Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 17 April 2013 at 14:00

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

AGENDA

Notes

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

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

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

minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday, 6 March 2013 (commencing at 2.00pm)

membership
Persons absent are marked with `A'

COUNCILLORS

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

DISTRICT COUNCILS

A Councillor Jenny Hollingsworth
A Councillor Tony Roberts MBE

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

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

LOCAL HEALTHWATCH

	Jane Stubbings	-	Nottinghamshire County LINk

NHS COMMISSIONING BOARD

A	Helen Pledger	-	Local Area Team, NHS Commissioning Board

SUBSTITUTE MEMBERS IN ATTENDANCE

Mayor Tony Egginton	-	Mansfield District Council
Councillor Jacky Williams	-	Broxtowe Borough Council
Phil Mettam	-	Bassetlaw Clinical Commissioning Group
Dr Barbara Stuttle CBE	-	Local Area Team, NHS Commissioning Board
David Hamilton	-	Adult Social Care, Health and Public Protection Department

OFFICERS IN ATTENDANCE

Tracy Burton	-	Public Health
Paul Davies	-	Democratic Services
Cathy Quinn	-	Public Health
Penny Spring	-	Public Health

ALSO IN ATTENDANCE

Allan Breeton	-	Nottinghamshire Safeguarding Adults Board
Joe Pidgeon	-	Healthwatch

MINUTES

The minutes of the last meeting held on 16 January 2013 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Hollingsworth, Rhodes and Roberts, Dr Kell, David Pearson and Helen Pledger.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

Allan Breeton, Chair of the Nottinghamshire Safeguarding Adults Board introduced the report on the work of the Board. In reply to a question, he stated that the Board covered the safeguarding of older people in hospitals, that health services were monitored, and that Health was well represented on the Board.

Discussion was mainly about the Multi-Agency Safeguarding Hub (MASH), which had gone live in January. Anthony May offered to provide a report to the Health and Wellbeing Board on MASH and to arrange a visit if there was interest. He invited feedback from agencies on their experience of MASH.

RESOLVED: 2013/009

That the report on Nottinghamshire Safeguarding Adults Board be noted.

SHERWOOD FOREST HOSPITALS TRUST - UPDATE

Dr Jefford reported orally on progress to resolve the issues described at previous Board meetings. The Mid-Nottinghamshire Integrated Care Transformation Board was developing proposals, which would be subject to public consultation. Attention was drawn to the involvement of the CCGs, clinicians, NHS Commissioning Board and Adult Social Care. There was also discussion about East Midlands Ambulance Service's (EMAS) proposals for ambulance services. It was recognised that the Joint City/County Health Scrutiny Committee was scrutinising the EMAS proposals, it would also be useful for the Board to be informed.

RESOLVED: 2013/010

That the report be noted, and a further report on Sherwood Forest Hospitals Trust be presented to the next meeting of the Health and Wellbeing Board.

SEXUAL HEALTH IN NOTTINGHAMSHIRE COUNTY

Tracy Burton and Penny Spring gave a presentation on sexual health in Nottinghamshire and services to improve sexual health. They responded to questions and comments.

- Did academy schools receive school nursing support and information on sexual health? - All schools received the school nursing service. The County Council maintained close links with academies. Briefings to head teachers had covered smoking and could include other public health issues.

- Was there adequate distribution of experts in Long Acting Reversible Contraception (LARC)? - There was a target to train more people in LARC.

- Giving out free condoms was a cost-effective way of reaching target groups.

- Young people were accessing information on sexual health through the internet, and seeing a wide range of sexual behaviour as being normal. Iceland was given as an example where access to pornography sites was being blocked.

- Information sharing could be improved. GPs would only know if a patient had been treated in a genito-urinary medicine (GUM) clinic if they had referred the patient. - Services were governed by confidentiality clauses. However sexual health and GUM services were separate, and there would be benefits from greater integration. The Board could help to broker better communication. This merited further discussion in a future workshop.

RESOLVED 2013/011

(1) That the report be noted and its contents endorsed.

(2) That the roles and responsibilities for local authorities for commissioning to support comprehensive sexual health services from April 2013 be noted.

(3) That the actions listed in paragraph 23 of the report be supported.

(4) That a detailed action plan be developed using a forthcoming Health and Wellbeing Board workshop.

HEALTH AND WELLBEING LOCAL OUTCOMES FRAMEWORK

Chris Kenny introduced the report which proposed indicators for a local health and wellbeing outcomes framework. In discussion, the importance of choosing suitable comparators was emphasised. Dr Kenny explained that it would be possible for the Board to devise other indicators, including qualitative ones, if so wished. However he stressed the need to ensure that data was easy to collect.

RESOLVED: 2013/012

That the proposed local outcomes framework be endorsed for implementation from 1 April 2013.

NHS COMMISSIONING BOARD LOCAL AREA TEAM COMMISSIONING PLANS

The Chairman invited any comments on the plans to be submitted to Barbara Stuttle by 5 April 2013.

RESOLVED 2013/013

That the NHS Commissioning Board's commissioning plans be noted, and any comments be submitted directly to Barbara Stuttle.

DEVELOPMENT OF CLINICAL COMMISSIONING GROUP COMMISSIONING PLANS FOR 2013/14

RESOLVED 2013/014

That the 2013/14 commissioning plans of the six Clinical Commissioning Groups be noted.

PUBLIC HEALTH GRANT AND BUDGET PLANNING

The report presented the outline financial plan for Public Health. The Board did not have time to consider the proposals for new developments. It was therefore agreed that these would be circulated after the meeting, and discussed further at the next workshop.

RESOLVED: 2013/015

(1) That the information on the Public Health Grant for Nottinghamshire be noted, including the allocation purpose and reporting arrangements.

(2) That the Outline Financial Plan be endorsed, and an innovation/ development fund be approved by Public Health Sub-Committee.

(3) That the proposals for further investment be circulated to Board members and discussed at the next workshop.

HEALTH AND WELLBEING BOARD REGULATIONS

The report summarised the recently published regulations about Health and Wellbeing Boards, and preparations for the Board taking on its statutory role from 1 April 2013. The regulations did not cover the Code of Conduct and declarations of interest. These would be subject to discussion at the next workshop, with a further report to the next Board meeting.

RESOLVED: 2013/016

That the report be noted.

The meeting closed at 4.15 pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health and Wellbeing Board

17th April 2013

Agenda Item: 4

REPORT OF NEWARK AND SHERWOOD AND MANSFIELD AND ASHFIELD CLINICAL COMMISSIONING GROUPS

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

Purpose of the Report

A presentation was provided to the November 2012 Health and Wellbeing Board from the Interim Chief Executive Officer of Sherwood Forest Hospitals setting out how the Foundation Trust is responding to the particular issues relating to financial viability and governance that gave rise to intervention by the Foundation Trust regulator (Monitor) in October 2012. A written report was provided to the January 2013 meeting of the Health and Well Being Board describing the "whole health economy" approach to transforming primary, secondary, community and social care services, which is being led through the engagement of senior leaders in the Mid-Nottinghamshire integrated Care Transformation Board. Further verbal updates have been provided. This report describes progress to date in ensuring the sustainability of the local health economy, and also the steps being followed by Sherwood Forest Hospitals to return to regulatory compliance.

Information and Advice

A. Update on the Transformation Work

1. Following extensive initial quantitative baselining work, the Mid Nottinghamshire Transformation Board has established a series of "Care Design Groups". These groups have been constituted to develop future models of health and social care under the broad headings of elective, urgent, frail elderly and long term conditions, and women's and children's services. The programme has engaged with clinicians and social care leaders to agree the scope of work in each of these areas and gather ideas for the development of future models of care. Patients, carers and other key stakeholders have also been involved to ensure that initial ideas are developed in to fuller, implementable options. It is anticipated that these groups will remain active throughout subsequent engagement about, and implementation of, the ideas generated by the transformation work.

2. Some potential design options arising from the work of the Care Design Groups will be included in an initial overview document that will be presented to the Integrated Care Transformation Board by the end of April 2013. Once the ideas have been formulated and collated, these will be subject to wide engagement and consultation.

3. Underpinning the development of these ideas have been some core design principles as follows;

- Prevent illness or crises wherever possible, and transfer resources (people, physical assets and finance) from reactive services to support this.

- Shift care closer to home, or to better value care settings where it can be demonstrated to provide improved outcomes

- Only provide services where there is the critical mass/volume for the services to be delivering best outcomes and be economical; but also to repatriate activity from out of area/private provision where this delivers better outcomes and is in line with patient choice.

- Optimise the use of fixed cost assets (buildings and equipment) but ensure that activity is provided locally where appropriate (acute, community, private and non-healthcare).

- Provide single points of access for patients, and integrated provision of services (aligning workforce as required)

- Use all of the above to enable the system to cope with growing demand within stable or reducing resource constraints.

4. The work is proceeding well with the full collaboration of commissioners and providers, and the engagement of patients and stakeholders at the design stage has been invaluable in shaping ideas. The work must, and will continue to, focus on meeting the needs of the local population. That notwithstanding the programme leaders are cognisant of the requirement to factor in the views of a wider range of stakeholders (both outside of the local geography and the public sector) to ensure that in securing future services for its population they have taken account of the requirements to ensure appropriate choice of services and also collaboration and competition with regard to the organisations established to do so.

B. Update on Sherwood Forest NHS Foundation Trust

1. Under the terms of the formal powers of intervention under section 52 of the National Health Services Act 2006, Monitor required the Foundation Trust to;

2. Commission reviews of quality and board governance and also a diagnostic review to assess the current financial position.

3. Report regularly on progress towards the delivery of key milestones to be stipulated by Monitor, and to meet Monitor on a regular basis until it is assured that the Foundation Trust has returned to full and sustainable compliance with its terms of Authorisation. Good progress has been made to date in each of these areas as follows;

- Quality governance; a key recommendation was that clinical governance was not given sufficient profile at Board level and across the organisation. A series of changes had been made, including the establishment of a committee of the Board to focus exclusively on clinical governance, quality and patient experience.

- Board governance; a number of key leadership changes have been made and recruitment is underway to ensure that the Board has experienced and appropriately skilled individuals. Furthermore, an action plan has been prepared and shared with Monitor and progress against the plan's milestones is considered at each monthly Board meeting.

- Financial governance; the action plan developed from the diagnostic review has been shared with Monitor and its performance is reviewed monthly at Trust Board meetings. A key focus is on creating a robust financial turnaround plan.

4. Furthermore, the Foundation Trust is participating in the review in to the quality of care of 14 hospital trusts in England. On 6th February 2013 the Prime Minister announced that he had asked Professor Sir Bruce Keogh to review the care and treatment provided by hospitals that had over a period been outliers (referenced as 2 years for either Hospital Standard Mortality Ratios – HSMR or Summary Hospital Level Mortality Indicator – SHMI). The reviews are being conducted in three phases;

- Gathering and analysing a wide range of information
- Review Team comprising clinicians, patients, managers and regulators to conduct an on-site review;
- The results will be brought together at a Risk Summit involving representatives across health organisations and partner organisations to review the results and consider any necessary actions.

5. The Trust was aware in October 2012 of the poor performance against the HSMR indicator whilst in SHMI, the Trust performed within acceptable parameters. A mortality review was commissioned from external experts who reported in December 2012 and set out a number of measures that should be taken in addition to those already implemented. The actions already taken have been publicly shared and the Trust will continue to review performance and the success of measures implemented at monthly Board meetings. The external review being developed by Sir Bruce Keogh is very much welcomed by the Trust to review progress to date and alert the Trust to any further measures it can take to improve treatment provided.

C. Next Steps

1. The initial baselineing, design and outline "blueprint" stage of the transformation work will conclude in late April 2013. In essence, the "blueprint" will comprise;

- Potential future options for the delivery of health and social care
- An assessment of all costs in relation to forecast available resources, taking account of estates, information technology and transition costs/ implications.

2. This will provide senior leaders and the health and social care community and service users with a description of viable options for services over the next five to ten years, and this will be in line with projected health and population needs.

3. They will then be used to create an engagement plan and document, in order to ensure that stakeholders can remain meaningfully involved in taking the ideas forward in to real plans for implementation. If appropriate, areas for statutory consultation will be clearly identified.

4. In parallel, Sherwood Forest Hospitals NHS foundation Trust will be concluding its refreshed strategy (the "Monitor Annual Plan") for submission at the end of May 2013 and this will be informed by the "blueprint" outputs of the transformation work and the guiding principles therein.

5. Work will be ongoing throughout the summer of 2013 to ensure appropriate engagement and also alignment of future plans for commissioning and providing health and social care services across Mid Nottinghamshire

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board:

1. Advises the CCGs on how the Health and Wellbeing Board would like to be engaged in the development of plans for sustainable services across Mid-Nottinghamshire.

2. Notes the progress made to date in the programme of work underway to secure a vision for sustainable hospital and community based services in Mid-Nottinghamshire in the future.

DR AMANDA SULLIVAN
CHIEF OPERATING OFFICER
NEWARK AND SHERWOOD AND MANSFIELD AND ASHFIELD CCGs

For any enquiries about this report please contact:
Lucy Dadge
Project Director
Newark and Sherwood and Mansfield and Ashfield Clinical Commissioning Groups
07775 942840

Nottinghamshire County Council

Report to the Health and Wellbeing Board

17 April 2013

Agenda Item: 5

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

HEALTH OF VULNERABLE CHILDREN AND YOUNG PEOPLE IN NOTTINGHAMSHIRE

Purpose of the Report

1. The report describes factors that increase children and young people's vulnerability, considers the impact of vulnerabilities on health and wellbeing and outlines the Nottinghamshire multi agency response to meet the needs of vulnerable children and young people. Comment is invited on the current approach, together with consideration of potential additional developments. Members of the Health and Wellbeing Board are asked to sign up to the recently published Department of Health Pledge to improve health outcomes for children and young people, reproduced in **Appendix 1.**

2. The paper outlines a wide range of often interrelated causes of children and young people's vulnerability but in many instances, the scale, severity and impact of vulnerability cannot be measured. The Children's Commissioner for England reminds us that:

   'Article 4 [of the UN Convention on the Rights of the Child] *says children and young people must rely on adults to protect and ensure their rights. Children and young people, especially the most vulnerable among them, are likeliest to be voiceless in a society that for all sorts of reasons takes an adult view of how life, law and policy should be*[1].

Information and Advice

Definition of vulnerability

3. This paper uses the definition of vulnerable children as described in *Healthy Children, Safer Communities* (DH 2009), which is:

   'Those who experience multiple and complex problems which restrict their life chances and need extra attention to improve their well-being.[2]'

Demographic information

4. There are 179,500 children and young people aged 0-19 living in Nottinghamshire. The 0-19 year old population is projected to increase by 13% across the County by 2030, with the largest growth in the 5-9 year old population (23%)[3].

What we know about children's physical and emotional health

5. The physical, mental and emotional health of a child has a fundamental impact and influence on the future of that child, and is an important outcome in its own right.

   "*Nothing can be more important than getting it right for children and young people. We know the importance of health services and healthy behaviours in childhood and teenage years in setting patterns for later life*[4] ".

6. By the age of five, early influences have already had an impact on the future outcomes for a child, be they cognitive, behavioural, social, emotional or health related. Influences include the home learning environment, mother's educational qualifications, parenting style, maternal mental health and mother's age at birth of first child, as well as demographic and family characteristics[5].

7. In 2007, a UNICEF report indicated that the wellbeing of children in the UK is poor compared to other industrialised countries[6]. More recent data shows that this county has the highest infant mortality rate in Western Europe[7] and a number of health outcomes for children and young people are poor, often linked to vulnerabilities and leading to inequalities in health which are significant and unacceptable. These can result in substantial costs to both the individual and to the state. Improving the health and wellbeing of children, young people and families is a key priority for the Nottinghamshire Children's Trust.

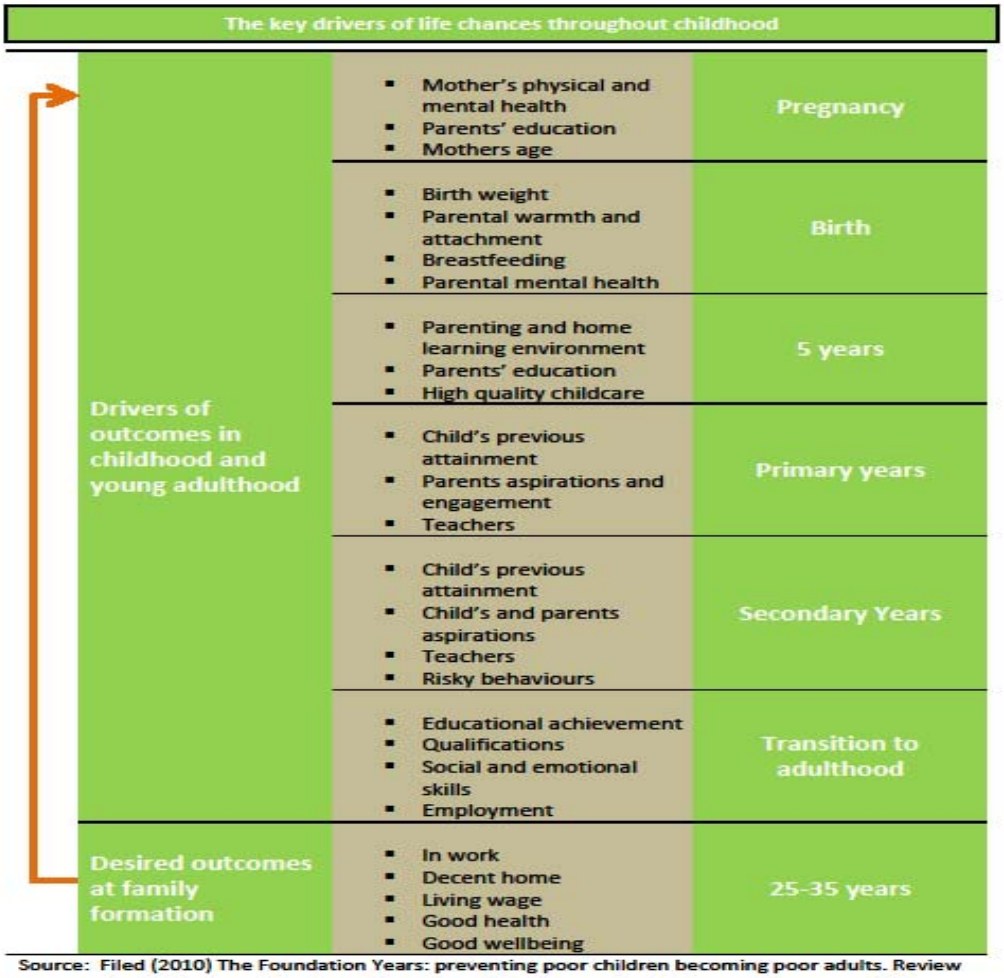
Factors that impact on children and young people's vulnerability

8. A range of factors affect the life chances and outcomes for a child or young person throughout his or her life, as shown in Figure 1[8].

Socio economic status, poverty and health inequalities

9. Children living in poverty in areas of deprivation are more commonly affected than others by a range of factors which increase their vulnerability and have a negative impact upon their health. These factors include living apart from their parents, suffering abuse, neglect or exploitation, being carers for others, suffering with physical or mental illness, having a parent in prison, being involved in the youth justice system or being marginalised as a result of learning or physical disabilities, ethnicity or cultural differences, or sexual identity and/or orientation[9].

Figure 1



Source: Filed (2010) The Foundation Years: preventing poor children becoming poor adults. Review team synthesis of research findings. The report of the Independent Review on Poverty and Life Chances.

10. The Joint Strategic Needs Assessment (JSNA) highlights the issue of health inequalities within Nottinghamshire, illustrating the correlation between poor health outcomes, child poverty and localities experiencing deprivation. Within the County, localities with higher levels of deprivation have higher levels of infant mortality, smoking in pregnancy, low birth weight births, childhood obesity, teenage conception and substance/alcohol misuse and low levels of breastfeeding.

11. It is well established that children growing up in poverty are more likely to suffer emotional and behavioural problems from early childhood. Socio-economic disadvantage can exacerbate chronic stress, family instabilities and parental mental health, which in turn can impair parenting. Children living in areas of deprivation are more than twice as likely to have conduct disorders than children living in more affluent areas[10].

12. In 2010 across Nottinghamshire, 27,950 children and young people aged 0-19 were identified as living in low income households, equating to 17.1% of the 0-19 population[11]. There is considerable variation in the proportion of 0-19 year olds living in poverty across Nottinghamshire's districts as follows: Ashfield 23%, Bassetlaw 18%, Broxtowe 15%, Gedling 15%, Mansfield 23%, Newark and Sherwood 16.5%, Rushcliffe 8%. All districts have at least one ward that is considered a poverty hot spot.

13. There are 1.8 million children living in workless households in the UK[12], with the UK and Ireland having the highest workless household rates in Western Europe[13]. In England, 15.2% of children live in workless households while the figure is 12.3% in the East Midlands and 12.3% in Nottinghamshire[14].

14. A high proportion of children living in low income households meet the eligibility criteria for free school meals (FSM). Nationally, FSM entitlement is used as a measure of vulnerability and is used as an indicator to focus improvements in educational attainment. Across Nottinghamshire, an average of 15.4% of children are eligible for FSM in primary and secondary schools, with higher eligibility rates in the districts of Mansfield and Ashfield (18-22% of all children) and among children attending special schools (an average of 35.7% of children).

The Nottinghamshire response

15. A range of strategic approaches and services are in place in Nottinghamshire to address childhood vulnerability and its impact on health and wellbeing. These are underpinned by the recognition that families play the most significant role in supporting children and young people who face vulnerability, while friends, schools and the voluntary sector can have important roles in supporting the health and wellbeing of children and young people. In addition, the voices of children and young people and their families are essential in determining the needs of children and young people.

16. In relation to vulnerabilities linked to socio-economic deprivation, poverty and health inequalities across the child's life course, the following strategies and plans with priorities and actions are in place:

- Health and Well Being Strategy
- Children, Young Peoples and Families Plan 2011-14
- The Child and Family Poverty Strategy
- Early Intervention and Prevention Strategy
- Closing the Gap Strategy

17. In addition to the above strategic approaches, there are a number of universal and targeted services and tools to support children, young people and families, these include:
    - **The Early Years and Early Intervention Service:** provides a range of universal and targeted services for families with children aged 0-12 years who

are in need of support. Fifty-eight children's centres across Nottinghamshire provide a Core Offer and enhanced family support services. This includes parenting programmes and 1:1 family support in relation to parenting/behaviour/emotional health and wellbeing

- **Extending free early education to the most disadvantaged two-year-olds:** in Nottinghamshire, from September 2013, 1,625 Early Education places will be offered to two year olds from lower income families. This first part of the expansion of places to target the 20% most vulnerable children will include two year olds who live in households eligible for FSM or have a looked after status. From September 2014 the expansion will increase to meet 40% of two year olds

- **Targeted Youth Support:** this service is for young people who are vulnerable but not at immediate risk of harm. Targeted Youth Support is a partnership managed by Nottinghamshire County Council, involving the Police, health services, Probation Service and the voluntary sector

- **The Common Assessment Framework (CAF)** is a holistic assessment tool that can be used by all services working with children and young people to offer Early Help. The CAF supports practitioners to work in partnership with parents/carers, children and young people to identify strengths, needs and goals

- **The Nottinghamshire County Pathway to Provision** document sets out the range of services available across the County within specific thresholds of care

18. Universal health services are commissioned to support all children, young people and families and in many instances use targeted approaches to increase engagement with the vulnerable children and their families and work to reduce health inequalities. Universal health services include:

- **General Practitioners:** often the first point of access for families with health concerns about a child. Each Clinical Commissioning Group (CCG) has identified a GP with a special interest in children and young people's health who acts as the clinical lead and champion for children and young people's health within their CCG

- **Health Visiting:** as part of the national plan, good progress is being made to increase numbers of health visitors in post in Nottinghamshire, so capacity is available to deliver the Healthy Child Programme, to provide greater support to vulnerable families and to develop local community capacity, working closely with children's centres

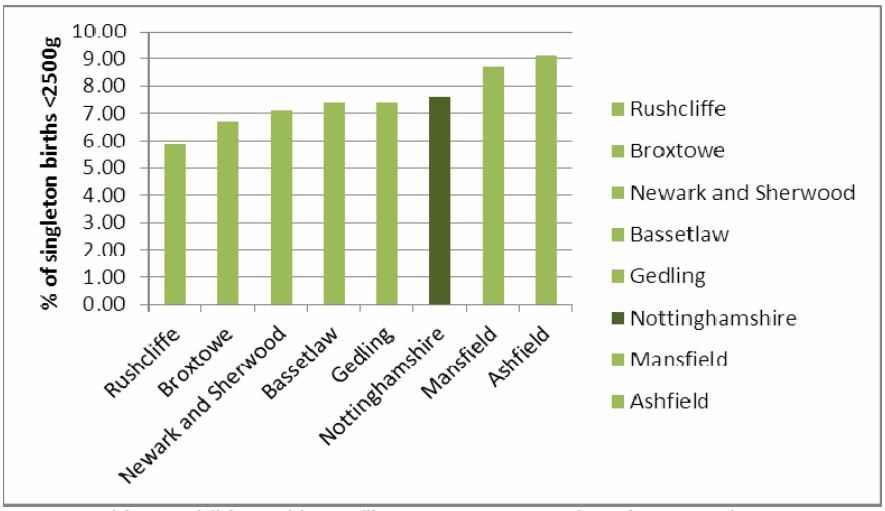
- **School Nursing:** a review of school nursing in Nottinghamshire is underway to ensure the service meets the health and wellbeing needs of children and young people across Nottinghamshire now and in the future. This includes

consideration of how the service supports vulnerable children. Findings from the review will influence future commissioning of the school nursing service.

Maternal and infant health

19. Women from poor families are more likely to have poor health and psychological problems during pregnancy. They are more likely to smoke, have poor nutrition and are more susceptible to genital infections, all significant determinants of the outcome of pregnancy, including birth weight. Birth weight in turn is an important determinant of infant health, mortality[15] and later adult health. Birth weight tends to decrease with decreasing socio economic status, a picture that is reflected in Nottinghamshire: in 2010, in England, 7.2% of all births were of babies with low birth weight, in Nottinghamshire the average was 7.1% while in Mansfield and Ashfield the figures were 9.1% and 8.5% respectively (see **Figure 2**).

Figure 2: Low birth weight (% singleton births <2500g) in Nottinghamshire, 2010



Source: ChiMat Child Health Profiles. Pregnancy and Early Years from ONS 2011 Compendium of clinical and health indicators 2010 data published in 2011.

20. Linked to birth weight, all causes of neonatal death show a socio-economic gradient, with higher infant mortality rates in the most deprived groups in the population[16].

The Nottinghamshire response

21. **Universal Maternity Services**: maternity services, including community midwifery services are provided to pregnant women in Nottinghamshire by Nottingham University Hospitals (NUH), Sherwood Forest Hospitals Foundation Trust (SFHFT) and Doncaster and Bassetlaw Hospitals Foundation Trust (DBHFT). Reviews are currently underway to ensure services are of high quality and are meeting the needs of women, including more vulnerable women. Of particular relevance is the extent to which services adopt guidance published by the National Institute for Health and Clinical Excellence (NICE) in relation to supporting women who are pregnant and have complex social needs.
22. **Family Nurse Partnership (FNP) Programme**: see paragraph 72

23. **Healthy Start Programme**: this national scheme is eligible to low-income pregnant women and families on benefits and tax credits, with the aim of improving the health of mother and baby. Healthy Start provides vouchers for families to spend on milk, fresh and frozen fruit and vegetables, and infant formula milk, plus free Healthy Start Vitamins for pregnant women and for those with children under the age of four. Healthy Start is available through certain children's centres and health centres across the County.

Children and young people with a disability or special educational need

24. Disabled children and young people face multiple barriers, making it more difficult for them to fulfil their potential, to achieve the outcomes their peers expect and to succeed in education. Families with a disabled child face a range of challenges that, in addition to the disability itself, increase vulnerability. These include: a higher rate of lone parenthood, parents less likely to be in full-time work, mothers less likely to be in work[17]. Other inequalities are evident. Black and minority ethnic families with a disabled child are more likely to live in poor-quality housing and the educational attainment of disabled children is unacceptably lower than that of non-disabled children. Families with disabled children report particularly high levels of unmet needs, isolation and stress.

25. In Nottinghamshire it is estimated that between 7,000 – 12,000 children and young people experience some form of disability with more than one in five children having a Special Educational Need. The numbers with life limiting and life threatening conditions has doubled over the last decade and there has been a 60% rise in young claimants (aged 0-24 years) of Disability Living Allowance over the last decade.

26. The prevalence of severe disability is increasing because more children and babies with complex needs are surviving for longer. This, together with projected increases in the population of children in Nottinghamshire, means that the number of children with disabilities will continue to increase over the next 15 years.

The Nottinghamshire response

27. **The Children with Disability and SEN Strategy**: implementation overseen by the Integrated Commissioning Group for Children with Disability and SEN.

28. **Special Educational Needs and Disability (SEND) Pathfinder, The One Project: t**he pathfinder is testing a single planning and assessment process, which from September 2014 will replace the statutory Statements of Special Education Needs (for under 16s) and Section 139a Learning Difficulty Assessments (for over 16s). Local authorities and CCGs will be required to make arrangements to ensure that services to meet the needs of disabled children and young people, and those with Special Educational Needs (SEN) are planned and commissioned jointly. It is also intended that the process will include an offer of a personal budget for all families with an Education, Health and Care Plan as a

means of offering more freedom of choice to families (detailed in the NHS Mandate).

29. **Integrated Children and Young People's Healthcare Programme:** the aim of this programme is to enable children and young people with acute and additional heath needs, including disability and complex needs, to have their health needs met wherever they are. The programme brings together providers of services, families, Nottingham City CCG, Nottingham North and East CCG, Bassetlaw CCG, Public Health and Nottinghamshire County Council to work to improve access to and co-ordination of community healthcare services for children and young people. This work is supported by the Children with Disability and SEN Strategy.

30. More broadly, health services for children include community and acute paediatric services, provided by NUH, SFHFT and DBHFT. These medical services are commissioned to assess and treat children and young people who have acute and long term medical problems, life limiting and life threatening conditions. Community paediatric services provide a consultant led community based service for children and young people under the age of 19 (or during transition into adulthood) who are vulnerable due to disease, disability and/or disadvantage. To improve access, services are delivered in a range of community settings. The provision includes the Child Protection/ Safeguarding Service, Medical Services for Children in Care, Designated and Named Doctor and Designated Doctor for Children in Care.

Children and young people excluded from school or not attending school

31. There are a range of negative outcomes associated with school exclusion, including a negative impact on emotional wellbeing, reduction in friendship networks, mental health problems, poor educational attainment and increased engaging in risk taking behaviours. Persistent non-attenders and school excludees are at particular risk of substance misuse and are more likely to take risks with their sexual health. For example, poor attendance at school is associated with higher teenage pregnancy rates[18].

32. Children who are eligible for free school meals are approximately four times more likely to receive a permanent exclusion than children who are not eligible for free school meals[19] .

33. For Nottinghamshire, Department for Education data shows the number of persistent absences remains in line with or below the national average[20]. Permanent exclusions are slightly above the national average for primary and secondary schools, but significantly lower for specials schools[21]. Fixed term exclusions in Nottinghamshire are slightly lower for primary, slightly higher for secondary and significantly lower for special schools than the national average.

The Nottinghamshire response

34. **The Early Years and Early Intervention Service: a**s highlighted previously, services are provided for families with children aged 0-12 years, which includes children not attending school.

35. **Supporting Families Programme:** this is the name given to the local delivery of the national Troubled Families Programme, a three year programme targeted at the most difficult to engage children, young people and their families. The Programme is funded by central government on a payment by results basis, focusing on reducing crime and anti-social behaviour, improving school attendance and engaging parents in work.

36. **Targeted Youth Support**: as highlighted previously, Targeted Youth Support works closely with the Youth Justice Service, recognising that about one in ten young people will require targeted support at some time during their teenage years. Not all young people needing targeted support are at risk of offending, but most young people who offend need targeted support. Targeted Youth Support works closely with the Youth Justice Service.

Young people not engaged in education training or employment

37. In Nottinghamshire 2.5% of 16-18 year olds are not in education, employment or training (NEET). Whilst this is well below the historical figure of 4%, there has been an increase in recording of *'not known'*. During 2012-13, the percentage '*not known'* has risen above previously recorded levels, though it is still below national and regional averages. In Nottinghamshire young people with a disability and teenage mothers are less likely to engage in education, training or employment.

38. There is a need to be mindful of the significant and often long term negative impact of NEET on a young person's future. In a survey by the Ministry of Justice, 40% of newly sentenced prisoners said they had been permanently excluded from school and 46% said they left school with no qualifications[22].

39. There is a range of poor health outcomes for this group including an increased likelihood that young people will use substances, have poor emotional health and become teenage parents.

The Nottinghamshire response

40. **Targeted Youth Support Service, Supporting Families Programme -** see paragraphs 35 and 36

41. **Nottinghamshire Futures** offers a complete, all-age, careers and employability advice service in Nottinghamshire. This service is part of Targeted Youth Support.

42. **Child and Adolescent Health Services (CAMHS):** a range of services are commissioned to meet the needs of children with emotional and mental health problems. This includes services in each of the seven districts, Specialist

Community CAMHS, CAMHS for Looked after Children and Highly Specialist CAMHS. A CAMHS review is planned for 2013 -14 to consider how services can develop to deliver improved access to psychological therapies and meet increasing demand, particularly in relation to eating disorders and self harm. This work is underpinned by a CAMHS Strategy, with implementation overseen by the Integrated Commissioning Group.

43. A multi-agency training programme is commissioned to support universal practitioners to promote children and young people's emotional health, wellbeing and resilience, **Healthy Young Minds.** This programme offers training to promote emotional health and wellbeing and resilience in children and young people together with specific training in the management of self-harm, attachment, depression and anxiety, conduct and behavioural difficulties, bereavement and loss and other related conditions.

44. **Substance Misuse Services:** See paragraphs 67 and 68.

Black and Minority Ethnic Groups

45. Some Black and Minority Ethnic (BME) children and young people groups experience higher incidences of certain physical and mental health conditions. The link between ethnicity and health outcomes is complex and a number of inter-related factors influence this situation, including income, educational attainment, social networks, occupation and employment[9].

Gypsy, Roma and Traveller Groups

46. Gypsy, Roma and Traveller (GRT) groups experience some of the worst outcomes of any ethnic or social group including: below average educational attainment; above average rates of miscarriage, still births and neo-natal deaths; widespread discrimination and hostility. GRT groups experience the highest levels of racial abuse of any ethnic group in the UK with 63% of young Travellers bullied or attacked[23] and 35% of people admitting to racism towards GRT groups[24].

47. There is often a strong familial support network, with an emphasis on a family centred culture where mothers support their daughters. However, a number of complex social, cultural and environmental barriers prevent many GRT groups from accessing essential health services. High levels of stigma and fear in relation to mental health, mistrust of public services and a lack of awareness of what services are available mean that people do not readily use health services, despite high levels of need.

48. In Nottinghamshire, the vast majority of GRT pupils registered on roll with schools are resident in Newark and Sherwood (76%) and at least 10% of the total population that are home educated are GRT children [25].

Asylum seekers

49. There are many factors that increase the vulnerability of a child or young person seeking asylum. Illegal migrant families are most vulnerable; they often stay in overcrowded conditions, rent privately and may regularly move home. Illegal migrant children often live in poverty as their parents' status limits their access to the job market and their recourse to action when working in exploitative conditions[26].

50. Unaccompanied asylum-seeking children (UASC) may have difficulty proving their age which leads to them being treated as adults. In these circumstances, by being judged as over 18, reduces their access to appropriate protection, safeguarding and young people focused services and can result in a young person being held in immigration detention[27]. In Nottinghamshire there were 43 UASC looked after during 2009, 72% of whom were aged 16 or over, a large increase since 2005 when there were only six UASC[28]. Asylum-seeking children have unclear immunisation histories and it is thought that the immunisation rates are low within this population group.

The Nottinghamshire response

51. Support to these groups of vulnerable children and young people is provided through services already detailed and through the work of the Nottinghamshire Safeguarding Children's Board (NSCB). Other relevant strategies include the Looked After Children Strategy, the Child and Family Poverty Strategy and the Strategy to prevent and tackle youth homelessness in Nottinghamshire.

Children and Young People in Need/with a Child Protection plan

52. The impact of witnessing violence in the home and being subjected to emotional, sexual or physical abuse has a long term negative impact on children and young people. In a survey of offenders, 41% reported witnessing violence in their home as a child and 29% reported emotional, sexual or physical abuse as a child[29] .

53. In Nottinghamshire over the last two and a half years there has been an increase in the number of children requiring social care input. In June 2010, 727 children required support from a social worker as part of a Child Protection Plan (CPP), compared with 765 children in December 2012, while the number of core assessments in the previous 12 months was 1,096 in June 2010, increasing to 2,104 by December 2012, a 92% increase. Children and young people in need or with a CPP are likely to have a number of services working with them including health visitors or school nurses.

54. The most common reason children became subjects of CPPs in 2009/10 was 'neglect' (32%), followed by 'emotional and physical abuse' (20%). Over 10% of children with CPPs in 2009/10 were from a black and minority ethnic background and over a third of all children with CPPs were in the 1-4 age range. The rates of children per 10,000 population becoming subject to a CPP was lower in the East Midlands than England.

Looked After Children and Care Leavers

55. Around 60% of looked after children (LAC) have some level of emotional and mental health problem and a high proportion experience poor health, educational and social outcomes after leaving care [30]. In comparison with their peers, LAC and care leavers are four to five times more likely to attempt suicide in adulthood; they have a five-fold increased risk of developing childhood mental, emotional and behavioural problems and a six to sevenfold increased risk of developing conduct disorders[9].

56. Being looked after is an important predictor of social exclusion in adulthood. Higher than average rates of poor mental health, drug use, poor sexual health, behaviour problems and poor educational attainment reduce prospects of employment, with significant cost to the individual and the state[31].

57. There is a higher proportion of LAC in the Youth Justice System; one in three children and young people in contact with the Criminal Justice System were looked after in their childhood[32]. A substantial majority of those living in care who also committed offences had already started to offend before they became looked after[33].

58. In Nottinghamshire, over the past two years and a half years, there has been a substantial growth in the number of children and young people looked after. In June 2010, 623 children were looked after, compared with 896 in December 2012, a 44% increase. Numbers are projected to increase further over the next year.

The Nottinghamshire response

59. There has been substantial increased investment in Children's Social Care Services in Nottinghamshire over the last four years, increasing from £50m in 2008 to £85m currently, in order to meet the needs of the increasing numbers of children with a CCP or who are looked after. In addition a range of safeguarding and child protection arrangements are in place:

- **The Multi Agency Safeguarding Hub (MASH):** the MASH is designed to improve and accelerate information sharing between agencies, involving close collaboration between Police, the Local Authority, Probation and the NHS to respond to safeguarding enquiries from professionals or the public

- **Nottinghamshire Safeguarding Children Board (NSCB)**: inter-agency training enables practitioners to safeguard and promote the welfare of children in their work. The NSCB aims to deliver high quality, up to date safeguarding training to enable participants to keep safeguarding and promoting the welfare of children at the centre of their work

- **The Looked After Children's Strategy: t**his strategy sets out a range of approaches to meet the needs of Looked After Children

- **The Children in Care Nursing Service** works closely with the Community Paediatric Service and Local Authority LAC Services to ensure that the heath needs of LAC are assessed and proactively met. This includes the completion of initial medicals and regular health reviews as a statutory requirement.

Child Sexual Exploitation (CSE)

60. A recent report by the Office of Children's Commissioner found that thousands of children are sexually abused by gangs and groups in England each year[34]. The report says that there were 2,409 victims in the 14 months to October 2011; it is likely that the true number is far higher. The report also identifies 16,500 children who were at "high risk of sexual exploitation" in 2010-11. A 'warning signs and vulnerabilities checklist' has been developed as a result of this work (Annex 1).

61. The inquiry informing the report received evidence of the devastating impact of the violent nature of CSE in gangs and groups. Areas of particular concern included: children going missing as a result of sexual exploitation; the health of victims (particularly drug and alcohol problems, self-harming and mental health; offending by victims either as part of the process of being exploited or as a consequence of it). 85% of the sexually-exploited young people interviewed had either self-harmed or attempted suicide as a result of CSE.

62. In Nottinghamshire, 1012 children and young people were reported missing in 2009. Of these, 25% went missing more than once. The highest numbers went missing in Mansfield (199), Ashfield (176), Bassetlaw (163) and Newark & Sherwood (162)[35].

The Nottinghamshire response

63. The Child Sexual Exploitation Cross Authority Group (CSECAG) is composed of representatives from statutory and third sector organisations in the City and County. The group is led by a senior police officer and is delivering work outlined in an action plan including: mapping to help identify the scale and nature of the problem; development of effective communication channels between the Local Safeguarding Children Boards (LSCBs) and partner agencies regarding CSE; development of a programme to enable engagement with young people regarding CSE; consideration as to how to minimise CSE risks to children and young people in children's homes.

64. This work is also underpinned by the NSCB Child Sexual Exploitation Strategy and Action Plan.

Young People using drugs and/or alcohol

65. Children and young people experiencing increased vulnerability (for example homeless young people, young people who have been sexually exploited, children looked after, teenage mothers and young people not in education, employment or training) have an increased risk of problematic substance use.

66. Those who smoke regularly, drink alcohol and experiment with drugs have an increased risk of starting sex under-16 (men and women) and teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience[36]. In Nottinghamshire, there were a total of 500 young people in specialist substance misuse treatment across the year (2008/09) – an increase of 15% from the previous year[37].

The Nottinghamshire response

67. **Substance Misuse Services:** there is a range of services available for young people in Nottinghamshire, commissioned by Targeted Youth Support Services and provided though Nottinghamshire Healthcare Trust. These include including What About Me (WAM), a service for children and young people affected by parental substance misuse.

68. This work is underpinned by the Young People's Substance Use Strategy and the Nottinghamshire Strategic Tobacco Alliance Plan.

Teenage parents and their children

69. Evidence is very clear that having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Teenage mothers are three times more likely to smoke during pregnancy, 50% less likely to breastfeed than older mothers and have a 63% increased risk of living in poverty compared to mothers in their twenties. Teenage mothers are three times more likely than older mothers to suffer postnatal depression and experience mental health problems in the first three years of their child's life[38]. Teenage mothers also have an increased risk of domestic abuse during the period just after giving birth[39].

70. The impact on the infant and child is seen in an increased rate of low birth weight babies born to teenager and infant mortality rates 60% higher than for babies born to older mothers. Children born to teenagers are more likely to experience a range of negative outcomes in later life; they are up to three times more likely to become a teenage parent themselves, to leave school at 16 with no qualifications, to experience domestic violence, to smoke and to experience poor mental health. Children of teenage mothers are more likely to have accidents and behavioural problems. A significant proportion of teenage mothers have more than one child whilst still a teenager. Nationally, around 20% of births conceived under-18 are second or subsequent births[40].

71. In Nottinghamshire the under-18 conception rate in 2010 was 32.9 conceptions per 1000 young women (461 conceptions with 44% of these resulting in termination). This is a reduction of 4.9% on 2009, and compares with an East Midlands average of 34.5 conceptions, and a national average of 35.5. The reduction in teenage conception rates in Nottinghamshire from 1998 is 29.1%, compared with a regional reduction of 29.3%, and a national reduction of 24.6 %. At district level there are marked variations in rates, with Mansfield and Ashfield having the highest teenage conception rates[41] and 'hot spot' wards within districts

where the rates are relatively high; these form the focus of continuing teenage pregnancy reduction activity.

The Nottinghamshire response

72. **Family Nurse Partnership (FNP) Programme**: this national evidence based programme has been commissioned jointly by Nottinghamshire County Council and Nottinghamshire CCGs and is now up and running. It focuses on vulnerable first time pregnant teenage women and has been shown to significantly improve health, social and economic outcomes for mothers and babies.

73. **Sexual Health and Contraception Services: t**here is a range of services across Nottinghamshire including a number of dedicated young people's services in localities of greatest need.

74. **C-Card condom scheme** is a condom distribution scheme for young people aged 13-19 years, offered in a range of settings including youth clubs, children's centres, health centres, colleges and schools.

75. **Teenage Pregnancy Training** is offered to the workforce across Nottinghamshire. The training aims to increase the skills and confidence of practitioners working in a range of settings to contribute to reductions in teenage pregnancies and to support teenage parents and their children to improve their outcomes.

Young People involved in Offending Behaviours

76. There are a number of adverse risk factors that disproportionately affect young people in contact with the Criminal Justice System[42]. These include:

- approximately 50% have problems with peer and family relationships
- 75% have a history of temporary or permanent school exclusion
- 66% come from a background where family structure has broken down
- 33% have been looked after by the Local Authority
- 33% have severe or complex mental health problems
- 25% have a learning disability or a physical disability
- over 50% have communication, speech and language and literacy problems
- many have histories that include high levels of smoking, alcohol and substance misuse
- high levels of dental health problems, sexually transmitted infections, asthma, blood borne virus infections such as Hepatitis B and C.

77. In many cases, children and young people in contact with the youth justice system have been exposed to multiple risk factors and traditionally they do not access universal preventive services[43].

78. The negative impact on mental health and wellbeing of using drugs and alcohol has been referred to in paragraphs 65 and 66 There are often direct links between heavy use of cannabis and alcohol and offending behaviour, with a

young person either offending to fund the habit or offending as a result of being under the influence of substances. In Nottinghamshire during 2012, young people in contact with the Youth Justice System reported a high use of substances, particularly tobacco, cannabis and alcohol. The use of class 'A' drugs (for example Heroin) had a very low incidence however. **Table 3** shows the percentage of young people in local settings who reported recently using substances.

Table 3: Recent use of substance in Nottinghamshire Youth Offending Service (YOS) and Clayfields Secure Children's Home

	Self-report recent use of…		
	Tobacco	**Cannabis**	**Alcohol**
Nottinghamshire Youth Offending Service (YOS)	76%	47%	65%
Clayfields House Secure Children's Home	69%	69%	52%

Source: Unpublished data 2012 Health Needs Assessment in YOS and Clayfields House SCH

79. Data collected at Clayfields House Secure Children's Home (SCH) shows that 54% of young people reported that substance use had a noticeable detrimental effect on their education, relationships and daily functioning, with an association between substance use and offending in 82% of cases[44].

The Nottinghamshire response

80. **Youth Offending Health Assessment Service:** a specialist nurse practitioner works within the Youth Offending Service (YOS), providing a screening health assessment and sign posting services to first time young offenders.

81. **The Nottinghamshire Strategic Tobacco Alliance Plan: a**ction to reduce the prevalence of smoking within this is group and young people more widely is lead by the group overseeing this plan.

82. **Clayfields House Secure Children's Home** - is a mixed gender secure residential children's home with 18 places available for children up to the age of 17, managed by Nottinghamshire County Council. From April 2013, Nottinghamshire Healthcare Trust (NHT) will act as the lead provider of health services, delivering a range of in-reach primary healthcare, CAMHS and substance misuse assessment, intervention and detoxification services to young people in Clayfields House.

Children affected by parental mental health, parental substance use, parental alcohol misuse and domestic violence

83. **Parental Mental Health** - households with a chronically ill person are among those with the highest levels of deprivation[45]. Children and young people

commonly undertake the role of a carer for a parent with mental health problems, with resulting negative impact on their own health[46].

84. **Parental Substance Misuse** - The Advisory Council on the Misuse of Drugs has estimated that there are between 200,000 and 300,000 children in England and Wales whose parent or parents have serious drug problems[47]. Those with a childhood history of abuse, neglect, trauma or poverty are disproportionately more likely to be affected by substance or alcohol misuse. In turn, the children of those dependent on drugs have to cope with the impact on their own lives and some may end up in local authority care[48] . It is estimated that up to 4,266 (2.7%) children and young people are affected by parents' illicit drug use in Nottinghamshire[49].

85. **Parental alcohol misuse** - parental alcohol and substance misuse is strongly correlated with family conflict, domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences. The Children's Commissioner reported that the number of children who are affected by or living with parental alcohol misuse is largely unknown but estimates that parental alcohol misuse is far more prevalent than parental drug misuse and there is a need for greater emphasis on parental alcohol misuse as distinct from other substance misuse[50].

86. Different patterns of consumption such as binge drinking, and not just dependency on alcohol, affect children and it cannot be assumed that higher levels of consumption equates to greater harm. Children living with problematic parental alcohol misuse come to the attention of services later than children living with parental drug misuse. Boys are less likely than girls to seek help, coming to the attention of services as a result of their behaviour or through Youth Offending Services, than for the harm they are experiencing.

87. In Nottinghamshire it is estimated that between 13,271 and 21,565 children (7.3 - 12%) are affected by parental problematic alcohol use.

Domestic Violence

88. The Health and Wellbeing Board received an in depth paper on domestic violence in January 2013, outlining the scale and impact of domestic violence in Nottinghamshire, together with information on the Nottinghamshire response. Suffice to say that approximately 75% of children living in households where domestic violence occurs are exposed to actual incidents. This group of children have an increased risk of developing acute and long term physical and emotional health problems[51], many are traumatised by what they witness and also at an increased risk themselves of abuse, death and serious injury[52] .

Young carers

89. The 2001 census identified 175,000 young carers in England. The impact of being a young carer varies according to the child's age and the extent of caring responsibilities deemed to be inappropriate. Younger children are more likely to

miss school and experience developmental delays, while older children may be more affected through feeling isolated or themselves misusing substances[53].

90. Children and young people frequently take on the role of carer when there is parental substance and alcohol misuse, experiencing emotional stress associated with feeling responsible for their parent's and other family members' welfare. Young carers most affected by such stress are those living with parental substance misuse or mental health problems [54].

91. In 2010, the BBC surveyed more than 4,000 secondary school pupils and found an "invisible army", 8% of those surveyed, taking on caring roles, including helping someone dress, bathe or shower. From the number of young carers based on the 2001 census, which was probably completed by parents, it had been estimated that only 2% of children were carers[55]. Professor Saul Becker, from Nottingham University's School of Sociology, said:

"The figures are a wake-up call to governments, carers' organisations, civil society as a whole, that in our midst are many children who are providing care to family members, often at the expense of their own childhood. Is this a situation that we can tolerate in our society that children are giving up to a large extent, their childhood?"

92. The true number of young carers aged 5 – 24 years in Nottinghamshire is unknown, but it is recognised that the number is significantly under-reported by the agencies working with them, due to the difficulty in identifying children and young people with inappropriate caring responsibilities. Applying 2001 census data to Nottinghamshire suggests that there are at least 3,100 young carers across the County. In Nottinghamshire, approximately 400 young carers are currently known to the Young Carers Service.

The Nottinghamshire response

93. **Young Carers Service:** the service works with a range of statutory, voluntary and independent sector partners to support young carers through assessing the needs of young carers, delivering tailored support directly to young carers, including positive activities, and providing training and advice to other professionals working with young carers. In order to ensure a continuing focus on support for young carers, a longer term strategy has been developed, the Nottinghamshire Young Carers Strategy.

Impact of changing family structures and vulnerability of children

94. Evidence suggests that children tend to enjoy better life outcomes when the same two parents are able to give them support and protection throughout their childhood[56]. Nationally, 28% of children in lone parent families live in poverty, compared with 17% for couple families[57] . In Nottinghamshire, 6.5% of families are described as one parent with dependent children, as compared to 7.1% for England. The percentage is slightly higher in Ashfield and Mansfield, at 7.9% and 7.4% respectively[58] .

Children and young people affected by poor housing conditions and/or homelessness

95. The relationship between poor housing and poor health for children and young people affected is well established, specifically in relation to fuel poverty, overcrowding, poor housing stock condition, affordability of housing, home security, fire safety and indoor pollutants.

96. Young people who are or have experienced homelessness are more likely than other groups to suffer a range of social, physical and mental health problems: they are twice as likely to suffer from psychiatric disorders; over a third have experienced physical or sexual violence; over a half have been bullied; levels of sexual activity tend to be high, leading to high levels of sexually transmitted infections and pregnancy, with up to 25% of homeless young women becoming pregnant within a year[59]. Research has also shown that young people living in supported housing can struggle to access a healthy diet due to gaps in their early health education and an inability to afford fresh healthy food.

97. For young offenders, having suitable accommodation arrangements significantly reduces the risk of re-offending. Young people released from custody have a wide range of needs and ensuring that they have access to suitable, stable accommodation is described by the Youth Justice Board as 'critical' if they are to engage or benefit from programmes crucial for effective rehabilitation[60]. A case worker in the secure estate shared that:

'If young people do not have somewhere safe to go they depend on others for accommodation which brings with it a lifestyle cost and makes them vulnerable[61].'

98. Homelessness in the East Midlands has increased by 24% in the last two years, with nearly 3,800 households accepted as homeless by local authorities in the region during 2011-12[62].

The Nottinghamshire response

99. **Targeted Youth Support**: as highlighted previously, the service works to support young people who are vulnerable, providing a range of services and interventions.

100. A number of existing strategies incorporate action to reduce family and youth homelessness including the **Child and Family Poverty Strategy** and the **Strategy to prevent and tackle youth homelessness in Nottinghamshire.**

101. **The Nottinghamshire County Pathway to Provision**, referred to previously, sets out clear thresholds for services available across the County. Environmental factors, including those relating to poor housing or homelessness can identify children and young people in need of targeted or specialist services.

Commissioning arrangements for children and young people's health services

102. From 1 April 2013, commissioning responsibilities for children and young people's health services are distributed across a number of commissioning organisations as shown below. There is a serious risk of fragmentation of service provision for children as a result of these changes:

- universal services 0-5 years (Health Visiting, Family Nurse Partnership) and immunisations and screening - NHS Commissioning Board (NCB) Area Teams
- universal services 5-19 years (School Nursing) - Public Health within the Local Authority
- CAMHS, community and secondary care paediatrics and therapy services (paediatric speech and language therapy, paediatric occupational therapy, paediatric physiotherapy), children's community nursing and Children Looked After nursing services, named and designated Safeguarding and Children Looked After doctors, termination of pregnancy services - Clinical Commissioning Groups (CCGs)
- Specialised children's health services, offender health (including Secure Children's Homes), HIV Treatment – NHS Commissioning Board Regional and National Teams

103. Following discussion with senior representatives of Nottinghamshire CCGs, the NCB Area Teams, Public Health and the Nottinghamshire Children's Trust, agreement has been reached to develop an integrated commissioning function/unit, which will have delegated commissioning responsibilities on behalf of CCGs, Public Health and Children, Families and Cultural Services for children's health services. The function/unit will report to the Children's Trust Board and ensure a multi-agency response to meeting the health needs of children.

104. Table 4 details the rationale for establishing an Integrated Commissioning Function. The agreed scope and areas for commissioning are shown in **Appendix 2.**

Table 4

Rationale for integrated commissioning for children's services:
▪ Whole system approach to planning and commissioning
▪ Maximise the quality of services for children and their families
▪ Focus on outcomes
▪ Reduce silo working and duplication
▪ Clear processes for engaging with children and families to inform commissioning
▪ Opportunity to integrate approaches to prevention
▪ Added value, greater savings, best use of available resources
▪ Clearer accountability
▪ Clearer links with recommendations from the JSNA and other in depth needs assessments to inform commissioning decisions
▪ In line with the Government's focus on better health outcomes for children

The Government's Pledge to improve outcomes for children and young people

105. On 19 February 2013, the Department of Health launched **Better health outcomes for children and young people: Our pledge** as part of the Government's response to the Children and Young People's Health Outcomes Forum. The Pledge has been developed in recognition of the fact that, nationally, outcomes for children and young people are poor in a number of areas, with marked room for improvement. System wide changes are required and the opportunity now exists in the new health and care system to focus on outcomes for children and young people, from conception through to adulthood.

106. The Pledge commits signatories to improving the health outcomes of children and young people so that they become amongst the best in the world, with a focus on five specific shared ambitions (see **Appendix 1**). The Department of Health is asking organisations who have the power to make a difference to sign up alongside the Government and do everything they can to improve the care that children and young people receive and reduce avoidable deaths. Many national organisations have already done so.

107. The Health and Wellbeing Board brings together all key players across the health and care system in Nottinghamshire and is thus in a position to improve health outcomes for children and young people. For this reason, the Board is asked to sign up to the Pledge.

Other Options Considered

108. No other options have been considered.

Reason/s for Recommendation/s

109. To ensure that the Health and Wellbeing Board has a full appreciation of the issues affecting vulnerable children and incorporates these into the Health and Wellbeing Strategy, to raise awareness of the developing arrangements for joint commissioning of services for children and young people. Lastly, to demonstrate commitment to the Government's pledge to improve the health and wellbeing of children.

Statutory and Policy Implications

110. 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

That the Health and Wellbeing Board:

1) is invited to comment on the current approach summarised in this paper to improving the health and wellbeing of vulnerable children and young people in Nottinghamshire.
2) considers what additional developments should be considered to reduce vulnerability and the impact on the health and wellbeing of children and young people in Nottinghamshire.
3) considers the health and wellbeing of vulnerable children, young people and families when developing the Health and Wellbeing Strategy for Nottinghamshire, recognising the importance of proactively identifying and target services to those children and young people who are most vulnerable whilst reducing contributory health inequality factors.
4) signs up to the Department of Health Pledge to improve health outcomes for children and young people, attached as **Appendix 1**.
5) endorses the establishment and scope of work of an Integrated Commissioning Function, as set out in **Appendix 2**.

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Constitutional Comments (LM 05/03/13)

111. The recommendations in the report are within the remit of the Health and Wellbeing Board.

Financial Comments (KLA 04/04/13)

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

Background Papers

Background papers comprise reference documents as listed on pages 24-26.

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

Electoral Division(s) and Member(s) Affected

All.

C0211

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Better health outcomes for children and young people

Our pledge

> “The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood.”
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

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APPENDIX 2

Services within the scope of the Nottinghamshire children's services Integrated Commissioning Function

- Public health services for children aged 0-5 (breast feeding, Healthy Start Programme)
- Public health services for children and young people aged 5-19 (school nursing)
- Child and Adolescent Mental Health Services (CAMHS) Tier 1/2/3
- Health services for Looked After Children (CAMHS/nursing/medical)
- Services for children with disabilities and SEN (community services)
- Elements of community paediatrics (where these relate to wider medical safeguarding, LAC and adoption roles, support to schools, disability and SEN services)
- Teenage pregnancy (C-Card Scheme, Teenage Pregnancy Training Programme
- Substance use services for young people
- Health services for young offenders in the community

Nottinghamshire County Council

Report to Health and Wellbeing Board

17th April 2013

Agenda Item: 6

REPORT OF THE SERVICE DIRECTOR PERSONAL CARE AND SUPPORT (OLDER PEOPLE)

UPDATE ON THE LIVING AT HOME PROGRAMME

Purpose of the Report

1. The purpose of the report is to update the Health and Wellbeing Board on the progress of the Living at Home Programme.

Information and Advice

2. Councillors Kevin Rostance and Stuart Wallace launched the Living at Home Programme to Adult Social Care and Health operational frontline staff during October and November 2012. The purpose of these events was to engage frontline staff in the delivery of the programme and to highlight the key aims and objectives of each of the six projects within the programme. During November and December the programme team then took forward a series of consultation and information events with a range of partners, stakeholders, service users and their carers to further develop links and collaborative opportunities across Nottinghamshire.

   Total permanent residential and nursing placements (adults aged 65+) were 2,822:
   Independent Sector Residential **1,898**
   Independent Sector Nursing **773**
   Local Authority **151**

   A total of 745 people were receiving free nursing care:
   some at a basic rate of £108.70 a week
   some at the higher rate of £149 a week

   16 older people received continuing health care, where Nottinghamshire County Council joint fund with Health (the amounts paid by health here are higher than the free nursing)

Project Updates

Care and Support Centres (Retained Residential Care Homes)

3. The project plan for the Care and Support Centres identifies a plan of work to increase the number of short term care and support services to suit local needs. Staff (Community Link Workers) from each centre are undertaking research in their local communities to identify what additional services could be provided to local people from the Care and Support

Centres. As a result of this work two of the centres are taking part in pilot activity to provide brief respite periods for carers or older adults where the caring relationship is at risk of breaking down, one Centre is also going to trial a bathing service.

4. Work is also being done to link in with work already being undertaken by the voluntary sector, such as Age UK and Alzheimer's Society to see how we can work together to support the overall aims of the Living at Home Programme. To assist with this, one of the Centres is also hosting a meeting of the voluntary sector groups at a venue in the centre of the County easily accessible for all of the groups.

5. Further work is also underway with regards to the finance of the Centres and existing contracts for plumbing, maintenance, utilities, food etc are being looked at. Corporate Procurement are assisting to establish that these contracts are as cost effective as possible and represent value for money. A briefing has been offered to each of the political parties about the programme.

6. A schedule of works has been developed to complete some landscaping and redecoration to improve the physical environment in the Care and Support Centre and this work has been completed or started in four of the centres with the other two planned to start soon.

7. In addition to this work additional funding has been identified to purchase new furniture and soft furnishings and linens as required for each of the bedrooms within the six Centres.

Extra Care

8. The recent procurement exercise identified a preferred bidder for the schemes in Eastwood and Retford. Work is continuing to ensure that formal contracts are completed and signed as soon as possible.

Department of Health Bid to the Care and Support Specialist Housing Fund with Mansfield District Council

9. The joint bid was submitted on 18th January 2013 with decisions expected in May 2013. There was an article in the Mansfield Chad that was very favourable with feedback from local people welcoming the scheme.

Gedling Homes

10. Officers are working with Gedling Homes and Gedling Borough Council to deliver an Extra Care Housing Scheme. The Council is able to enter into a public to public partnering arrangement and deliver a scheme designed to the Council's design brief in the Gedling District. The County Council would pay a subsidy to Gedling Homes who are investing in the refurbishment of the whole site so that the end result meets the Council's requirements in terms of it being suitable for people with Extra Care needs. As the work progresses and the exact funding required is established a further report will be submitted to Committee for formal approval to proceed.

Ashfield

11. Ashfield District Council have accommodation in Hucknall that they have been considering demolishing for some years. Officers and Councillor Rostance in the past have visited Ashfield District Council to enquire as to whether they would consider developing an Extra

Care Scheme on the site. This work was not progressed however, following a recent press release about the site in December 2012 contact was again made with Ashfield District Council with regards to the possibility of working in partnership in the delivery of an Extra Care scheme, they have also been given the Council's design brief so that when they were looking at the design of the scheme they could establish whether or not they could work with the requirements of the Council.

12. On 6th February 2013 there was a further meeting with the officer at Ashfield District Council who has agreed to look at the costings as a part of the appraisal of the scheme and come back to the Council as soon as possible. A letter has been drafted to this effect.

Assistive Technology (AT)

13. A draft project plan has been completed with timescales to agree the review of the current Nottinghamshire County Council website information for AT and the establishment in three Nottinghamshire County Council Care and Support Centres to enable staff, service users and carers to see AT equipment working in a real environment.

Admissions to Care

14. A briefing report has been completed identifying the current processes and procedures that are in place for operational staff to agree applications for admissions into long term care. This report has formed the basis of an options appraisal and business process review, which will enable more robust consideration of all applications prior to decisions being taken to agree an admission into long term care.

Joint Working with Health and Other Partners

15. A report has been completed focussing on the facilitation of hospital discharges and the future proposals for developing further the work with integrated discharge teams to reduce the numbers of people going into long term care directly from hospital. An officer will shortly begin working with the Community Programme (NUH); this is a collaborative opportunity between Nottinghamshire County Council and the trust to support the development of Comprehensive Geriatric Assessments for older people moving from hospital settings back into the community. Work is also underway across a number of Clinical Commissioning Group areas exploring better ways of working together across Health and Social care.

Reablement Project

16. Further work has been undertaken to increase the number of people accessing Reablement services and to develop and increase the number of assessment beds. The two main workstreams of activity include an assessment of the size of the service required for the future which in collaboration with health partners will identify key areas for expansion and secondly an activity to map existing processes to identify areas for improvement within the Reablement services generally.

Communications and Cultural Change

17. In addition to the projects outlined above there is a change management programme which will be implemented acknowledging and addressing the current cultural issues within the organisation and within partnering organisations. The programme has developed an intranet page as a tool to engage with operational staff and to ensure external partners can access

the relevant information. External partner publications have been utilised to promote the programme and bespoke presentations to Community Geriatricians, carers and service users, voluntary sector organisations and Trade Union colleagues have also been undertaken.

Current activities

18. Each of the projects has now produced their project plans, aims, objectives, initial business cases, risks and issues logs and benefits realisation plans. This work has also been done at a programme level. The full financial modelling is not yet completed as work is still underway with regards to the Base Budget Review.

19. The Living at Home board has been established and meets monthly to monitor risks, issues and report on highlights and project progress. The Board membership includes John Gladman, Professor of the Medicine of Older People at the University of Nottingham who has agreed to be a "critical friend" for the programme. In addition to this the programme produces monthly Highlight Reports for the Transformational Board.

Statutory and Policy Implications

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

Implications for Service Users

21. Equality Impact Assessments are to be developed for each of the projects as they progress.

Financial Implications

22. The financial implications are set out in paragraph 5 of the report.

RECOMMENDATION/S

1) It is recommended that the contents of the report are noted.

DAVID HAMILTON
Service Director for Personal Care and Support - Older Adults

For any enquiries about this report please contact:
Cherry Dunk
Strategic Development Programme Manager
Tel: (0115) 97 73268
Email: cherry.dunk@nottscc.gov.uk

Constitutional Comments

23. As the report is for noting only no constitutional comments are required.

Financial Comments (CLK 11.02.13)

24. The financial implications are contained within the body of the report.

Background Papers

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

a) 10th April 2008 – Modernising Services for Older People in Nottinghamshire – County Council (published):

http://dominoapps.nottscc.gov.uk/apps/pr/diary/memdiary.nsf/0/A04E3B8C7477E472802572CA0034B2E9/$file/09r_Modernising%20Services%20for%20Older%20People%20in%20Notts.pdf

b) 14th July 2010 – Aiming For Excellence - Cabinet report (published):

http://dominoapps.nottscc.gov.uk/apps/ce/memman/memman.nsf/26959B6CD01BFC578025761000320E95/$file/R10_aiming%20for%20excellence.pdf

c) 25th February 2010 – Aiming for Excellence - Council report (published):

http://dominoapps.nottscc.gov.uk/apps/ce/memman/memman.nsf/AEB0F3B095DA5E80802575FD0031ED98/$file/11_aiming%20for%20Excellence.pdf

http://dominoapps.nottscc.gov.uk/apps/ce/memman/memman.nsf/AEB0F3B095DA5E80802575FD0031ED98/$file/11_Aiming%20for%20Excellence%20App1.pdf

d) Equality Impact Assessment.

e) ITT documentation for Aiming for Excellence – Tender for Extra Care Housing.

Electoral Division(s) and Member(s) Affect

All

Nottinghamshire County Council

Report to the Health and Wellbeing Board

17 April 2013

Agenda Item: 7

REPORT OF THE CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

CODE OF CONDUCT AND DECLARATIONS OF INTEREST

Purpose of the Report

1. To explain how the County Council's Code of Conduct and requirements to declare interests will apply to the Health and Wellbeing Board, and report on discussion at the workshop on 27 March 2012.

Information and Advice

2. A report to the Board on 6 March 2013 indicated that the recently published regulations were silent about whether the Councillors' Code of Conduct would apply to the whole membership of the Board. Guidance was awaited to clarify this.

3. Guidance has now been issued by the Local Government Association and Association of Democratic Services Officers, making clear that "all voting members of health and wellbeing boards will be covered by the local authority's code of conduct".

4. The Health and Wellbeing Board workshop on 27 March discussed the County Council's Code of Conduct and arrangements for registering and declaring interests. Discussion at the workshop is reflected in the following paragraphs.

5. The Code of Conduct places emphasis on individuals' personal responsibility to abide by the seven "Nolan" principles for standards in public life, to register and declare their interests, and behave in a transparent and accountable manner.

6. The Code requires Board members to register their disclosable pecuniary interests (DPIs), to declare them at meetings where relevant and to refrain from discussion and voting where a matter on the agenda relates to that interest. Consideration is being given to the most effective way ensuring that Board members can participate as fully as possible in meetings.

7. Board members would usually be expected to register their home address as one of their DPIs. There is however scope to withhold "sensitive interests" from publication if disclosure would lead to violence or intimidation. In discussion at the workshop, some Board members were of the view that they would not wish

their home address to be published. The Monitoring Officer will individually consider requests from Board members if they wish their home address to be regarded as sensitive interests.

8. As well as disclosable pecuniary interests, Board members may have private interests which they should declare in meetings and would be recorded in the minutes. These could be non-pecuniary interests of any kind, or the pecuniary interests of wider family or friends.

9. Substitutes registering and declaring their interests was also discussed at the workshop. Board members are permitted to nominate substitutes to attend meetings in their absence. As these substitutes would be voting members of the Board, the requirements to comply with the Code of Conduct would apply to them. In order that substitutes can have prior knowledge of the Code and have registered their DPIs in advance of meetings, it was felt appropriate for Board members to nominate one or two substitutes. The County Council's Monitoring Officer has subsequently considered the matter, and is of the view that Board members should nominate one substitute.

10. There was also some discussion about who might best serve as substitute members. It was recognised that this was a decision for the nominating organisation, but that there were benefits for the Board in ensuring that the clinical viewpoint is well represented at meetings.

11. It was also felt that the range of substitutes for the two District Council representatives should be reconsidered. One option would be that each of the seven District Councils would have a named member who could be called on as a substitute if necessary.

12. The Code of Conduct requires interests to be registered within 28 days of taking office. For Board members, the deadline is therefore 28 April. In order that Board members may register their interests before the meeting on 17 April, guidance about the Code and related forms have already been sent to the non-County Councillor members.

13. Board members are encouraged to contact Democratic Services, in advance of meetings if possible, if they have any queries about the Code of Conduct or declarations of interest.

Other Options Considered

None.

Reason/s for Recommendation/s

To brief Board members on the Code of Conduct and declarations of interests.

Statutory and Policy Implications

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

RECOMMENDATION/S

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

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

For any enquiries about this report please contact:
Paul Davies, Democratic Services ext 73299

Constitutional Comments

As the report is for noting only, constitutional comments are not required.

Financial Comments (NR 8.4.13)

There are no financial implications arising directly from this report.

Background Papers

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

a. Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
b. Health and Wellbeing Boards: A Practical Guide to Governance and Constitutional Issues, LGA/ADSO, March 2013

Electoral Division(s) and Member(s) Affected

All.

APPENDIX 1

NOTTINGHAMSHIRE COUNTY COUNCIL

CODE OF CONDUCT FOR COUNCILLORS AND COOPTED MEMBERS

INTRODUCTION

1. The public is entitled to expect the highest standards of conduct from all Councillors and co-opted members of the County Council.

2. The Code sets out the standards of service that are expected from Councillors and co-opted members of the Council. In particular, Councillors and co-opted members should act in an open and transparent manner and should not do anything which would prejudice the reputation of the Council.

3. It is important Councillors and co-opted members understand their position as regards standards of conduct, and if in any doubt should seek guidance. This is because in some circumstances a breach of the Code could be a criminal offence and because any person could make a complaint to the Council if they believe a Councillor or co-opted member has breached the Code.

4. This Code is adopted in accordance with Section 27(2) of the Localism Act 2011.

UNDERLYING PRINCIPLES

5. As a Councillor or co-opted member of the Council you must have regard to the following principles – selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

GENERAL CONDUCT

6. Accordingly, when acting in your capacity as a Councillor or co-opted member:

    a. You must act solely in the public interest and should never improperly confer an advantage or disadvantage on any person or act to gain financial or other material benefits for yourself, your family, a friend or close associate;

    b. You must not place yourself under a financial or other obligation to outside individuals or organisations that might seek to influence you in the performance of your official duties;

    c. When carrying out your public duties you must make all choices, such as making public appointments, awarding contracts or recommending individuals for rewards or benefits, on merit;

    d. You are accountable for your decisions to the public and you must co-operate fully with whatever scrutiny is appropriate to your office;

e. You must be as open as possible about your decisions and actions and the decisions and actions of the Council and should be prepared to give reasons for those decisions and actions;

f. You must declare any private interests, both pecuniary and non-pecuniary, that relate to your public duties and must take steps to resolve any conflicts arising in a way that protects the public interest, including registering and declaring interests in a manner conforming with the procedures set out in the box below;

g. You must, when using or authorising the use by others of the resources of the Council, ensure that such resources are not used improperly for political purposes (including party political purposes) and you must have regard to any applicable Local Authority Code of Publicity made under the Local Government Act 1986;

h. You must promote and support high standards of conduct when serving in your public post, in particular as characterised by the above requirements, by leadership and example

REGISTERING AND DECLARING PECUNIARY AND NON-PECUNIARY INTERESTS

7. You must, within 28 days of taking office as a Councillor or co-opted member, notify the Council's Monitoring Officer of any Disclosable Pecuniary Interest (we have set out the definition of a Disclosable Pecuniary Interest in the Annex to this Code), where the pecuniary interest is yours, or that of your spouse, civil partner, or a person you are cohabiting with.

8. You must declare any Disclosable Pecuniary Interests and private interests, both pecuniary and non-pecuniary, to any meeting of the Council at which you are present and have an interest in any matter being considered.

9. If the interest being declared is a "sensitive interest" you only have to disclose the fact you have an interest but do not need to disclose the nature of the interest.

10. Following any disclosure of a Disclosable Pecuniary Interest not on the Council's register, you must notify the Monitoring Officer of the interest within 28 days of the date of disclosure.

11. Unless dispensation has been granted, you may not participate in any discussion of, vote on, or discharge any function related to any matter in which you have a Disclosable Pecuniary Interest.

12. Additionally, you are required to leave the room in which the meeting is being held whilst the matter is under consideration in accordance with the Council and Committee procedure rules, paragraphs 17 and 12 respectively.

SENSITIVE INTEREST

13. Where you are concerned that the disclosure of an interest would lead to you or a person connected with you being subject to violence or intimidation, you may request the Monitoring Officer to agree that the interest is a “sensitive interest”.

14. If the Monitoring Officer agrees, then you merely have to disclose the existence of the interest rather than the detail of it, at a meeting, and the Monitoring Officer can exclude the detail of the interest from the Council’s publicly available version of the register.

15. You must, within 28 days of becoming aware of any change of circumstances which means that information excluded is no longer a “sensitive interest”, notify the Council’s Monitoring Officer in writing.

ANNEX

DISCLOSABLE PECUNIARY INTERESTS

Interest	**Prescribed description**
Employment, office, trade, profession or vocation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the Council) made or provided within the previous 12 months (up to and including the date of notification of the interest) in respect of any expenses incurred by you carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between you, your spouse or civil partner or person with whom you are living as a spouse or civil partner (or a body in which you or they have a beneficial interest) and the Council (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged
Land	Any beneficial interest in land which is within the Council's area. For this purpose "land" includes an easement, servitude, interest or right in or over land which does not carry with it a right for you, your spouse, civil partner or person with whom you are living as a spouse or civil partner (alone or jointly with another) to occupy the land or to receive income.
Licences	Any licence (alone or jointly with others) to occupy land in the Council's area for a month or longer.
Corporate tenancies	Any tenancy where (to your knowledge) – (a) the landlord is the Council; and (b) the tenant is a body in which you, your spouse or civil partner or a person you are living with as a

	spouse or civil partner has a beneficial interest
Securities	Any beneficial interest in securities of a body where – (a) that body (to your knowledge) has a place of business or land in the Council's area; and (b) either – i. The total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or ii. If the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, your spouse or civil partner or person with whom you are living as a spouse or civil partner has a beneficial interest exceeds one hundredth of the total issued share capital of that class. For this purpose, "securities" means shares, debentures, debenture stock, loan stock, bonds, units of a collective investment scheme within the meaning of the Financial Services and Markets Act 2000 and other securities of any description, other than money deposited with a building society.

Nottinghamshire County Council

Report to Health and Wellbeing Board

17 April 2013

Agenda Item: 8

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

3. The attached work programme has been drafted in consultation with the Chairman and Vice-Chairman, 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)
17 April 2013	**Update on Sherwood Forest Hospitals Trust** (Dr Mark Jefford) **Vulnerable Children** (Anthony May / Kate Allen) **Living at Home Programme** (David Hamilton) **Code of Conduct & Declarations of Interest** (Martin Suthers)	
May 2013	**No Meeting – Council Elections**	
5 June 2013	**Verbal Update on Sherwood Forest Hospitals Trust** (Dr Mark Jefford) **Campaign to End Loneliness** (Mary Corcoran) **Children's Disability Needs Assessment** (Anthony May / Sue Gill) **Making Health Services Children Friendly** (Anthony May/ Kate Allen / Irene Kakoulis) **CCG Commissioning Plans** (TBC) **HealthWatch** (Joe Pidgeon)	
3 July 2013		**Sexual Health-** Action Planning
4 September 2013	**Homelessness** (Barbara Brady) **Update on Sherwood Forest Hospitals Trust** (Dr Mark Jefford) TBC	

	Winterbourne View Review (Jon Wilson) **Publication of Public Health Annual Report** (Chris Kenny)	
2 October 2013		**Vulnerable Children & Disability**
6 November 2013	**Health Checks** (John Tomlinson) **Verbal Update on Sherwood Forest Hospitals Trust** (Dr Mark Jefford) TBC	
4 December 2013		
8 January 2014		
5 February 2014		
5 March 2014		
2 April 2014		
7 May 2014		
4 June 2014		
2 July 2014		

Proposed Future Items (& suggested date)

Public Meeting	**Workshop**
• Workplace Health • Dental public health • Accidental injury prevention	• SHA review outcomes – scrutiny of QOF data / Quality of Primary Care services (May/July) • QIPP

• Campaigns to prevent cancer and long-term conditions • Interventions to reduce and prevent birth defects • Learning Disabilities • End of Life • Housing • Use of social media to portray health messages • Family & Friends Test for Bassetlaw • MASH report • Role of Police & Crime Commissioner	• Links with scrutiny