cultural Services

Chris Kenny
Director of Public Health

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Constitutional Comments (LM 13/02/14)

23. The contents of the report fall within the remit of the Health and Wellbeing Board.

Financial Comments (KLA 11/02/14)

24. It is assumed that the actions proposed can be resourced from within existing budgets, therefore there are no financial implications arising directly from the report.

Background Papers and Published Documents

Annual Report of the Chief Medical Officer 2012, Department of Health
https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

Public Health England Health Profile 2013 (Extract) – by district and by statistical neighbour

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

Electoral Divisions and Members Affected

All.

C0367

Nottinghamshire County Council

Report to Health and Wellbeing Board

5 March 2014

Agenda Item: 8

REPORT OF NHS ENGLAND SCREENING & IMMUNISATION TEAM WITH DIRECTOR OF PUBLIC HEALTH

ARRANGEMENTS FOR NATIONAL IMMUNISATION PROGRAMMES IN NOTTINGHAMSHIRE COUNTY & UPDATE ON THE MEASLES, MUMPS AND RUBELLA CATCHUP PROGRAMME

Purpose of the Report

1. To notify the Health & Wellbeing Board of arrangements for protecting the population from the impact of vaccine preventable disease and recent progress on Measles, Mumps and Rubella (MMR).

Information and Advice

Background

2. After the provision of clean drinking water, immunisation programmes are one of the most cost effective health protection interventions and a cornerstone of public health (PH) practice. High immunisation rates are key to preventing the spread of infectious disease, complications and possible early death among individuals.

3. Immunisation programmes aim to protect population health through both individual and herd immunity (also known as community immunity). Herd immunity is achieved when a sufficient proportion of the target population is immunised to suppress the spread of disease to non-immune or unimmunised individuals. For most infectious diseases in the national programmes, official estimates are that an uptake of 95% of the population is required to ensure herd immunity. This constitutes a target level for the population[1].

4. High immunisation uptake rates support good school attendance and educational attainment, reduced inequalities, and healthy independent living in later years.

[1] When there is sufficient immunity to slow down the spread of a disease in a population, this is referred to as community immunity (sometimes called 'herd immunity'). It is critical to note that although this results in slowing down the spread of the disease within the overall group, it does not provide protection to the small number of unimmunised individuals who may still come into contact with someone who is infected. These individuals still need to be immunised to be protected; without this, they remain at risk.

Commissioning arrangements and responsibilities

5. Under Section 7a of the National Health Service Act 2006 and the Health and Social Care Act 2012, NHS England are responsible for the commissioning of national immunisation programmes. This responsibility is transacted locally though NHS England Area Teams. Each Area Team has an 'embedded' Public Health England (PHE) Screening and Immunisation Team to provide PH expertise and support to the commissioning process. Programmes for people in Bassetlaw are commissioned by NHS England's South Yorkshire and Bassetlaw Area Team. For the remainder of Nottinghamshire County they are commissioned by the Derbyshire and Nottinghamshire Area Team.

6. Immunisation programmes in all areas are commissioned against sixteen nationally determined service specifications https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2014-to-2015 to ensure consistency of service provision across England.

7. The Area Team commission immunisation services from a range of providers including primary care, school nursing and health visiting services as well as acute hospital providers.

8. The quality and performance of these programmes are monitored through the Nottinghamshire County and Nottingham City Immunisation Programme Board. Similar arrangements exist for Bassetlaw. Assurance is provided to the Director of Public Health (DPH) through the Nottinghamshire County & Nottingham City Health Protection Strategy Group.

9. Appendix A is a detailed report of the commissioned immunisation programmes and associated uptake in Nottingham City and Nottinghamshire County for key immunisation programmes.

10. On an annual basis, local rates of uptake for many of these programmes are included in the health protection section of the Public Health Outcomes Framework.

MMR catch-up programme: uptake in Nottinghamshire County

11. In April 2013, PHE, NHS England and the Department of Health announced a national catch-up programme to increase MMR vaccination uptake in children and teenagers. The aim of the programme was to prevent measles outbreaks by vaccinating as many unvaccinated and partially vaccinated 10 - 16 year-olds as possible. The target associated with this was that 95% of 10 – 16 year olds should have received at least one dose of MMR vaccination.

12. The best available data at that time shows that in Nottinghamshire County (excluding Bassetlaw) 96.7% of 10-16 year olds had received at least one MMR dose. The equivalent data for Bassetlaw shows that 94.7% of 5-18 year olds had received at least one dose. Notwithstanding these relatively high levels of uptake compared to other areas, letters were sent with the assistance of Head Teachers to parents, encouraging them to ensure that their children take up the offer of vaccination.

Ongoing national MMR programme

13. The catch-up programme is now finished, but work continues to maintain and improve uptake rates of the ongoing national MMR programme. At the end of quarter 2 in 2013-14, 94.7% of 2 year olds in Nottinghamshire County (excluding Bassetlaw) had received a first dose of MMR. Uptake of the second dose of MMR vaccine among children aged 5 years was 91.8%. These represent record levels for Nottinghamshire County and are the result of sustained effort by general practice supported by an extensive visiting programme undertaken by the former Nottinghamshire County Primary Care Trust. This support is now led by the Area Team with the active collaboration of Clinical Commissioning Groups (CCGs). For example, Mansfield & Ashfield CCG has received particular support on data cleansing. The CCG has identified a Locality Development Manager to champion and support practices.

14. The Area Team is also working to ensure that future service specifications clarify the critical role of health visitors in promoting immunisation and, in particular, of follow up of unimmunised vulnerable children.

15. In Bassetlaw, by the end of quarter 2 in 2013-14, 93.7% of 2 year olds had received a first dose of MMR. Uptake of the second dose amongst 5 year old children was 84.6%. The South Yorkshire & Bassetlaw Area Team is commissioning a one-off exercise with general practices in Bassetlaw to identify and follow up parents of children who miss appointments for their pre-school MMR booster.

Further developments and challenges

16. Communities and populations are ever changing and the challenge to commissioners and service providers is to adapt and improve the way we deliver services to maintain and improve immunisation uptake rates. The Nottinghamshire Immunisation Programme Board has an annual work plan to deliver planned developments for 2014/15 which includes:

- Audit of vaccine preventable hospital admissions
- Review of commissioning models for teenage vaccination programmes
- Expansion of the seasonal flu programme to all children aged four years and, dependent on national guidance, up to age 17 years

  Regarding the children's seasonal flu expansion, at the time of writing, the details of how this programme extension will be rolled out are yet to be determined nationally. However, there is an expectation that immunisation should be offered through school-based programmes.

17. The Nottinghamshire Screening and Immunisation Team have started initial discussions regarding this with Local Authority PH School Nursing commissioners and primary care (including the Local Medical Committee and School Nursing providers) to discuss potential future delivery models. The views of Local Authority education leads and Head Teachers including Academy Head Teachers will be an essential part of this, as will be their support in implementing any new arrangements.

Other Options Considered

18. N/A

Reason/s for Recommendation/s

19. N/A

Statutory and Policy Implications

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

RECOMMENDATION/S

The Health & Wellbeing Board is requested to:-

1. Note the arrangements for commissioning national immunisation programmes for Nottinghamshire County
2. Note for assurance the uptake of MMR vaccination in Nottinghamshire County.

Linda Syson-Nibbs	**Screening & Immunisation Lead**
Caroline Jordan	**Screening & Immunisation Manager**
	NHS England Area Team Derbyshire & Nottinghamshire
Jonathan Gribbin	**Consultant in PH Nottinghamshire County & Nottingham City**

For any enquiries about this report please contact:
Jonathan Gribbin
Consultant in Public Health

Constitutional Comments (SG 24/2/14)

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

Financial Comments ([initials and date xx/xx/xx])

22. To follow

Background Papers and Published Documents

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

- 'None'

Electoral Division(s) and Member(s) Affected

- 'All'

APPENDIX A

NHS ENGLAND AREA TEAM DERBYSHIRE AND NOTTINGHAMSHIRE

IMMUNISATIONS PROGRAMMES UPDATE TO NOTTINGHAM CITY AND NOTTINGHAMSHIRE HEALTH PROTECTION STRATEGY GROUP AND HEALTH AND WELLBEING BOARDS

JANUARY 2014

Introduction

This paper updates the Nottingham City and Nottinghamshire County Health Protection Strategy Group and Health and Wellbeing Boards on immunisation uptake in Nottingham City and Nottinghamshire County including progress on the introduction of new national immunisation programmes during 2013 and a progress report on the measles, mumps and rubella (MMR) catch up programme for 10-16 year olds.

New national immunisation programmes

A number of new immunisation programmes were introduced during 2013. These include:-

- Change in the Meningitis C programme
- Introduction of rotavirus vaccine
- Introduction of shingles vaccine
- Introduction of seasonal flu vaccination to all two and three year olds

In response to these new programmes, the Screening and Immunisation Team planned and delivered a number of new immunisation workshops for primary care and other clinicians during June 2013. Eight were held across Nottingham City and Nottinghamshire.

Change in the Meningitis C programme

Summary

- The removal of the second dose of MenC at age 16 weeks from the routine schedule for infants from 1 June 2013
- Introduction of an adolescent MenC booster dose at around age 14 years (school year 10) for the academic year 2013-14
- The adolescent MenC booster dose, together with the adolescent tetanus, diphtheria and polio (Td/IPV) vaccine, should be given routinely at age 13-14 years; it is intended that, over time, there will be a planned, coordinated, country-wide approach to enable areas to move towards giving these vaccines between the ages of 13-14 years (School Year 9); the national letter suggests that this should be delivered through a schools immunisation programme;

NB. Td/IPV vaccine is administered solely by primary care in Derbyshire County. This vaccine is funded in primary care through the General Medical Services (GMS) Global Sum or Personal Medical Services (PMS).

Primary care ceased administering the second dose of MenC at age 16 weeks from 1 June 2013. With regard to the requirement to administer both the MenC and Td/IPV vaccines at the same time, discussions are continuing with both Nottingham City

Council and Nottinghamshire County Council public health school nursing commissioners, Nottinghamshire Healthcare Trust Health Partnership and Nottingham CityCare School Nursing Services and primary care, including Nottinghamshire Local Medical Committee (LMC), to clarify the current status of the models and contracts for the delivering the current Td/IPV vaccine programme and how this might be considered for not only MenC vaccine, but consideration of other and future teenage vaccines – see later.

For Td/IPV vaccine in Nottingham City, there has been a mixed delivery model i.e. by primary care and school nursing services. In Nottinghamshire County, Nottinghamshire Healthcare Trust Health Partnership Health Partnership School Nursing deliver this. In addition to the county based school nursing service, primary care can also administer this vaccine in response to individual patient requests or children that are not in school.

Rotavirus vaccine
This oral live vaccine was introduced from July 2013 to the childhood immunisation schedule to protect babies against rotavirus gastroenteritis. It comprises two doses given at ages two and three months administered four weeks apart along with other primary vaccines. It is delivered by primary care. The first complete measurement of the uptake on this new vaccine for children aged one year will be available in the 2014-15 Cover of Vaccination Evaluated Rapidly (COVER) Quarter 1 data at the end of August 2014.

Shingles vaccine
This vaccine is being introduced from September 2013 for people aged 70 years (routine cohort) and 79 years (catch-up cohort) to protect against herpes zoster. It is being delivered by primary care. The first complete measurement of the uptake of this new vaccine for the routine and catch up cohorts will be through an Annual Shingles Survey in August 2014. This will entail a manual and automated collection from all GP practices. The first eleven months of the uptake from September 2013 for uptake in 2013/14 will be through a sentinel collection so only GP practices who are with a GP IT Supplier that have the capability to extract data automatically will participate in this survey.

Many GP practices were hoping to give this vaccine at the same time as the seasonal flu vaccination. However, most practices have been unable to do this due to national vaccine supply shortages. The current position is that capped numbers of vaccine are available to order per week by each practice.

The uptake on IMMFORM of the vaccine up to 30.11.13 in each Clinical Commissioning Group area (CCG) and for the whole Area Team for GP Sentinel practices is shown below in Table 1

Table 1

Clinical Commissioning Group (CCG)	Uptake age 70 years 30.11.13	Uptake age 79 years 30.11.13
Nottingham City	42.0%	36.4%
Newark and Sherwood	43.7%	47.9%
Nottingham North & East	43.7%	48.2%
Nottingham West	53.8%	49.7%
Mansfield and Ashfield	44.5%	45.1%
Rushcliffe	38.8%	37.2%
Derbyshire & Nottinghamshire	44.8%	44.5%

Seasonal flu vaccination to all two and three year olds
This is an extension of the existing seasonal flu immunisation programme. It is a phased introduction over the next three years of Fluenz which is a live nasal vaccine to include all children aged two to 17 years inclusive. During the 2013-14 season, as part of the national plan, the Area Team has commissioned the vaccination of all two and three year olds through primary care.

In addition to the programme for two and three year olds, there are six pilots for children aged four to ten years are being carried out across England. Most of these pilots are testing school based models but one is also piloting a community pharmacy based approach to inform the future roll out of the programme. The nearest pilot area is in the Leicestershire and Lincolnshire Area Team with whom the Screening and Immunisation Team have close links.

NHS England and Public Health England now wish to implement an accelerated rollout of this immunisation programme to all children up to age 17 years (Year 12) during the 2014-15 season to maximise the protection to the wider population from the spread of any flu virus. It is expected that this programme will be commissioned from primary care for children aged 4 years (in addition to the two and three year olds).

A national workshop in December 2013 was attended by the two of the Screening and Immunisation Team members to explore the different options for this accelerated roll out to school age children. The challenges around this are managing the scale of this to approximately 188,229 - 55,031 children in Nottingham City and 133,198 children in Nottinghamshire County within a short time i.e. before implementation from September 2014. The Screening and Immunisation Team are aware of the reviews of the school nursing service by public health departments in both local authorities in their role as leading the commissioning of school nursing. NB. In Derbyshire, no immunisations are given by school nurses – all are given by primary care e.g. HPV vaccination and school leaving booster vaccinations.

As part of the on-going planning for this the Screening and Immunisation Lead and Manager have already had initial discussions in November about this programme with both Local Authority Public Health School Nursing commissioners. The team are also starting to scope and explore through completion of a national template in January what might be reasonably and practically considered. The opportunity to discuss this further at both the Nottingham City and Nottinghamshire Health Protection Strategy Group and Health and Wellbeing Boards is welcomed.

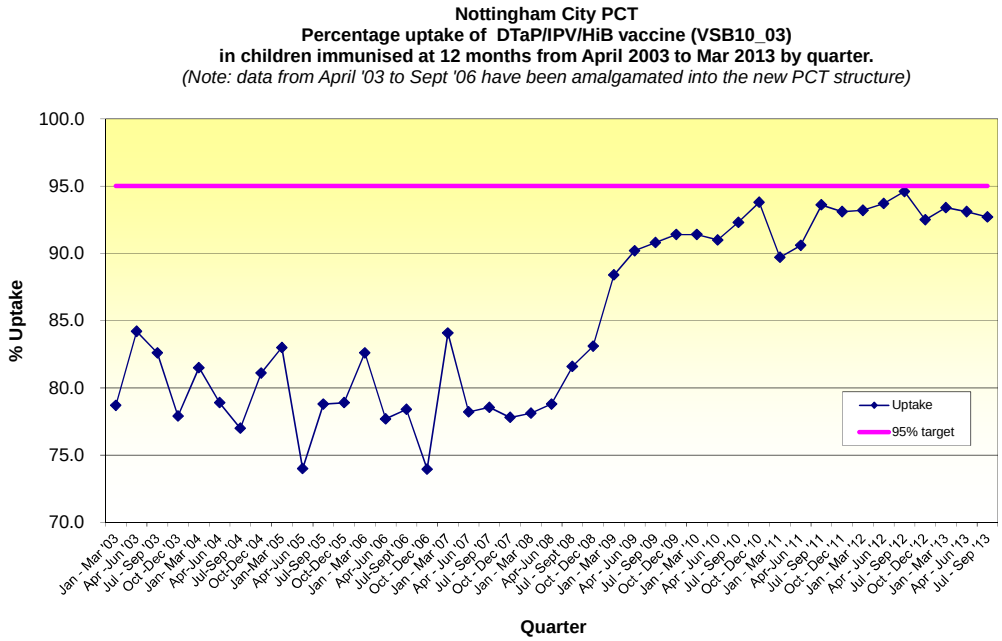
Implications for the future of adolescent immunisation programmes

The introduction the teenage MenC vaccine aligned to the teenage Td/IPV vaccine programme, along with the future introduction of seasonal flu vaccine to all children aged up to 17 years in addition to the existing Human Papilloma Virus (HPV) vaccine to girls aged 12-13 years (Year 8) raises a number of questions about the future delivery models for all these vaccines to adolescents. It is therefore timely that there is a strategic review of this. The Screening and Immunisation Team have started initial discussions regarding this with Local Authority Public Health School Nursing commissioners, primary care including and Local Medical Committees and School Nursing providers to discuss potential future delivery models. The views of Local authority education leads and Academy Head Teachers will be an essential part of this too.

Childhood Immunisation uptake in Nottingham City

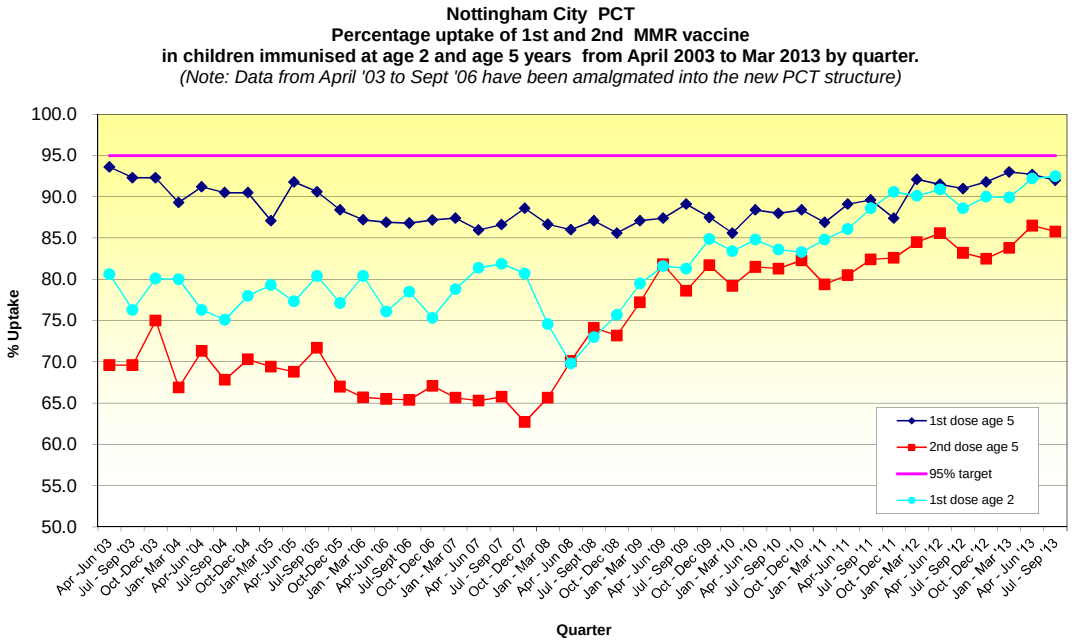
The uptake of the childhood immunisation programme in Nottingham City continues to improve year on year towards the 95% herd immunity target. The uptake for the key tracer immunisations measured at ages one, two and five
Years up to 2013-14 Quarter 2 are shown below.

Graph 1
Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine



- 2013-14 Quarter 2 – 92.7% - down slightly by 0.4%

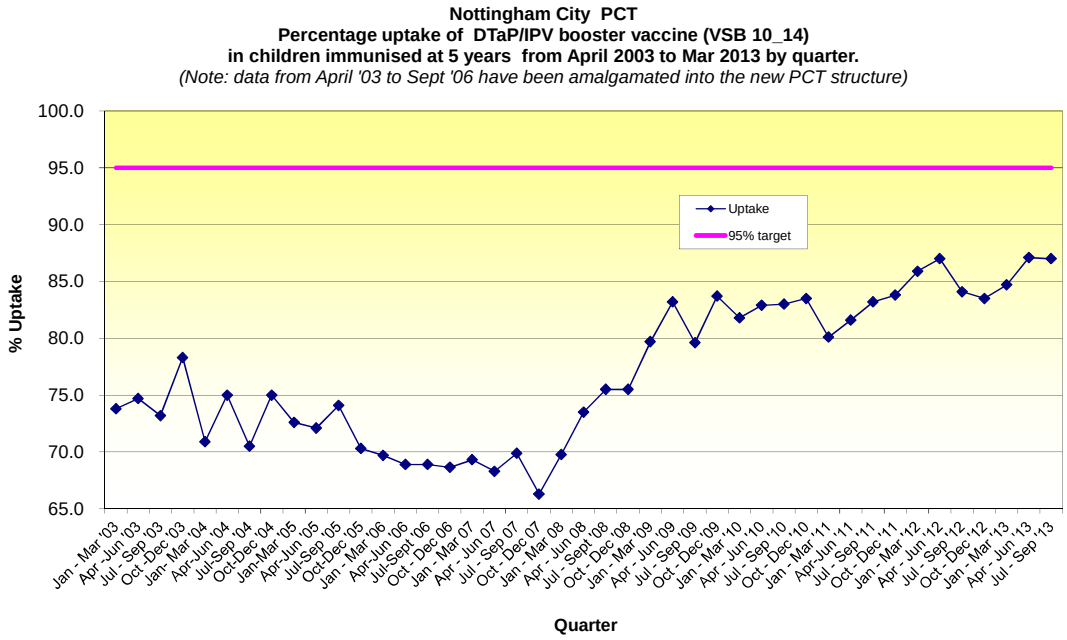
Graph 2
Age 2 and 5 years Measles, mumps and rubella (MMR) primary and secondary



2013-14 Quarter 2

- Primary MMR age 2 years – 93.0% - highest ever level – up 0.8% from Quarter 1
- Second MMR age 5 years – 85.8% - down slightly by 0.7%

Graph 3
Age 5 Diptheria, tetanus pertussis and polio (pre school booster)



- 2013-14 Quarter 2 – 87.0% - maintaining performance from Quarter 1

This improvement in performance is following targeted actions over the last four years to support practices through a number of actions. These include:-

- Practice leadership, data cleansing, improved recording and reporting and call and recall processes
- Practice and Nottingham CityCare Child Records Department support to cleanse data
- Promotion of good practice in immunisation programmes also championed by Nottingham City Clinical Commissioning Group (CCG)
- Increase in supportive work from Nottingham CityCare health visiting service
- Supportive information, advice and visits to underperforming practices by the Area Team
- Circulation of self-audit tool to practices

There has been close cooperative work with Nottingham City Clinical Commissioning Group (CCG) through their lead GP for children and families, CCG visits to practices including immunisations and frequent communication in the CCG newsletter 'Connect'. More recently, following the Quarter 1 performance, the positive improvement across the CCG was highlighted in the newsletter including in at least one practice whose patients comprise a highly mobile population.

NHS Nottingham City Public Heath (previously) and now the Area Team, Nottingham City CCG and Nottingham CityCare have also worked together in the development of

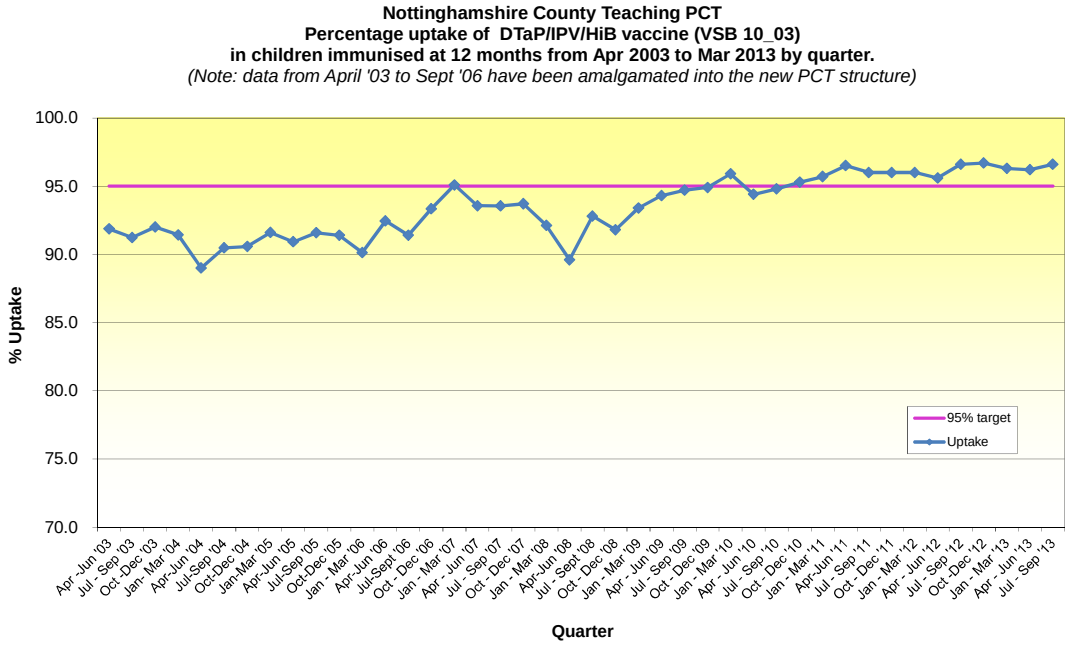
a protocol between primary care and the health visiting teams to support the referral of un/under immunised vulnerable hard to reach children to the health visiting team for home immunisation and to encourage attendance at primary care for future immunisations. The impact of this is currently being evaluated.

Immunisation uptake in Nottinghamshire County 2013-14 Quarter 2

Clinical Commissioning Group (CCG)	Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine	Age 2 Measles, mumps and rubella (MMR) primary and secondary	Age 5 years Measles, mumps and rubella (MMR) second	Age 5 Diptheria, tetanus pertussis and polio (pre-school booster)
Newark and Sherwood	96.6%	92.5%	92.1%	92.7%
Nottingham North & East	95.7%	94.4%	88.7%	89.7%
Nottingham West	96.6%	94.9%	93.0%	92.1%
Mansfield and Ashfield	96.5%	95.4%	91.9%	90.4%
Rushcliffe	97.7%	96.9%	96.5%	96.3%
All Nottinghamshire	96.5%	94.7%	91.8%	91.4%
Nottingham City	92.7%	93.0%	85.8%	87.0%

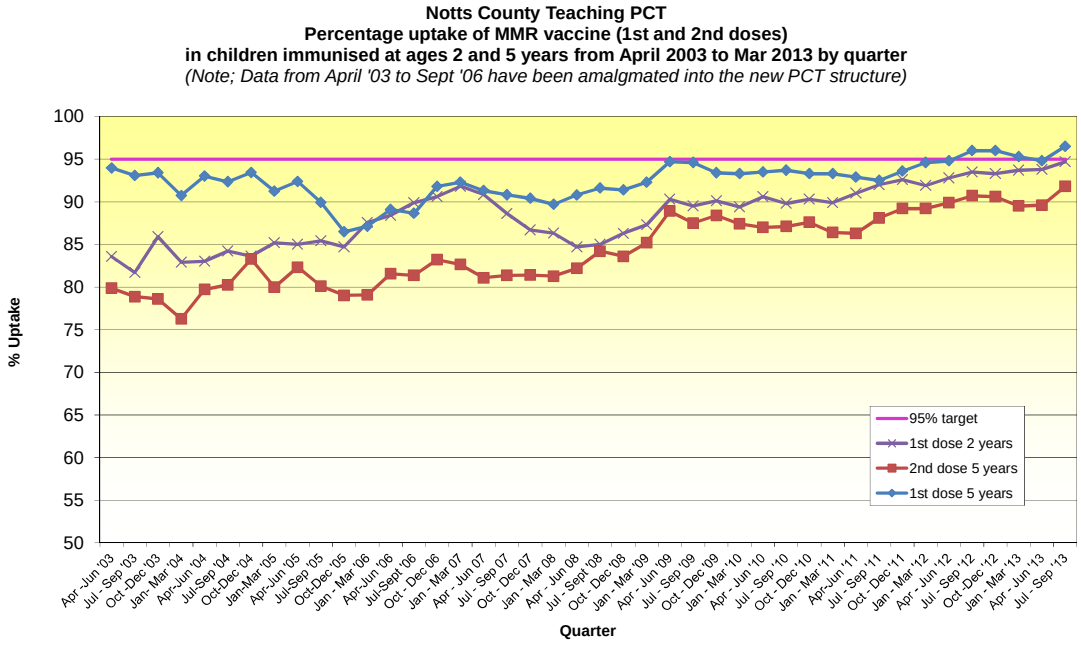
The uptake of the childhood immunisation programme in Nottinghamshire County remains high and above the 95% herd immunity target for most vaccine measure points. The uptake for the key tracer immunisations measured at ages one, two and five years up 2013-14 Quarter 2 are shown below along with the latest Quarter 2 COVER data performance.

Graph 4
Age 1 Diptheria, tetanus, pertussis, polio and haemophillus influenza B vaccine



- 2013-14 Quarter 2 – 96.5% - up 0.3% from Quarter 1

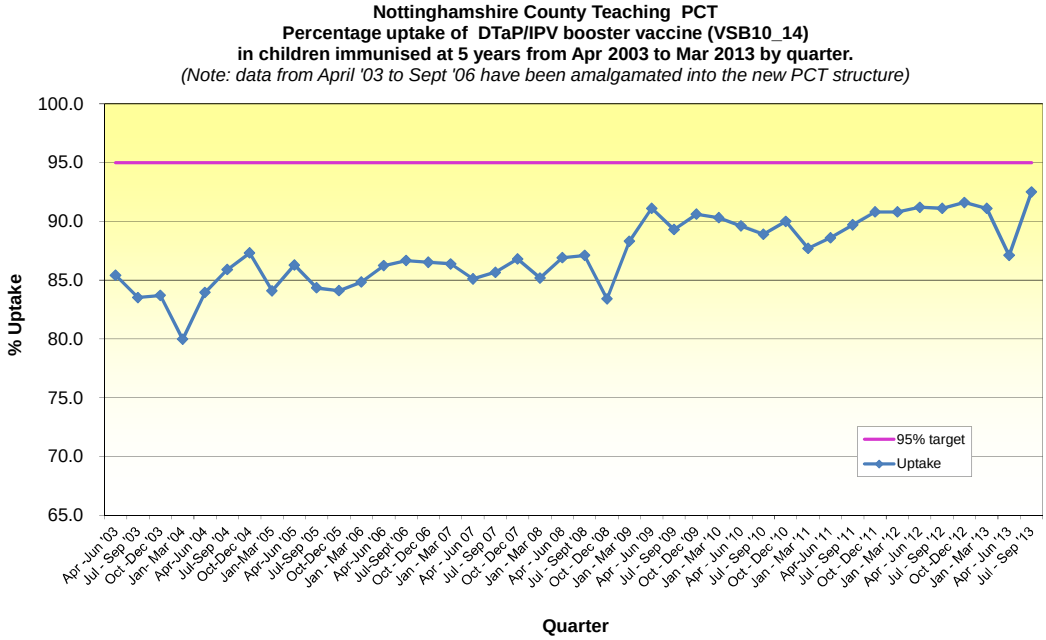
Graph 5
Age 2 and 5 years Measles, mumps and rubella (MMR) primary and secondary



2013-14 Quarter 2 –

- Primary MMR age 2 years – 94.7% - highest ever level – 0.3% short of herd immunity target
- Second MMR age 5 years – 91.8% - highest ever level

Graph 6
Age 5 Diptheria, tetanus pertussis and polio (pre school booster)



- 2013-14 Quarter 2 – 91.4% - up by 4.3% from Quarter 1 and just short of highest ever at 91.6% in 2012-13 Quarter 3

Work is underway to maintain the performance and supportive actions through liaising with the Clinical Commissioning Groups and through the Area Team giving supportive information and circulation of self-audit tool. Mansfield and Ashfield CCG have been particularly supported data cleansing and identified a Locality Development Manager to champion and support practices. Practices have also benefited from an extensive visiting programme previously undertaken by the Primary Care Trust.

For both authorities, the Screening and Immunisation Team are also working closely with their Public Health Area Team colleagues who commission health visiting services to ensure the future inclusion in service specifications for their role in not only promoting immunisation, but in cases of need, immunising vulnerable unimmunised children.

Human Papilloma Virus (HPV) vaccine
This national programme is administered routinely to all girls in Year 8 age 12-13 years by the School Nursing Services in Nottingham CityCare and Nottinghamshire Healthcare Trust Health Partnership. This programmes run from September to August i.e. by academic year. This vaccine requires three doses to be administered over six months. The annual figures for year 2012-13 are due soon. Indications are that uptake for all three doses is close to the 90% target in Nottingham City and Nottinghamshire County. The uptake for 2011-12 is shown below.

Table 2
HPV Year 8 uptake 2012- 2013 *(2011- 2012)*

	Dose 1	Dose 2	Dose 3
NHS Nottingham City	91.3% (91.4%)	90.8% (91.1%)	90.0% (89.6%)
NHS Nottinghamshire County	91.8% (93.2%)	90.3% (91.5%)	86.3% (89.8%)

The achievement of the 90.0% target in Nottingham City for the first time for dose three of this vaccine is very positive and notable due to the assertive follow-up approach by Nottingham CityCare School Nursing service and on-going monitoring of cohort numbers of by the Child Health Records Department. The drop in performance in Nottinghamshire is being investigated by the Trust at a locality level. The Area Team are also establishing contract and performance meetings with both providers.

Seasonal influenza vaccine
The 2013-14 seasonal influenza vaccine programme runs from September to January. The first national letter published in June outlined the requirements and priority groups for this year's programme covering all people aged over 65 years, people in clinical at risk groups aged 6 months to under 65 years and all pregnant women. The target uptake is 75% for all of these groups.

See page 3 for update on children's seasonal flu campaign developments. The expected target uptake is 75% as outlined in the national service specification although this is not stated in the national letter about this programme.

There is also a health and social care workers flu vaccination programme for frontline staff. Planning and implementation of this programme is led through a county-wide implementation group.

Uptake for primary care in the 2013-14 season up to 31.12.13 from bulk upload NB. final data for 31.12.13 due mid-January

Nottingham City - for 57/62 practices	
Age 65yrs	70.8%
Age 6mths-<65yrs in a clinical at risk group	46.5%
All pregnant women	33.0%
Pregnant women at risk	49.6%
Pregnant women not at risk	31.6%
2 years NOT in a clinical at risk group	37.6%
2 years and in a clinical at risk group	51.6%
All age 2 years	37.9%
3 years NOT in a clinical at risk group	31.5%
3 years and in a clinical at risk group	45.8%
All age 3 years	32.0%

Rushcliffe CCG for 14/15 practices	
Age 65yrs	78.4%
Age 6mths-<65yrs in a clinical at risk group	51.6%
All pregnant women	46.0%
Pregnant women at risk	65.8%
Pregnant women not at risk	44.3%
2 years NOT in a clinical at risk group	47.9%
2 years and in a clinical at risk group	53.3%
All age 2 years	48.0%
3 years NOT in a clinical at risk group	45.8%
3 years and in a clinical at risk group	69.2%
All age 3 years	46.7%

Nottingham West CCG for 12/12 practices	
Age 65yrs	75.6%
Age 6mths-<65yrs in a clinical at risk group	55.2%
All pregnant women	45.3%
Pregnant women at risk	70.0%
Pregnant women not at risk	43.1%
2 years NOT in a clinical at risk group	53.7%
2 years and in a clinical at risk group	54.2%
All age 2 years	53.8%
3 years NOT in a clinical at risk group	51.3%
3 years and in a clinical at risk group	59.1%
All age 3 years	51.6%

Nottingham North and East CCG for 21/21 practices	
Age 65yrs	72.5%
Age 6mths-<65yrs in a clinical at risk group	48.8%
All pregnant women	42.9%
Pregnant women at risk	60.2%
Pregnant women not at risk	41.4%
2 years NOT in a clinical at risk group	45.0%
2 years and in a clinical at risk group	72.7%
All age 2 years	45.7%
3 years NOT in a clinical at risk group	41.7%
3 years and in a clinical at risk group	54.7%
All age 3 years	42.3%

Newark and Sherwood CCG for 15/15 practices	
Age 65yrs	76.5%
Age 6mths-<65yrs in a clinical at risk group	47.5%
All pregnant women	47.2%
Pregnant women at risk	59.2%
Pregnant women not at risk	46.2%
2 years NOT in a clinical at risk group	45.9%
2 years and in a clinical at risk group	52.9%
All age 2 years	46.1%
3 years NOT in a clinical at risk group	45.2%
3 years and in a clinical at risk group	70.0%
All age 3 years	46.0%

Mansfield and Ashfield CCG for 31/31 practices	
Age 65yrs	74.2
Age 6mths-<65yrs in a clinical at risk group	49.2
All pregnant women	44.3
Pregnant women at risk	56.5
Pregnant women not at risk	43.2
2 years NOT in a clinical at risk group	46.0
2 years and in a clinical at risk group	60.9
All age 2 years	46.4
3 years NOT in a clinical at risk group	43.5
3 years and in a clinical at risk group	57.4
All age 3 years	43.9

Healthcare workers flu vaccination uptake to 30.11.13

Organisation	**Uptake**
NUH	60.5%
SFHT	64.6%
Nottinghamshire Healthcare Trust	34.3%
Area Team including Nottingham CityCare	48.6%

Progress report on the measles, mumps and rubella (MMR) catch up programme for 10-16 year olds

The Area Team MMR catch up programme for 10-16 year olds continues to be implemented through primary care in both local authorities and supported by Nottingham CityCare in Nottingham City. The target is for 95.0% of 10-16 year olds to have at least one dose of MMR.

At the time of the catchup programme the most recent data (August 2012 annual IMMFORM survey) showed that uptake in this age group is:-

- Nottinghamshire County – 96.7%
- Nottingham City – 89.5% (a more recent interim update recorded an uptake of 90.7% as at 23.12.13)

The biggest challenge is in demonstrating improving uptake in Nottingham City is related to the accuracy of the data. All practices, supported by Nottingham CityCare Child Records Department, have undertaken a data cleansing exercise.

Nationally, Public Health England and NHS England required all Area Teams to produce MMR Phase 2 actions plans for mid September. The priority for Phase 2 plans is around the introduction of school based programmes based on local need. It has been agreed that Nottingham City is the local priority area for consideration.

Nottingham CityCare Child Health Records Department has supported the identification of the three city schools and the GP practices that have most (n. 362) of the school children registered with them with the highest numbers of children with no MMR vaccination. These are:-

- Djanogly City Academy (highest)
- Nottingham Academy (second highest)
- The Nottingham Emmanuel School (third highest).

This targeted Phase 2 vaccination plan by Nottingham CityCare school nurses has been funded through the Area Team and is currently being completed in these three

secondary schools in addition to the existing primary care and health visiting protocol. The final report on is due from Nottingham CityCare on 17.1.14. Initial information shows that consents were gained from 20% of those invited which compares favourably with a Phase 1 plan elsewhere in the country that had a 12% return. The conversion of these to being vaccinated will be in the final report. Early indications showing that there has been a 20% return of consent forms with approximately 15% of the total invited being vaccinated or subsequently confirmed as already vaccinated.

This is in addition to the on-going primary care programme and supportive work done with Nottingham CityCare utilising the already agreed Primary Care/Health Visiting protocol to follow- up un/under immunised children. This work is being led by the Specialist Health Visitor for Immunisations. This is continuing to demonstrate the intense challenge for practices and Nottingham CityCare to follow up a complex mobile population who often are no longer living in the city, yet remain on both the practice lists and CHIS. The mobility of this population runs ahead of accurate national population data used by the CHIS in order to calculate accurate cohort lists.

It is encouraging too that there have been no confirmed cases of measles locally since May 2013.

Vaccine Patient Group Directions (PGDs)

Legislation establishing PGDs was introduced in 2000 and the Health Care Service (HSC 2000/026) provided additional guidance. A PGD must be signed by a doctor and a pharmacist, both of whom should have been involved in developing the direction. Vaccine PGDs provide a legal framework to allow registered nurses to administer a vaccine to a pre-defined group of patients, without them having to see a prescriber. PGDs are widely used in primary care to facilitate the administration of immunisations.

There are two historical and existing different processes in Derbyshire and Nottinghamshire to develop vaccine PGDs. The Nottinghamshire based model has been developed through a long established health communitywide group for primary care and other Trusts whereas PGDs in Derbyshire have been developed by Southern Derbyshire CCG Medicines Management Team (MMT) for primary care only. Other Derbyshire providers access these and authorise them for their own use within their own organisations.

Following the publication of national National Institute for Health and Clinical Excellence (NICE) and two national letters in 2013, the Screening and Immunisation Team are reviewing the current processes for the development and authorisation of vaccine PGDs through a multiagency stakeholder group. A number of options were discussed. A recommendation is to be taken through to the Area Team and Clinical Commissioning Groups to develop an Area Team-wide steering group comprising the Screening and Immunisation Team and CCG Medicines Management Team. NB. there is no named pharmacist within the Area Team. There are a number of pros and cons around this. Pros include that it gives one process within the governance of the local Area Team, shares pharmacy MMT capacity required across 10 CCGs, supports CCGs' role in supporting the quality of primary care and involves the experienced local PHE Centre Consultant involvement to sign off the clinical content of PGD. Cons include that it relies on MMT capacity and expertise from CCGs, that there is minimal dedicated administrative support available in the Area Team to

support the efficient significant administration of process for approximately 15 vaccines.

It should also be noted that feedback to NHS England and Public Health England (PHE) national leaders from NHS England/PHE Screening and Immunisation Leads (SILs) and CCG and Trust pharmacists has urged PHE and NHS England to develop one clinically signed off PGD per vaccine which is then issued to Area Teams to authorise locally.

Immunisation Training

Training on immunisations and vaccinations is central to the provision of a safe immunisation service. There are national minimum standards for immunisation training and an accompanying core curriculum that were published by the Health Protection Agency in June 2005.

Public Health England nationally will be reviewing immunisation and vaccination training. The NHS England and Public Health England 'Immunisation and Screening National Delivery Framework and Local Operating Model' May 2013 states that Area Teams have a role in system management in monitoring quality standards for training. It also states that Area Teams are responsible for seeking assurance from GP Practices and providers that staff undertaking immunisation and screening meet national quality standards. NB. the Area Team does not commission or provide immunisation training courses. Employers have a responsibility to ensure that their staff are adequately trained as well as all practitioners being are responsible for their own competency through keeping their knowledge and skills up-to-date.

Locally the Screening and Immunisation Team are undertaking a local review across the Area Team. In Nottingham City, Nottingham Citycare contract with an independent clinical trainer to provide immunisation training to in-house staff as well as charging primary care for places which is mostly taken by Nottingham City practices. It is also offered to Nottinghamshire practices but due to being often oversubscribed and. There is no dedicated Nottinghamshire based provider of immunisation training to primary care. In Derbyshire, training is offered to primary care by Derbyshire Community Health Services (DCHS). It is the view of the Area Team that it is timely to undertake this review as the continuing provision of the current training cannot be assured.

Other issues will also need consideration including:-

- What expert capacity and expertise is there within local health communities to deliver training?
- What is the 'market' for providing training?
- How are courses accredited?
- How is competency assessed?
- Accountability - are employers and staff clear about their accountability for staff competence if they are providing an immunisation service?
- What do the primary care employers and staff need and want?
- How is immunisation training funded and contracted?
- Interim updates - how are staff updated about new immunisation programmes that are introduced in between formal update sessions?

The Area Team therefore wish to facilitate discussions with Clinical Commissioning Groups (CCGs) and other stakeholders regarding the future provision.

Conclusion

This paper summarises the latest position against the national immunisation service specifications. It demonstrates the breadth of the programme and the work that has been undertaken in primary care, providers and the Area Team along with local authority colleagues.

Recommendation
The group are asked to note and comment on the content of this report.

Caroline Jordan
Screening and Immunisation Manager

Iolanda Shaker
Screening and Immunisation Coordinator

January 2014

Nottinghamshire County Council

Report to Health and Wellbeing Board

Agenda Item: 9

REPORT OF CORPORATE DIRECTOR, ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION

LEARNING DISABILITY SELF ASSESSMENT FRAMEWORK

Purpose of the Report

1. To inform the Health and Wellbeing Board of the outcome of Nottinghamshire's Learning Disability Self-assessment as reported to the Public health observatory in November 2013 and to seek support from the board regarding the future progress of work in order to improve our work in this area.

Information and Advice

2. The Joint Health and Social Care Self-Assessment Framework (JHSCSAF) replaces the *Valuing People Now* Self-Assessment which was primarily undertaken by Social Care and the Learning Disability Health Self-Assessment, primarily undertaken by Health.

3. This year's self-assessment was completed by commissioners from Bassetlaw and Newark and Sherwood CCGs (the latter on behalf of all county CCGs) and Adult Social Care, with valuable input from carer representatives and stories to support the ratings from service users. Input was also received from District & Borough Councils, NHS England, The GEM (Greater East Midlands), Nottinghamshire Healthcare NHS Trust, provider services and social care practitioners. The assessment was consulted on before submission with the learning disability partnership board.

4. As part of this submission, there was a requirement for each Health and Wellbeing Board to discuss the content of the self-assessment before the end of March 2014.

5. The first part of the self-assessment was made up of a number of questions relating to data, e.g. how many people with a learning disability are there in your partnership board area or how many people are currently in long stay hospitals. The second part was split into 3 sections, each with 9 questions in, asking us to rate red, amber or green, with some narrative to support this. The criteria for scoring red, amber or green (RAG) was set for each question (please see link at the end of this report for detail of the RAG criteria). We were also expected to collate evidence to support the answers we gave; this was not required to be submitted but will be available if and when we are validated. We also included some real life stories from carers and service users to support the return we made.

6. The three sections were:

- Staying Healthy – 2 Red, 5 Amber and 2 Green
- Being Safe – 2 Red, 3 Amber and 4 green
- Living well – 5 Amber and 4 Green

7. Some examples of areas working well (where we have scored Green) include
    - Acute Liaison Nurses – they provide a valuable resource for people with learning disabilities going into hospital. not only are they available to work with individuals to ensure good access to services and a positive experience of patients when in hospital but also are key to identifying and delivering training across the wider health community, encouraging partnership working and shared communication tools.
    - Joint work - Nottinghamshire has a health and wellbeing board. Integrated commissioning groups across health and social care meet on a regular basis and have joint action plans covering all service user groups with specific plans for people with learning disabilities and people with autism. Priorities are agreed by and progress against is monitored and reported to the LD partnership Board and the H&W board. The Winterbourne project (moving people out of long stay hospitals back into the community) is being jointly project managed by health and social care, with a joint project board meeting monthly and plans are being explored to develop pooled budgets to ensure services for people with complex needs and/or challenging behaviours are appropriately met.
    - Arts and Culture and Sports and leisure – there are a wide range of opportunities throughout the county for people with learning disabilities to be involved in social activities and be part of the community. Care and support plans and provider contracts all emphasise the importance of this.
    - Carer and user involvement in planning and commissioning services – carers and service users are routinely involved in all tenders for learning disability services. Commissioning plans are consulted on through the partnership boards and there are numerous forums specifically for people with Learning disabilities and/or their carers across health and social care. Big health days provide specific consultation opportunities and people with learning disabilities are involved in more universal services such as the safeguarding board and Sherwood hospitals steering group. Provider contracts all include the requirement for involvement.

8. Some of the areas where we need to make improvements (where we rated Red) include:

    - Ensuring everyone with a learning disability has an up to date health action plan which gives details of all the support they may need relating to keeping healthy. Previously this is not consistently monitored but a new template has been created which will be filled in as part of the annual health check. We rated Amber for the number of annual health checks completed which was 67%.
    - Offender health - Currently offender health commissioners (NHS England) don't yet have informed representation of the views and needs of people with learning disability or autism either in custody suites or prisons within Nottinghamshire. A health needs assessment is being undertaken in Nottinghamshire police custody suites (to support

the transfer of commissioning responsibility) and are also refreshing some health needs assessments in prisons.

- Undertaking annual contract reviews with providers. To reach amber we needed to have had a formal review with 90% of all of our providers. Health had reviewed all of their hospital providers but within social care, while some providers had been quality audited more than once in a year (where there were concerns) not all providers had ha d a formal review/quality audit. It is anticipated that 100% will receive a review in 2014/15
- Undertaking individual annual reviews. To reach amber we had to have reviewed over 90% of people known to social care or funded by health. Only 77% of those known to adult social care had a formal review. Most of those who did not have a formal review will have been visited/had contact with social care and had minor adjustments made to care plans etc. without having had a formal review. However, we need to ensure that where we are unable to give everyone a review within 12 months we ensure that those least likely to be in contact with other services are reviewed as priority. e.g. we are monitoring out of county placements and long term hospital placements to ensure they all have a review.

9. In previous years, where the need for improvements have been highlighted from the health self-assessment, the Better Health group, which is a subsidiary of city and county learning disability partnership boards, have helped to draw up the action plan and monitor progress. Carers involved in this year's self-assessment have suggested that this would be a good process to carry forward. The Health and Wellbeing Board are asked to agree this approach.

10. A report will be brought back to the Health and Wellbeing Board towards the end of 14/15 to update on progress made.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) The Board accepts the report.
2) The Board agrees the principle of a joint action plan to ensure improvement in areas currently scoring red or amber, with priority for 14/15 being on the red areas, to be monitored with the help of the Better Health Group.

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

For any enquiries about this report please contact:
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01159773135
cath.cameron-jones@nottscc.gov.uk

Constitutional Comments (SLB 05/02/2014)

12. The Health and Wellbeing Board is the appropriate body to consider the content of this report.

Financial Comments ([initials and date xx/xx/xx])

13. To follow.

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.

- Nottinghamshire Learning Disability Self-Assessment and easy read version – available from Nottinghamshire learning Disability partnership Board website

  http://www.nottscountypb.org/default.aspx?page=27944

- Learning Disability self-assessment guidance and RAG rating – available from the Public health observatory website:
  http://www.improvinghealthandlives.org.uk/projects/hscldsaf

- Nottinghamshire JSNA – chapter 2, vulnerable and seldom heard groups – available on Nottinghamshire County Council's website

http://www.nottinghamshire.gov.uk/thecouncil/plans/strategydevelopment/joint-strategic-needs-assessment/

Electoral Division(s) and Member(s) Affected

- 'All'

Nottinghamshire County Council

Report to the Health & Wellbeing Board

5 March 2014

Agenda Item: 10

REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING BOARD

IMPROVING HEALTH AND PATIENT CARE THROUGH COMMUNITY PHARMACY- A CALL TO ACTION

Purpose of the Report

1. To invite comments on work being undertaken by NHS England to shape local strategies for Community Pharmacy.

Information and Advice

2. NHS England is responsible for commissioning community pharmacy services that meet the pharmaceutical needs of local people. As part of the Call to Action strategy, NHS England is seeking views on future community pharmacy services. **Appendix One** provides further information on the consultation.

3. The main purpose of this community pharmacy Call to Action is to stimulate debate in local communities, to shape local strategies for community pharmacy and to inform NHS England's strategic framework for commissioning community pharmacy.

4. The Health & Wellbeing Board has a statutory duty to develop and maintain a Pharmaceutical Needs Assessment for Nottinghamshire County. The Board is therefore asked to consider the Call to Action and feed comments into the consultation.

5. It is suggested that the Chair of the Board receive member's comments and a response be made in her name on behalf of the Board.

RECOMMENDATION/S

The Health & Wellbeing Board is asked to

1) Note the report and feed comments back to the Chair on the Call to Action consultation.
2) Support the Chair to submit these comments to NHS England on the Boards behalf.

Councillor Joyce Bosnjak
Chair of Health and Wellbeing Board

For any enquiries about this report please contact: Cathy Quinn, Associate Director of Public Health cathy.quinn@nottscc.gov.uk.

Constitutional Comments ([initials and date xx/xx/xx])

6. To follow

Financial Comments ([initials and date xx/xx/xx])

7. To follow

Background Papers and Published Documents

None

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

The NHS belongs to the people — A CALL TO ACTION

NHS England

IMPROVING HEALTH AND PATIENT CARE THROUGH COMMUNITY PHARMACY– A CALL TO ACTION

NHS England
December 2013
Gateway Reference: 00878

THE NHS CONSTITUTION
the NHS belongs to us all

Purpose of the Call to Action

Every year in England, 438 million visits are made to community pharmacy for health related reasons. This is more than any other NHS care setting.

NHS England is, through this Call to Action, seeking to secure community pharmacy services that deliver great outcomes cost effectively, reaching into every community and which make the most of the expertise of pharmacists and of pharmacy's unique accessibility for patients in England.

The main purpose of this community pharmacy Call to Action is to stimulate debate in local communities, to shape local strategies for community pharmacy and to inform NHS England's strategic framework for commissioning community pharmacy.

Local discussions

NHS England area teams will host local discussion events over the next three months.

Who can get involved?

- Everyone who works in community pharmacy, including support staff and employers.
- Clinical commissioning groups (CCGs), commissioning support units (CSUs) and health and wellbeing boards.
- Local authorities, other community partners and NHS hospital trusts.
- Patients and carers and local Healthwatch organisations.
- NHS England's area teams, including chairs of local professional networks (LPNs).
- Local education and training boards (LETBs) and academic health science networks (AHSNs).

Process

- We are publishing this Call to Action alongside an evidence resource pack with key facts and figures about community pharmacy in England.
- This document should be read in conjunction with ‘Improving General Practice: A Call to Action’: http://www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-slide.pdf.
- We propose to publish a further document in 2014 which will set out in more detail the proposed key features of our strategic framework for commissioning community pharmacy services, connecting up with our approach to general practice.

Local discussions

- Local discussions will focus on some key questions aimed at agreeing how to best develop high quality, efficient services that can improve patient outcomes and can be delivered by pharmacists and their teams in a community pharmacy setting.
- We also ask a number of questions about how NHS England can best support these local changes, for instance through the way that we develop the national contractual framework.
- NHS England will also work closely with a range of national partners, including the Department of Health, Public Health England, Health Education England, the Local Government Association, patient groups, professional organisations, employers and pharmacy educators, to develop our strategic approach to commissioning of community pharmacy services.

Local and national engagement

NHS England through its area teams will:

a) work with local communities to develop strategies based on the emerging principles set out in this Call to Action, with close engagement with patients and the public and health and wellbeing boards, to ensure that community pharmacy develops in ways that reflect their pharmaceutical needs and priorities and build on their insights;

b) through the pivotal role of LPN chairs, discuss with local community pharmacists and contractors, CCGs, CSUs, local authorities and other health and social care partners what changes we need to make to support these local needs and emerging strategies;

c) ensure that all outcomes are linked appropriately to the five domains of the NHS Outcomes Framework and help reduce inequalities:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213055/121109-NHS-Outcomes-Framework-2013-14.pdf.

The case for change

In our engagement to date we have heard that primary care services face increasingly unsustainable pressures. Community pharmacy can play its full role in the NHS transformational agenda by:

- providing a range of clinical and public health services that will deliver **improved health** and **consistently high quality;**
- playing a stronger role in the **management of long term conditions;**
- playing a **significant role in a new approach to urgent and emergency care and access to general practice;**
- providing services that will **contribute more to out of hospital care**; and
- supporting the delivery of **improved efficiencies** across a range of services.

Building on the strengths of community pharmacy (1)

To support the reform of primary care, we must take great care to build on the strengths of community pharmacy and its workforce and the opportunities they present:

- Pharmacists are the **third largest health profession.**
- Community pharmacy is the **gateway to health** for **1.6 million patients each day.**
- Owners of pharmacies are required to ensure that staff have the **appropriate skills, qualifications and competence** for their role or are working under the supervision of such a person whilst being trained.
- A **core component of current pharmacy service** supports the public to stay well, live healthier lives and to ‘self care’ .
- **Central role in management of long term conditions**. Pharmacists currently carry out Medicines Use Reviews (MURs) and provide the New Medicine Service (NMS) to patients newly prescribed certain medicines.

Building on the strengths of community pharmacy (2)

- **Range of provider models**: the public values the range of pharmacies, based in communities, on the high street, in supermarkets, in shopping centres, in health centres and online.
- People from deprived populations, who may not access conventional NHS services, do access community pharmacies, helping to improve the health of the local population and **reducing health inequalities.**
- Patients greatly value the fact that they **don't need an appointment** to see a pharmacist. Pharmacy's **accessibility** in terms of location and long opening hours is seen as a significant benefit to the public.
- **Triage and signposting** to health and social care services is a core component of the work in community pharmacy.
- Good access to the **supply of medicines**.

Aims for community pharmacy

Our aims for community pharmacy are to:

- develop the role of the pharmacy team to provide personalised care;
- play an even stronger role at the heart of more integrated out-of-hospital services.
- provide a greater role in healthy living advice, improving health and reducing health inequalities;
- deliver excellent patient experience which helps people to get the most from their medicines.

We want to develop a contractual framework that better supports these aims and secures the most efficient possible use of NHS and taxpayer resources.

What could this mean for patients, the public and carers? (1)

- I have easy access, online or in person, to information, advice and support to help me manage my medicines and receive support for better health and self care.
- There is a wide range of services accessible through my local community pharmacies, both to help keep me and my family healthy and to provide personalised care and support when I am unwell – “the same day, every day”.
- My community pharmacy will work with my family doctor, community nurse, hospital and social services to make sure my care is joined up and effective and then I only have to tell my story **ONCE**.
- I have good information about the services, in addition to dispensing, that all of my local community pharmacies provide and that I am free to choose to use.

NHS England

What could this mean for patients, the public and carers? (2)

- I am aware that community pharmacists and their teams can be a source of advice to help me care for myself and treat minor ailments.
- I feel empowered to look after my own health.
- If I need to go into a care home my health needs can be met fully in that setting, where appropriate.
- All members of the pharmacy team will have a professional relationship with me and, where appropriate, my carers.
- I can be confident that, whichever community pharmacy I visit, it will meet essential quality standards and I will be treated and cared for in a safe environment.
- I have good and timely access to my medicines.

NHS England

Emerging themes about the future of community pharmacy

"Pharmacies (should) be fully integrated into provision of primary care and public health services, and (should) have a substantial and acknowledged role in the delivery of accessible care at the heart of their community."

Pharmacies want to be "seen as a healthy living centre providing a range of clinical services supporting long term conditions management".

"Strengthening the voice of community pharmacists and offering patients the best quality care and access to medicines is vital. This partnership will play an important role in helping community pharmacists to fulfil their potential."

"Community pharmacy services can play an important role in enabling self-care, particularly amongst patients with minor ailments and long-term conditions; however there is little public awareness of the range of services provided by pharmacists and their teams."

We want to "articulate the benefits to patients of involving pharmacists in the delivery of a wider range of services".

"We need to build a professional understanding of how the patient pathway works in relation to medicines and specifically at which points in that journey pharmacists and pharmacy technicians can most add value."

NHS England

Underlying objectives for community pharmacy

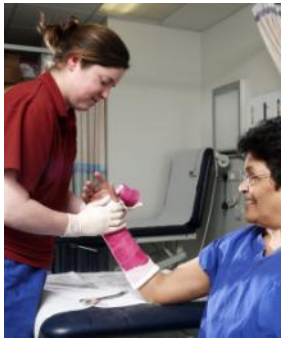
Objective	Community pharmacy unique strength	Opportunity for the next five years
Ensuring patient safety	• Medicines expertise. • Reduce harm from medicines.	• Reduce medication errors especially in vulnerable patient groups (e.g. frail older people, children, people with mental health issues or those with learning disabilities).
Ensuring best value from taxpayer resources	• Efficient medicines supply chain. • Enables out of hospital care.	• Wider role supporting patients with long term conditions. • Reduction of avoidable medicines waste. • Greater use of technology and skill mix. • Continue to drive procurement efficiencies. • Greater role in prevention and early intervention

NHS England

Underlying objectives for community pharmacy

Objective	Community pharmacy unique strengths	Opportunity for the next five years
Improving patient experience	• Open access to a pharmacist (or e.g. health champion) • Range of providers • True choice	• Relieving pressure on other key NHS services. • Pharmacy becomes the first port of call. • Improved support for self care.
Improving patient outcomes and reducing inequalities	• Patients in the community supported to take medicines correctly. • Public has easy access to healthy living advice. • People from deprived backgrounds more likely to access pharmacy than other services	• Further reduce avoidable admissions to hospital. • Improving health from better medicines taking and healthier lifestyles, supported by access to care records • Particular opportunities to improve health for people in deprived communities

Questions for local discussion



1. **How can we create a culture where the public in England are aware of and utilise fully the range of services available from their local community pharmacy now and in the future?**

The prompts for this discussion might encompass:

- how the NHS can work with local authorities to enhance the public health role of community pharmacies, including making every contact count and the concept of Healthy Living Pharmacies;
- community pharmacy teams as the first port of call for minor ailments and better use of community pharmacy for the management of stable long term conditions;
- better marketing of clinical and public health services to ensure the public and patients are fully informed of the range of services that community pharmacies offer;
- how the public expects pharmacists to work together with GPs, hospitals, community nurses and care homes to improve health outcomes.

2. **How can the way we commission services from community pharmacy maximise the potential for community pharmacy to support patients to get more from their medicines?**

Prompts for this discussion might include:

- national versus local commissioning;
- whether pharmacies are in the right place locally and whether we have the right number;
- ways in which better alignment of the Community Pharmacy Contractual Framework and the General Medical Services contract could improve outcomes e.g. the management of repeat medicines and medication review;
- the balance of medicines supply role and provision of clinical services;
- how we can work more effectively across the current commissioning landscape to ensure the NHS and local government (public health) can commission services from community pharmacy more easily and avoid duplication.

NHS England

3. How can we better integrate community pharmacy services into the patient care pathway? (1)

The prompts for this discussion might include:

- how to accelerate pharmacists' access to the Summary Care Record;
- better management of 'high risk' or vulnerable patients;
- how collaboration on a population basis can support the delivery of better health outcomes;
- improving the digital maturity of community pharmacy;
- community pharmacy's role in the transformation and integration agenda for out of hospital care;
- getting the most from the whole pharmacy team (skill mix).

NHS England

3. How can we better integrate community pharmacy services into the patient care pathway? (2)

The prompts for this discussion might include:

- data for commissioners to improve the population's health and ensure quality of service (including a role in research and development);
- how to ensure GPs have access to clinical pharmacy advice, for example in their practices;
- how best to secure pharmacy expertise in the care of vulnerable groups, including children, frail older people in their own home/care home, those with mental health issues, dementia and those with learning disabilities;
- how to work with employers, training providers, LETBs and other commissioners to identify the development needs of the community pharmacy workforce to deliver high quality services and care across patient pathways.

4. **How can the use of a range of technologies increase the safety of dispensing?**

The prompts for this discussion might include:

- how we can best accelerate progress toward community pharmacy access to the Summary Care Record, which is considered pivotal to maximising the contribution of community pharmacy to patient outcomes;
- a greater uptake and use of local and centralised robotics within the dispensing and supply process;
- improving the cultural, operational and IT systems to make medication safety incidents easier to report and share learning;
- the design of pharmacy premises;
- the role of digital technology in improving patient care.

How to get involved

If you have views on the issues and questions raised in the slide pack:

- contact your NHS England area team;
- respond to our questions on the web site (www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pharm-cta/).

We are also seeking examples of where area teams have worked with local pharmaceutical committees and community pharmacy teams to deliver improvements in people's health through community pharmacy.

It would also be helpful to understand the factors that have contributed to local success and any barriers to change that you have experienced. Please send local examples to england.sfcpc@nhs.net

Next steps

- NHS England area teams will hold their local discussion events over the following three months.
- Online responses will be analysed.
- A strategic outline will be produced in 2014.

End of call to action slides.

Nottinghamshire County Council

Report to Health and Wellbeing Board

6 March 2014

Agenda Item: 11

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

1. To consider the Board's work programme for 2014.

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 February 2014	**Exceptional Board Meeting to agree draft Better Care Fund Plan**	**Child and Adolescent Mental Health**
5 March 2014	**Health Protection Arrangements** (Jonathan Gribbin / Vanessa McGregor) **Integrated Commissioning Function – commissioning priorities** (Kate Allen) **Nottinghamshire Health & Wellbeing Strategy** (Cathy Quinn) ***Learning disability self-assessment*** *(Cath Cameron-Jones)TBC* ***CCG Five Year Strategic Plans*** *TBC*	
2 April 2014	**Exceptional Board Meeting to agree final Better Care Fund Plan**	***Adult Mental Health*** *TBC*
7 May 2014	**Health Checks** (John Tomlinson) **Breast Feeding** (Kate Allen) **NHS England Primary Care Strategy** (Tracy Madge / Vikki Taylor) **Publication of Public Health Annual Report** (Chris Kenny) ***Avoidable Injuries Strategy*** *(Penny Spring) TBC* ***Adult Mental Health*** *(Jon Wilson) TBC* **Winterbourne View Project Update** (David Pearson) **JSNA annual Summary** (Chris Kenny/Jo Copping)	

Updated: 21 January 2014

	Libraries and Community Learning – Health and Wellbeing - role, impact and potential (Anthony May/Peter Gaw) ***Healthy Child Programme and Public Health Nursing for Children and Young People*** *(Kate Allen/ Irene Kakoulis)*	
4 June 2014		***Homelessness*** *TBC*
2 July 2014	***Roles and Responsibilities for NHS England*** *(Helen Pledger)TBC* ***Local nature partnership*** *(Cllr Suthers/Helen Ross) TBC*	