Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 02 October 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:-

Customer Services Centre 0300 500 80 80

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

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

Nottinghamshire County Council

minutes

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

Membership
Persons absent are marked with an 'A'

COUNCILLORS

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

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

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 (Vice-Chairman)
A	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 Paul Oliver	-	Nottingham North & East Clinical Commissioning Group

LOCAL HEALTHWATCH

A	Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

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

SUBSTITUTE MEMBERS IN ATTENDANCE

Claire Grainger	-	Healthwatch Nottinghamshire
Julie Bolus	-	NHS England

ALSO IN ATTENDANCE

Councillor Kay Cutts
Councillor Kate Foale

Amanda Sullivan - Chief Operating Officer, Ashfield and Mansfield and Newark and Sherwood CCGs
Lucy Dadge - Programme Director, Mid Nottinghamshire Integrated Care Transformation Board
Sue Gill – Head of Partnerships, Bassetlaw CCG
Rachel Tyler - Parent

OFFICERS IN ATTENDANCE

Kate Allen	-	Public Health
Paul Davies	-	Democratic Services
Sarah Everest	-	Public Health
Gill Oliver	-	Public Health
Penny Spice	-	Public Health
Cathy Quinn	-	Public Health

APPOINTMENT OF CHAIR

The appointment by the County Council of Councillor Joyce Bosnjak as Chair of the Health and Wellbeing Board was noted.

APPOINTMENT OF VICE-CHAIR

Dr Steve Kell was appointed Vice-Chair of the Board.

MINUTES

The minutes of the last meeting held on 17 April 2013 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Kell, Dr Sheikh, Joe Pidgeon and Helen Pledger.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

MEMBERSHIP AND TERMS OF REFERENCE

RESOLVED: 2013/022

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

MID NOTTINGHAMSHIRE NHS INTEGRATED CARE TRANSFORMATION PROGRAMME

Amanda Sullivan and Lucy Dadge gave a presentation about the Mid Nottinghamshire NHS Integrated Care Transformation Programme, the principles underlying it, and the next steps to be taken. They responded to questions and comments.

- GP surgeries in Newark were all located in the town centre. Might a practice be encouraged to relocate to the Newark Hospital site? - There had been in-principle discussions with the Sherwood Forest Hospitals Trust (SFHT) about primary care services on the hospital site, in addition to the Fernwood Unit, which was led by primary care.

- Could other hospital trusts learn from the experience of Sherwood Hospitals? How secure was the future of small rural hospitals? - Discussions about integrated care had begun in Bassetlaw, but were not as far advanced.

- This was an excellent example of working across organisations. The programme was likely to raise concerns, and the Health and Wellbeing Board, with its responsibility to promote joint working, was in a good position to help resolve or respond to those concerns. Nottinghamshire Integrated Care (formerly Productive Nottinghamshire) was drawing together best practice.

- It was important for programmes to be resourced properly if they were to work as well as pilot projects. - The estimated costs of the programme were best estimates.

- Assessments of service users were often repeated, giving rise to a loss of confidence in services. - This was recognised. The ward manager had a key role, and in the virtual ward, there would be a nominated key worker.

- Would clinicians have ownership of admission decisions? – Clinicians had been part of the work, and been challenged by it. Targets were ambitious but

achievable. It was pointed out that Nottingham North and East CCG had a project which would be starting soon.

- What were the plans for engaging the public? - It was planned to use existing groups in Ashfield and Mansfield and Newark and Sherwood to create a "citizens' board". There was also an extensive outreach programme, and a keenness to work with Healthwatch and members of SFHT and Nottingham Community Healthcare Trust.

- Was it realistic to offer 35 service lines at Kings Mill Hospital, and would they meet immediate needs? - The 35 service lines included Kings Mill and Newark Hospitals. There would be discussions with a view to reducing the number of lines.

- What was the communications strategy, at a time when the media often took a negative view? - There were some excellent facilities at both hospitals. As commissioners, the CCGs would be looking at whether they were getting the best outcomes.

RESOLVED: 2013/023

That the presentation be received.

JOINT WORKING TO IMPROVE THE CARE OF FRAIL ELDERLY PEOPLE

Dr Mansford introduced the report on joint working in Nottingham City and south Nottinghamshire to improve care for frail older people. Comments made during discussion included:

- Would the programme address complaints that service users were put to bed too early, or that care workers switched time between service users? - David Pearson stated that this should not happen. Care workers were monitored, and the County Council followed up issues raised with it. He referred also to the time it might take to arrange a care package, and to direct payments, which allowed service users to arrange their own package.

- Hospitals were not seen as part of the community. Rushcliffe CCG was encouraging hospital doctors to undertake some work in the community, and community based doctors to go into hospitals.

RESOLVED: 2013/024

That the report be noted.

AGENDA ORDER

The Chair agreed to alter the order of the agenda.

NEEDS ASSESSMENT FOR CHILDREN AND YOUNG PEOPLE WITH DISABILITIES AND/OR SPECIAL EDUCATIONAL NEEDS

Sue Gill introduced the report on the needs assessment for children and young people with disabilities and/or SEN in Nottinghamshire. Rachel Tyler spoke of her experiences as the parent of a child with learning disabilities. Officers responded to comments and queries.

- The requested changes seemed reasonable, and the proposals for a more integrated approach would appear to answer them. Could anything be achieved sooner rather than later? - Officers were already converting statements of special educational needs into individual health care plans.

- Would specialised commissioning be part of the integrated commissioning hub? – They were not, but could be invited to be involved.

- GPs might well see very few patients with complex needs. GP training sessions could be used to inform GPs of the programme. – Guidance had been sent to GPs, but there might be further thought about how information was presented.

- Information sharing had presented real challenges. Some progress had been made, but there remained cultural and legislative barriers. The Health and Wellbeing Board had a role in promoting better information sharing.

RESOLVED: 2013/025

(1) That the ongoing work be noted both in the Special Educational Needs and Disabilities Pathfinder and the Integrated Community Children and Young People's Healthcare Programme to move to an integrated model of commissioning and delivery for children and young people with disabilities and/or special educational needs.

(2) That the Board sign up to the Disabled Children's Charter for Health and Wellbeing Boards.

(3) That the Board receive an update on this area of work when the Children and Families Bill is published in 2014.

(4) That a report be presented to a future meeting on information sharing.

HEALTH AND SOCIAL CARE INTEGRATION PIONEERS

David Pearson introduced the report which invited support for the proposed bid to become a "pioneer" for integrating social care and health. The Mid Nottinghamshire Transformation Programme and Care of Frail Elderly People project would form part of the proposal.

RESOLVED: 2013/026

That the report be noted, and the Board support the submission of an expression of interest to become an integration pioneer.

LONELINESS IN OLDER PEOPLE

Gill Oliver and Penny Spice introduced the report on the health risks of loneliness, the Campaign to End Loneliness, and the action which the Board and partners could take. Comments by the Board included:

- It was important to embed the principles of the Campaign before it ended in March 2014; and for social care workers to be alert to loneliness as an issue.

- While participating in group activities was positive, such involvement often ceased when someone became unwell, thus putting them at risk of loneliness. Loneliness might be something which Patient Participation Groups could help to address.

- People should feel empowered to make contact with a lonely person. However this should be balanced against their privacy.

- Transport was an important factor. The County Council's integrated transport project (TITAN) could help, and Councils for Voluntary Service could contribute. People in sheltered accommodation could be lonely. Therefore arts projects could be useful.

- The Board should identify opportunities where a small amount of social spend could result in great health benefits. There was experience of this in Cornwall. Another example was art colleges and hairdressers working with care homes.

RESOLVED: 2013/027

(1) That the Board support the roll-out of the Campaign to End Loneliness across partners in Nottinghamshire.

(2) That the Board promote the incorporation of evidence-based measures to combat loneliness in all service proposals for relevant care groups.

(3) That the Board promote work with non-statutory sector partners to combat loneliness.

(4) That the Board continue to monitor the impact of measures to address loneliness locally through both the Outcomes Framework and Annual Satisfaction Survey.

HEALTH AND WELLBEING CONSULTATION PLAN 2014/15

Suggestions for inclusion in the draft strategy were greater emphasis on the Board's role to promote integration and on the role of housing.

RESOLVED: 2013/028

(1) That the plan to review the Health and Wellbeing Strategy for 2014 onwards be noted.

(2) That the comments made be reflected during consultation on the strategy.

(3) That a further report be presented in September on progress against the priorities and the full review of the strategy.

WORK PROGRAMME

The Chair indicated that the County Council was considering changing the composition of the Board to include a representative from each district council and from the Police and Crime Commissioner. She emphasised the value in terms of continuity for organisations to have named representatives.

Non-accidental injuries were suggested as a possible future item. Anthony May stated that this was a responsibility of the Children's Safeguarding Board, but he would check whether there were significant issues to bring to the Board.

Another suggestion was the effectiveness of the Health and Wellbeing Strategy on the population. It was explained that this was measured through the outcomes framework, and through priorities set by the Health and Wellbeing Implementation Group for the groups which reported to it.

RESOLVED: 2013/029

That the work programme be noted.

The meeting closed at 5.05 pm.

CHAIR

Nottinghamshire County Council

Report to Health and Wellbeing Board

2 October 2013

Agenda Item: 4

REPORT OF THE SERVICE DIRECTOR, CHILDREN'S SOCIAL CARE

CHILDREN WHO GO MISSING FROM HOME OR CARE: END OF YEAR REPORT 2012/13

Purpose of the Report

1. The purpose of the report is to update members of the Health & Wellbeing Board on the activity and progress relating to children who go missing from home or care within Nottinghamshire during 2012-13. The report highlights accomplishments during the year and the priorities for 2013-14. These priorities will build on the strong foundations within Nottinghamshire as this area of work has been invested in and been a priority for both Children's Social Care and the Nottinghamshire Safeguarding Children Board (NSCB).

Information and Advice

Background

2. A brief definition of a missing child is one *'who is absent from their home or placement without permission for any length of time where their age, experience, background or ability make this a concern' (*NSCB Protocol). The Police definition adopted within Nottinghamshire is that a missing person is one *'whose whereabouts are unknown, whatever the circumstances of disappearance. He or she will be considered missing until located and his or her wellbeing, or otherwise, established'* (ACPO (Association of Chief Police Officers) / NSCB Protocol). The ACPO guidance has recently been revised and the Department for Education Statutory Guidance is being reviewed; this will result in the NSCB protocol being updated in due course to take into account both revisions.

3. The issue of children who go missing from home or care is a safeguarding issue as some children who go missing may be at risk of or suffering from harm due to going missing. Children from all backgrounds may run away in response to problems that are making them unhappy or feel unsafe. There are also clear links between child sexual exploitation and going missing which are taken into account in the work we do. Children who go missing from care are clearly a specific group of children who are of concern as they are particularly vulnerable.

4. The Children's Society research (2011 Still Running 3) indicates that running away is still a problem nationally and it thus remains a priority for the NSCB.

5. A wealth of local data relating to missing children is collated quarterly with the aim of developing understanding and analysis around the subject of missing children. An accompanying presentation will show some of the detail that is available and work is ongoing to improve our understanding and apply the information usefully. It is regretful that there is no national data which would enable national or local comparison but research by Ofsted and the voluntary sector provides an opportunity for a degree of practice comparison.

6. The information from research and the Nottinghamshire data available would indicate that the work around children who go missing within Nottinghamshire is positive and that the work is developing and progressing.

Governance

7. The strategy and the development of missing children work is undertaken through a multi-agency steering group. There has been quarterly reporting to the NSCB through the Performance and Quality Sub-Group and, as of this year, annually to the Board.

National and Local Strategy and Partnerships

8. The local NSCB protocol '*Children Who Go Missing From, Home, Care or Education Protocol (2012*)' guides our work. The protocol derives from statutory guidance (2009) and from a Home Office strategy (2011). Work is also informed by a raft of guidance and research which either relates to or is closely aligned to child sexual exploitation.

9. All of the work around missing children is multi-agency; this is reflected in the steering group although the lead agencies are the Police and Children's Social Care.

10. Three main multi-agency, cross-authority training events were held during the 2012-13 which attracted a wide variety of participants and the subject is also regularly raised at other events i.e. NSCB 'What's New' events. More formal training is planned for 2013/14 when the DfE has revised the statutory guidance although there are ongoing briefings and information sharing meetings where possible.

Current Service Provision

11. A clear process is followed once a child is reported missing; in brief:

- the Police receive a call from a parent or carer to report a child missing
- the Police visit the home or residence of the child and take a missing child report
- Children's Social Care (CSC) is notified of the missing report (called an episode)
- when the child is found the Police will complete a 'safe and well' check
- where there is a delay in the child being found there is an ongoing dialogue between the Police and CSC Children Missing Officer (CMO)
- CSC are sent a 'found' report by the Police
- the CSC Children Missing Officer co-ordinates the request for a return interview or a multi-agency meeting from the relevant team
- a worker will visit the child to complete the return interview and possibly co-ordinate a multi-agency meeting.

12. A return interview should be completed within 72 hours and is an opportunity for the young person to discuss why they have gone missing and for the worker to plan help and support. A multi-agency meeting is an opportunity for professionals to co-ordinate a response to the young person going missing and agree an appropriate plan.

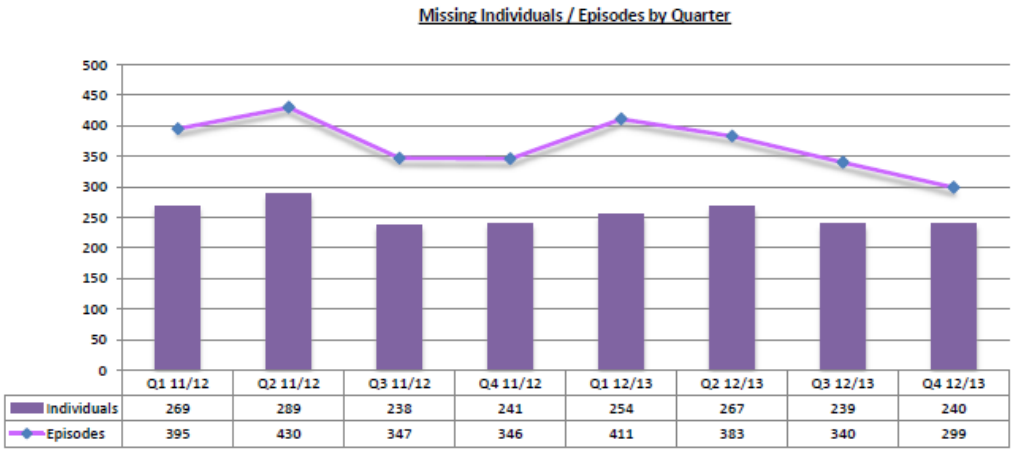
- a return interview is held when the young person has gone missing for the second time, or the first time if there are particular vulnerabilities identified or they have been missing for 24 hours
- a multi-agency meeting will be held after the third time of going missing, or the young person has been missing for 72 hours or if they are engaged in risky behaviour.

13. In 2012/13 the majority of requests (57%) for return interviews were made to Children's Social Care with 6% to Targeted Support. 23% went to the Runaways Service which is a partnership between Catch 22 (a voluntary agency) and Targeted Support. The Runaways Service responds where the young person is not known to other services. The remaining 14% of requests went to Other Local Authorities who had children placed within Nottinghamshire boundaries, usually in private residential homes or independent foster placements.

Data

14. The key findings for 2012/13 are as follows:

- there were 1,433 missing notifications (6% reduction on 2011/12)
- this related to 776 individual children (10% reduction on 2011/12)
- the number of children who go repeatedly missing appears to have decreased



	Q1 11/12	Q2 11/12	Q3 11/12	Q4 11/12	Q1 12/13	Q2 12/13	Q3 12/13	Q4 12/13
Individuals	269	289	238	241	254	267	239	240
Episodes	395	430	347	346	411	383	340	299

- the gender of children who go missing is 50:50 male: female
- the ethnicity of children going missing roughly reflects the child population within Nottinghamshire
- the peak age range of children going missing is 13-17 years

- the percentage of children in the general population who went missing last year was approximately 0.5%. A higher percentage of children who are looked after go missing.

- data is being analysed to identify whether or not there are particular areas/hot spots where there is a higher or lower incidence of young people going missing

- the majority of Nottinghamshire children return home or to their placement within 24 hours

- the reasons young people give for going missing are varied but mostly about relationships with parents but also some school based issues or drug and alcohol factors

Main Achievements

15. A comprehensive strategy and action plan has been completed which both reflects the work currently being done and that planned (**Appendix 1**).

16. We have improved on the recording and reporting of missing children.

17. The data indicates that the number of children going missing has reduced over the last year.

18. There has been an improvement in the completion of both return interview and multi-agency meeting compliance although this is something that we are determined to improve further. What works well however, and is a positive feature of the work we do, is the monitoring and tracking of this by the Children Missing Officer.

19. There has also been pro-active work to ensure that any Nottinghamshire child who is placed out of the County is responded to in the event that they go missing. This work will continue over the coming year. Details of the Nottinghamshire Looked After Children population, their placement types and geographical location are attached as **Appendix 2** and will be covered in the presentation.

20. Nottinghamshire has also been working with private providers of residential care homes and private fostering companies in Nottinghamshire and continues to work with other local authorities who have children placed in Nottinghamshire. This recognises that children placed at a distance from their home are potentially more vulnerable. It also recognises that from a multi-agency point of view Nottinghamshire Police have to respond to instances of children missing and that there may be a potential impact on Nottinghamshire as an Authority if there were to be significant incident of harm occurring to a child within our boundaries.

Key priorities for 2013/14

21. There is a work plan for the coming year and the priorities are to:

- review the NSCB missing children protocol in response to the anticipated revised Statutory Guidance
- improve the number of missing interviews completed

- improve the quality assurance work we do; particularly evaluating the quality of the return interview process and intervention in terms of the outcome for the child
- improve our engagement with young people to ensure their voice is heard
- ensure a more sophisticated analysis of the data, looking at 'hot spots' and repeat missing persons as well as understanding of any risk or harm the child has experienced
- monitor the use of disruption techniques by the police i.e. child abduction warning notices
- strengthen intelligence sharing processes with the police
- further develop work with the looked after children's teams including a focus on children placed out of the County.

Other Options Considered

22. The report is for noting only.

Reason/s for Recommendation/s

23. The report is for noting only.

Statutory and Policy Implications

24. 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.

Safeguarding of Children Implications

25. The Children Missing from Home and Care protocol is issued under the Nottinghamshire Safeguarding Children Board procedures, the governance of which is through the NSCB.

RECOMMENDATION/S

1) That the update on the activity relating to children who go missing from home or care within Nottinghamshire during 2012-13 and the progress made with regard to the response to those children who go missing from home or care be noted.

Steve Edwards
Service Director, Children's Social Care

For any enquiries about this report please contact:

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Service Manager, Safeguarding (Strategic)
T: 0115 9773921
E: terri.johnson@nottscc.gov.uk

Constitutional Comments

26. As this report is for noting only, no Constitutional Comments are required.

Financial Comments (ZM 18/09/13)

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

Background Papers and Published Documents

Children who go missing from home, care or education protocol – Nottinghamshire Safeguarding Children Board, 2012
Children Who Run Away or Go Missing from Home or Care – DfE Statutory Guidance, July 2009
Missing Children and Adults: A Cross Government Strategy – Home Office, December 2011
Still Running 3: early findings from our third national survey of runaways 2011 – Children's Society

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.

C0294

Missing Children
Multi-Agency Strategy 2013-14

Working Together to Safeguard Children going Missing from Home & Care in Nottinghamshire

Nottinghamshire
SAFEGUARDING
CHILDREN Board

Statement of Intent

Children who go missing from home and care are an extremely vulnerable group of children and young people. It is estimated that nationally every year there are approximately 240,000 notifications of children going missing which relate to approximately 140,000 children. Within Nottinghamshire in 2012/13 there were 1440 missing notifications which related to 776 individual children.

Missing children is a safeguarding issue as, whilst the majority of children who go missing return quickly, many others will either be at risk of or suffer harm in the form of physical abuse or sexual exploitation. They may sleep rough or commit crimes to survive and their physical and emotional health may suffer as well as their general health, education and social relationships. There are also links between going missing, being sexually exploited and trafficking.

From research there are many reasons why children go missing from home or care often referred to as push-pull factors; for example they may be pushed away from home or pulled towards something. Children who go missing from care are an especially vulnerable group of children, 21% of the individual numbers of children who went missing within Nottinghamshire in 2012-13 were from care and 79% were from home.

We will develop an effective local strategy to ensure a co-ordinated multi-agency response to children going missing from home or care.

It is our clear intent to contribute to improving the lives of children living in Nottinghamshire both within home and care. We will do so by ensuring children and young people understand the risks of going missing and of being exploited. This will lead to better outcomes for children and young people.

This strategy and action plan is based on *Missing Children and Adults: A cross Government Strategy* (Home Office 2011) and on the Statutory Guidance on children who run away and go missing from home of care (DfCSF 2009) as well as the Nottinghamshire Safeguarding Children Board (NSCB) Inter-agency Practice Guidance *Children Who Go Missing from Home, Care or Education Protocol* (May 2011) and the All Party Parliamentary Group (APPG) '*Report from the Joint Enquiry into Children who go missing from care'* (July 2012). It will be updated as required in line with developments from central government and policy, practice or research.

The strategy covers children of all ages that are reported missing to the police and meets the criteria within the protocol.

The strategy for 2012-2014 has an emphasis on:

- Prevention: Reducing the number of children who go missing
- Protection: Reducing the risk of harm to those who go missing
- Provision: Providing missing children & families with support and Guidance

Our key strategic priorities are:

- Mapping data and needs in relation to levels of missing children
- Putting systems in place to effectively respond to children who go missing
- To offer children who go missing a return interview in a timely manner (in line with the *missing protocol*)
- Increase understanding & awareness of missing children issues among children, their parents and carers as well as with professionals
- Ensure a multi-agency response to meeting the needs of children and young people who go missing

How we will achieve our priorities?

There is a strategic service manger lead for missing children within NCC as well as a dedicated police manager.

A multi-agency missing children steering group will meet regularly to monitor and progress strategy and planning taking into account new legislation, research, policy or guidance.

Strategic planning and working in a multi-agency way will enable us to work collaboratively, consistently, and effectively to improve the lives of children and young people at risk of harm from going missing from home or care.

The missing children steering group will:

- Take a strategic lead in the co-ordination of children who go missing
- Scrutinise performance taking a robust approach to data collation and analysis to inform practice.
- Drive forward and support the multi-agency work that needs to be done to tackle missing children

The work of the group will report to the Nottinghamshire Safeguarding Children Board (NSCB) Performance and Quality Sub-Group. Elected members will also be updated annually.

Prevention	
What are we going to do?	How will we do it?
Ensure that there are clear policies and processes to support the work of responding to missing children.	Through the provision of cross-authority inter-agency practice guidance and standards to professionals involved in responding to missing notifications. There is also Nottinghamshire practice guidance available for staff.
Have an understanding of the 'picture' and context of 'missing' in Nottinghamshire and whether there are locations or venues which are high risk and where children are regularly going missing.	The police and local authority will collate and share data which will be analysed to identify hot spots which will then be targeted and shared as appropriate with partner agencies.
Develop a better understanding of the reasons why children and young people run away and go missing from home and care.	By the use of data collated from return interviews to try and understand the reasons why children go missing from home or care and consider if a strategic response is required. Through the use of available research to develop a complete picture of missing and to identify actions and practices for tackling missing in a preventative and early intervention way.
Ensure that colleagues working with, or in contact with, children understand missing children issues to support them in developing intervention strategies to prevent escalation.	Through multi-agency training and development to ensure staff have sufficient awareness of missing children issues.
Ensure that colleagues working with, or in contact with children who go missing, understand the impact children may suffer upon their physical and emotional health.	Through multi-agency training and development to ensure staff have sufficient awareness of the possible impacts on physical and emotional health and awareness of the services available.
Offer support to schools to deliver an education package to the children and young people of Nottinghamshire designed to heighten awareness and reduce risk taking. Encourage schools to access and deliver CEOP Thinkuknow	Develop and deliver a package of training resources for young people. Engage with schools to raise awareness of the CEOP training

training.	resources.
Improve connectivity with both the local authority & private provider residential sector and fostering services to ensure that there are policies and practice to minimise the likelihood of children going missing and respond appropriately when they do. Endeavour to support foster carers and residential staff in their understanding of what they can do to make running away less likely.	Include the residential and fostering service in policy and practice development and in training. By sharing information from the Ofsted report 'Running Away' 2012 away with colleagues. We will share children's views about the need to be listened to, to have understanding about why they go missing, to feel supported, to feel cared about and their need to be supported by help to sort out their problems. Through an emphasis on missing children within the LAC strategy. Take on board the messages from the APPG inquiry into children missing from care (2012)
We will ensure that the link between going missing and child sexual exploitation (CSE) is well known and understood.	Emphasise the link within our policies, procedures, training and awareness raising and ensure that those who undertake return interviews are aware. Ensure there is a clear remit within the Missing Children multi-agency steering group to maintain the link to CSE. The strategic lead within social care has responsibility for both missing children and CSE and the Police Manager also has links to both. CSE is a priority area within the NSCB action plan for 2012-13 and is an issue subject to a cross-authority group.

Protection	
What are we going to do?	How are we going to do it?
We have a multi-agency co-ordinated approach to missing children.	We will do this through our partnership working at a strategic level i.e. through the work of the missing children steering group and at a practical and operational level to information sharing and planning at multi-agency meetings.
Information sharing is a critical factor in correctly identifying vulnerability and in ensuring that children are found quickly.	Agencies will share information and intelligence with each other to assist in the rapid location of young people.
The police will inform the Local Authority of all missing children notifications and subsequent found notifications. The police will respond robustly in investigating missing children.	Automatic missing and found notifications will be sent to Children's Social Care who will screen them. The police will make efforts to locate missing children using available information and intelligence and using a robust risk assessment model.
Using the information and data gathered from return interview at a strategic level we will endeavour to better understand the reasons why children and young people run away and go missing from home.	We will use this information to respond on an individual level to the young person by seeking appropriate support. We will use this data to review any trends and these to inform service provision.
We will intervene at an early stage of a child or young person going missing to attempt to reduce the risk of them going missing again and to reduce the harm they may suffer if they go missing again.	Children will be offered a return interview either the first time they go missing if the concerns are significant or otherwise they will be offered a return interview on the second and subsequent missing occasions. Multi-agency meetings, co-ordinated by the social worker or targeted support worker will also be held as per the criteria to enable a co-ordinated response. We will identify children at risk of going missing at an early stage to enable an assessment of their needs through the completion of a return interview to then enable appropriate support and

	intervention to reduce the factors which will cause the young person to remain in a risky situation. Through multi-agency meetings we will seek the commitment of all agencies to work with the young person and their family to agree plans of support to address, for example physical and emotional and emotional health issues identified or educational issues or any other specific need. Where appropriate safeguarding procedures will be followed. The police will lead in the use of disruption strategies as appropriate
We will ensure that there is a robust approach to completing return interviews and multi-agency meetings.	We will robustly monitor and track compliance of the undertaking of return interviews and multi-agency meetings.
Information and data will be collected and reported on regularly to ensure that there is oversight of the 'problem' and response.	Regular reporting will be undertaken and shared with partners at the missing children steering group and the Performance & Quality Sub-Group to enable scrutiny and governance. A performance framework and management information data set will be developed with the support of analysts.
We will ensure that we seek national support through the Missing Person's Bureau and CEOP to review cases where appropriate.	The Police lead officers will access this resource as required.

Provision	
What are we going to do?	How are we going to do it?
We will ensure that services to young people and families are of a high standard and that safety and well being remain paramount.	We will ensure that young people receive a service in a timely manner. We will ensure that young people and their family receive a supportive and effective service or that they are signposted to the appropriate service. We will audit cases to ensure that the quality of the work is good.

Missing Children
Multi-Agency ACTION PLAN 2013-14

Working Together to Safeguard Children going Missing from Home & Care in Nottinghamshire

Nottinghamshire SAFEGUARDING CHILDREN Board

Overarching strategy and governance

Responsibility

There will be an effective local strategy to ensure there is a co-ordinated multi-agency response to children missing from home and care based on a robust, thorough risk assessment of the extent and nature of missing children locally. The work on missing will be monitored through the Missing Children Steering Group and ultimately by the Performance & Quality Sub-Group of the Nottinghamshire Safeguarding Children Board. .

Action	Lead	Timescale	Progress to date	Rag Rating
a) Complete a Strategy Document	Terri Johnson		Complete	
b) Complete an Action Plan	Terri Johnson	June 2013	Complete	
c) Complete revised terms of Reference for the cross-authority group	Terri Johnson		Complete	
d) Update the cross-authority protocol to reflect national policy and practice	Terri Johnson		Awaiting the DfE revised guidance.	
e) The APPG inquiry for Runaways to be absorbed.	Terri Johnson		Partially done - ongoing.	

1. Prevention

Reduce the number of children going missing

The ambition is to protect and prevent children from going missing. We need to reduce the number of children going missing and to have effective prevention strategies, education work and early intervention by agencies in repeat cases. This will help to reduce the vulnerability and likelihood of vulnerable children going missing and reduce the number of repeat cases.

Action	Lead	Timescale	Progress to date	Rag Rating
1.1 Establish effective communication channels between NSCB and partner agencies to share information and training	Terri Johnson Missing Children steering group	Ongoing	A multi-agency steering group meets quarterly Training within 2011/12 & 2012/13 has been undertaken. Training for 2013/14 is planned and missing issues are regularly raised at NSCB 'What's New'. Visits to teams are undertaken and a session at the Schools 'Designated Person's' Forum has been done in 12/13.	
1.2 To provide current inter-agency practice guidance.	Terri Johnson Viv McCrossen (City) Emma Adams (Police)		As per (d) awaiting the DfE revised guidance.	
1.3 To develop LA practice guidance (PPG)	Terri Johnson		This has been signed off at OMT is on Tri-Ex.	
1.4 Establish an effective independent service to respond to missing notifications for those	Terri Johnson		The service is now up and running, the contract is monitored quarterly. The effectiveness is currently subject to	

children who do not have a social worker or other statutory worker. 1.4.1 Monitor compliance with RI & MAM requirements and timeliness.	Denis McCarthy		challenge and scrutiny and issues about performance have been escalated to the TSS.	
1.5 Children who have a social worker or statutory worker will receive a return interview and associated support in line with the protocol. 1.5.1 Monitor compliance with RI & MAM requirements and timeliness.	Terri Johnson Carl Riley	Ongoing	Compliance has improved year on year but there is still room for improvement. Work with the LAC team has been undertaken and other teams need to be re-visited. Escalation to team manager is done on a monthly basis.	
1.6 To develop a clear preventative strategy for engaging with schools and young people and for this to be reported on quarterly.	Denis McCarthy		The TSS have been requested to report on this through the contract meeting. More connectivity between this strategically and operationally is planned. This work is unlikely to develop any further at present due to vacancies.	
1.6.1 To absorb the Children's Society report 'Lessons to Learn' looking at the link between running away and absence.	Terri Johnson Denis Mccarthy	Meeting in diary for Sept.	Mtg required to evaluate work needed.	
1.7 To engage with private providers (fostering and residential) to raise awareness of the missing children inter-agency practice guidance and for this to be reported on quarterly.	Terri Johnson Service Manager Placements		Specific training was provided in 2011 and again in 2013 to private providers. Private providers linked to the LA have references to missing within their contract and notify the LA when they have children placed. Further training via the NSCB will be provided once the DfE Statutory Guidance	

			and the Protocol have been revised.	
1.8 To share information with fostering and residential staff (LA and PP) on ways to reduce the risk of missing children including the views of children.			This work needs to be formalised and build on previous training and engagement. A training event for later in the year is planned.	
1.9 To reflect missing children and CSE in the LA LAC strategy.	Terri Johnson		There is already a brief reference to missing children but consideration needs to be given to this being more explicit when it is next revised.	
1.10 To ensure that children who are placed out of the county receive the same response to instances of going missing. 1.11 The CMO will be notified of all children placed outside of Nottinghamshire.	Terri Johnson Service Manager Placements Service Manager IRO	October 2013	The Placements team alerts the CMO to all placements out of the County. Liaison occurs with other LA to try and ensure that any missing events are notified. This remains a challenge as OLA's and police forces often have very different processes and points of contact. There is reference to missing within the placement contracts. The LAC team are required to alert the CMO of any missing event. Continue engagement with the IRO's. Need to arrange a meeting with placements, LAC and safeguarding to formalise practice.	
1.12 To seek to facilitate OLA children within Nottinghamshire access to a return interview from their placing authorities			Extensive work has been undertaken to try and engage with OLA's and other police forces but this has been a challenge. TSS have begun to offer return interviews to OLA's. This will be implemented and kept under review.	

2. Protection

Reduce the risk of harm caused to those who go missing

It is important to understand the scale and nature of the problem and there should be systems in place to monitor the prevalence and response to it. It is vital that once professionals are aware of notifications of missing that there are clear and robust systems in place.

Action	Lead	Timescale	Progress to date	Rag Rating
2.1 The police will routinely inform the LA of all missing notifications and found	Emma Adams		There are effective systems in place for this to happen although a new police computer system has disrupted this.	
2.1.1 The Police will apply a risk model to children who are reported missing.	Emma Adams		This system is in place.	
2.2 The CMO will screen all notifications on a daily basis	Terri Johnson		This system is in place	
2.3 The CMO will monitor and track compliance with the requirement for a RI or MAM	Terri Johnson		This system is in place	
2.4 Map the levels of missing and related data within the Police & NCC. The Police will share monthly data. NCC will produce monthly, quarterly and annual reports	Terri Johnson Emma Adams Jon Ward	October 2013	Some data is already reported on and work has been undertaken to develop a new module within the client record system as well as a suite of reports developed which will lead to more comprehensive reporting and analysis.	
2.5 A performance management framework to be developed to enable better accountability.	Jon Ward Data Team Terri J	November 2013	A brief has been provided to the analyst – this needs to go back to the steering group in October.	

2.6 Data should be routinely analysed to ensure that 'hot spots' are responded to.	Terri Johnson Emma Adams	October 2013	This is happening on an informal basis but this could be done in a more co-ordinated multi-agency way.	
2.7 The Police to actively lead on the use of disruption techniques 2.7.1 To monitor the frequency and use of disruption strategies through the use of quarterly reporting.	Emma Adams	October	This is not currently reported on to the steering group – this should be reported on and included in the quarterly reports. Annually for the 2012-13 the numbers were low.	

3. Provision

Provide missing children and their families with support and guidance

Vulnerable children and their families have a right to understand how and where to access support and guidance to minimise anxiety and distress at difficult times.

Action	Lead	Timescale	Progress to date	Rag Rating
3.1 Return interviews and multi-agency meetings to be held in a timely manner. Reported on a quarterly basis.	Terri Johnson		This is being reported on.	
3.2 Auditing of cases will be undertaken to ascertain the quality of the response to the young person and their family to include the voice of the young person.	Terri Johnson	January 2014	An audit has been commissioned under the NSCB which will take place in November and will report in January. This will include a sample of young people being spoken to.	

4 **Public Confidence**

Engage with local communities to raise awareness of Missing Children and how it affects individuals and communities.

Communities will be enabled to understand what the scale of the problems is and how it impacts on them individually or as a whole community.

Action	**Lead**	**Timescale**	**Progress to date**	**Rag Rating**
4.1 Sign up to Children's Society Missing Children Charter			Completed	
4.2 Sign up to the Barnardos 'Cut Them Free' Campaign'			Completed	
4.3 Regular reporting to Elected Members on work in relation to missing children.			Commenced and in progress	

APPENDIX 2

Nottinghamshire Looked After Children

Total number of children looked after is 896.

Of these there are 274 children who are placed outside of Nottinghamshire, and of these 70 are placed in Nottingham City.

There are 659 children placed in foster care of which 396 are with NCC foster carers and 263 in Independent Fostering Agency (IFA) placements.

95 children are placed in residential placements, of which 48 are outside of Nottinghamshire and 10 of these are in Nottingham City as shown in the table below.

Residential Placements outside of Nottinghamshire

Area	No. of Children Placed
Barnsley	1
Cambridgeshire	1
Cumbria	2
Derby City	1
Derbyshire	10
Doncaster	1
East Yorkshire	1
Leicestershire	2
Lincolnshire	4
Northamptonshire	5
Nottingham	10
Sheffield	1
Shropshire	1
Staffordshire	6
Tameside	1
Warwickshire	1

Data as of 20 September 2013

Nottinghamshire County Council

Report to Health and Wellbeing Board

2 October 2013

Agenda Item: 5

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

YOUNG PEOPLE FRIENDLY HEALTH SERVICES IN NOTTINGHAMSHIRE

Purpose of the Report

1. This report seeks approval of proposals from the Children's Trust Board for health service commissioners to adopt the use of quality standards to ensure that health services are assessed as 'young people friendly'. The paper outlines an approach to assurance, with the aim of increasing young people's access to services. Board approval of this proposal will encourage commissioners to consider the achievement of the standard when commissioning and evaluating services.

2. The report outlines how commissioners of universal and targeted health services can ensure services are 'young people friendly' and meet the quality standards outlined by the Department of Health, by approving the following:

   - Commissioners of health services aimed at children and young people in both health and non-health settings include the quality standards and performance measures outlined in *You're Welcome*[1] into contracts and service specifications, assuring themselves that the *You're Welcome* criteria are being met on an on-going basis.

   - For health services aimed at all ages, commissioners consider use of the mystery shopper approach to identify good practice and areas for improvement and work with providers to encourage learning from mystery shopper findings.

   - Commissioners and providers share information on user feedback (including the results of mystery shopping) and also their plans to tackle issues identified with the Children's Trust on behalf of the Health and Wellbeing Board.

Information and Advice

Rationale for Supporting Health Services to be Young People Friendly

3. *"The health needs of young people are often given a low priority by both policy makers and clinicians. However young people's health is important not just because this age group has a right to effective health provision, but also because the appropriate management of adolescent health will pay long-term dividends for individuals and society. The particular needs of adolescents are frequently missed because much policy thinking*

[1] https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services

deals with children and adolescents as one age group. Furthermore adults, even professional adults, often know little about the stage of adolescence, and are unaware that young people have separate and individual needs where health matters are concerned." [2]

4. Teenage years are a critical time for adopting health for later life and it is now recognised that new approaches are needed to engage young people more effectively. Teenagers often find it difficult to locate or access services appropriate to their needs, often falling between children's and adult's services.

5. Services do not always meet young people's needs with respect to confidentiality, privacy and appropriate communication or adequate knowledge of the basic biological and psychological changes of adolescence.

6. Anecdotally it is known that a small number of local GP practices still do not agree to consultations with young people under the age of 16 without a parent or carer present.

7. Young people themselves state that there are barriers to their access of health services as the following comments suggest.

   - *"It's mainly just getting hold of information, that's the hardest thing - you're not sure where to go, especially if it's something you're embarrassed about - that's what people are afraid of, that you might be laughed at, so people don't try."*

   - *"They treated me like I was thick."*

   - *"Confidentiality not to be judgemental a degree of understanding/empathy not intimidating."*

   - *"People get intimidated at reception people who are miserable and rude. I'm shocked at the things people say, I can't imagine a 13 year old having these things said to them".*

   - *"Someone you can go to with the kind of problems we have, to treat you properly, listen to you, not just sit back in the chair... confidentiality is important, and the way you're treated."*

8. Such barriers can deter young people from accessing services, potentially leading to poor outcomes. Sexual health is of particular concern to many young people but they may not access appropriate services until after they become sexually active, if at all. Young people report feeling fearful of being judged when seeking contraceptive services, believing that most services are run for older people who disapprove of them having sex.

9. National guidance and international research states that young people focused contraception/sexual health services must be trusted by teenagers and be well known by professionals working with them. This factor is most often cited as having the greatest impact on reducing teenage conception rate in high performing areas. "… access to good quality advice and contraception is an essential component of a successful sexual health

[2] Coleman, J. (2011) Adolescent health in the UK today: where next? http://www.ayph.org.uk/publications/177_Adolescent%20health%20in%20the%20UK%20today_FINAL%2025may.pdf last accessed 11/01/2013

and teenage pregnancy policy. Practical issues - such as access, availability, coverage, etc. – should be addressed as a matter of course; this involves addressing challenges concerning school-based placement, the use of pharmacies, primary care outlets, etc[3]".

10. All young people are entitled to appropriate health services and the Children's Trust Board is keen to ensure they are actively welcomed into services that they value and use, to contribute to improving health outcomes for this group.

11. The *You're Welcome*[1] quality criteria set out principles to support health service providers to improve their services and be more young people friendly.

National Drivers

12. In 2007 the Department for Health published 'You're Welcome quality criteria - Making health services young people friendly'[1], guidance that outlined and took account of the differing needs of young people. The guidance was targeted at all health services where young people aged 11-19 are potential users.

13. This guidance gained the support of the World Health Organisation[4] as a way of helping improve health outcomes and tackle health inequalities. The guidance has also been endorsed by the Royal College General Practitioners, Royal College Nurses, Royal College Pharmacists, Association of Young People's Health; National Youth Agency; and the British Association of Sexual Health & HIV amongst others.

14. The *You're Welcome* quality standard aims to provide accessible, appropriate, confidential, non-judgmental services for young people who often fear that adults will judge them and generally provide a negative experience. It is underpinned by the ethos that all young people are entitled to receive appropriate healthcare wherever they access it.

15. The quality standard comprises ten topics covering eight core area and two specialist areas, namely sexual health and reproductive services and Specialist Child and Adolescent Mental Health Services (CAMHS). The criteria appear in **Appendix 1**.

Providing assurance that services are young people friendly

16. For commissioners, it is important to ensure that services meet young people's health needs and that this is considered an essential part of services provided. Health services needed by young people are of two main types:

- Services commissioned specifically for young people (e.g. school nursing, young people focused contraception and sexual health services, CAMHS, young people's substance use services)

- Services provided for all ages that young people may access (e.g. general practice, pharmacy, Pharmacists, Genito-Urinary Medicine).

[3] Ingham R (2009) Teenage Pregnancy Strategy Rapid Assessment Research Overview, August 2009
[4] World Health Organisation (2012) Making health services adolescent friendly – developing national quality standards for adolescent-friendly health services

17. Where services are commissioned explicitly for young people, *You're Welcome* standards should be considered a core part of delivering the service, with commissioners able use the contracting process to ensure that the standards are met.

18. Where services are provided for all ages (e.g. general practice, pharmacies), using a contracting process may not be appropriate. However other approaches are available to encourage these services to be more young person friendly.

19. It is acknowledged that as members of Clinical Commissioning Groups, GPs are now commissioners and providers of health services for young people. Working with the Local Medical Committee, it is hoped to agree an approach to engaging General Practice as providers of health services.

Ensuring that services commissioned specifically for young people meet *You're Welcome* standards

20. The contracting process offers an opportunity to specify that providers meet the *You're Welcome* standards and provides a mechanism by which the commissioner, the provider and the public can assure themselves that this is occurring. Suggested text for inclusion in service specifications is attached as **Appendix 2.** Commissioners can adopt and performance manage this area of work for services for young people.

21. The *You're Welcome* quality standard covers ten specific criteria and rather than detail achievement of specifics, this report recommends that providers incorporate the following three elements of recognised good practice in order to assess and improve the services they provide. These elements will also generate information to reassure commissioners and the public that standards are being met. The three elements are:

    a) Obtain regular feedback from young people, involve them in service development.
    b) Have clear, relevant and up to date policies and procedures in place.
    c) Routinely audit training, facilities, procedures and clinical care.

    A summary of how the ten criteria can be achieved is included in **Appendix 1**.

Ensuring that services commissioned for all ages are suitable for young people

22. It may be possible to include specific reference to *You're Welcome* in contracts and service specifications for services for young people but this is less practical in services for all ages. However, this aspect of health services is important; services such as general practices and pharmacies are key points of contact for young people.

23. One approach that Health & Wellbeing Board members can use to assure themselves that services they commission are young person friendly is through the use of appropriately trained young people as 'mystery shoppers'. This approach is currently used by Nottinghamshire County Council's Youth Service which runs a programme to train young people as inspectors for services such as youth clubs and libraries. Discussions with the Youth Service have identified willingness for this existing programme to be used to looking at a wider range of services including health services. A small amount of funding would be required to implement this work and plans are in

place to identify £8,000 - 10,000 within existing budgets to fund the training and travel for young mystery shoppers.

Sharing User Feedback and Mystery Shopper Findings

24. Young people themselves are the best people to assess whether a service is suitable for their needs. A process of on-going feedback from those using and eligible to use a given service provides a valuable insight on whether the service is young people friendly.

25. Active involvement of young people in service design, planning and review is critical to ensure services meet their needs. Young people have helpful advice for commissioners and providers as the following comment from a young person suggests.

"If young people aren't involved and adults do all the planning then it isn't as good or effective for us".

26. The Children's Integrated Commissioning Hub (ICH) located in Children, Families and Cultural Services, Nottinghamshire County Council plans to routinely engage children and young people in helping to shape commissioning plans and will support and encourage other commissioners to do the same.

27. The ICH will performance manage providers of young people's health services to ensure they have gathered feedback from service users and target groups, and have acted on the feedback appropriately. The ICH will also commission mystery shopper activity and act as a central point of information from young people for the Children's Trust.

28. By sharing information from service users and mystery shoppers, healthcare providers and commissioners can obtain information that will benefit young people and improve health outcomes now and in the longer term. The Children's Trust Board can oversee the collection and sharing of information to shape commissioning plans with agreement of commissioners and providers to information share.

Elements of *You're Welcome* omitted from local plans

29. This report considers how the *You're Welcome* standard can be adopted through several of approaches. One significant aspect of *You're Welcome* that is missing from these is that of an accreditation and branding process for providers to use to promote their services to young people. If a unified brand for 'young people friendly' services is seen as valuable, a *You're Welcome* style scheme could be incorporated. This would require an on-going commitment of resources in order to administer the scheme.

Other Options Considered

30. This report has examined how a national quality assurance scheme can be translated locally, ensuring that that the benefits of the scheme are achieved without an overly bureaucratic and costly process. When *You're Welcome* was first launched a local planning group was established to progress the standard, with full implementation requiring a dedicated function to visit all services and support them to complete a self assessment form, use of the national toolkit and organise regular review. This model is not sustainable since it requires additional long term resource.

Reason/s for Recommendation/s

31. Historically the national *You're Welcome* programme required substantial resource and capacity for provider organisations to achieve the standard. This has resulted in very few local organisations achieving the quality standard. The proposed recommendations require commissioners and providers of health services to consider the *You're Welcome* criteria and the adoption of an approach for their inclusion and assurance in relation to the provision of young people friendly health services. This will lead to improved uptake of services by young people, improving health outcomes and reducing inequalities.

Statutory and Policy Implications

32. 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.

Safeguarding of Children Implications

33. The proposed work to engage and train young people as mystery shoppers has been considered in detail and there will be clear criteria set in relation to the role of the mystery shopper at a health service. Young mystery shoppers will not be expected to accept treatment and their safety will be paramount. Engaging young men and young women as mystery shoppers across the 14-19 age groups will be integral to the work, to ensure that a range of views is obtained.

RECOMMENDATIONS

That:

1) the proposal from the Children's Trust Board to adopt quality standards and performance measures outlined in *You're Welcome* are approved, in order to assure that health services are 'young people friendly'

2) commissioners of health services aimed at young people in both health and non-health settings consider integrating the quality standards and performance measures outlined in *You're Welcome* into contracts and service specifications with providers, seeking assurance that the *You're Welcome* criteria are being met on an on-going basis, and where issues are identified, that actions are taken to resolve them. Suggested performance measures are attached in **Appendix 2**.

3) for health services aimed at all ages, commissioners consider using mystery shoppers to identify good practice or areas for improvement and work with providers to encourage them to learn from the results.

4) commissioners and providers consider sharing information on user feedback (including the results of mystery shopping) and also share plans to tackle issues identified with the Children's Trust on behalf of the Health and Wellbeing Board.

Chris Kenny
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Anthony May
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Constitutional Comments (SG 26/04/13)

34. The Board is the appropriate body to decide the issues set out in this report.

Financial Comments (ZKM 08/08/13)
35. The financial implications are outlined in paragraph 23 of the report.

Background Papers and published Documents

'Do we know young people are welcome at our services?' - report to Children's Trust Board on 25 February 2013 http://www.nottinghamshire.gov.uk/caring/childrenstrust/about-the-childrens-trust/childrenstrustboard/?entryid217=247009

Background papers also comprise reference documents as listed in the footnotes.

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.

C0213

APPENDIX ONE

Planned Local Assessment of You're Welcome criteria

	Patient Feedback			Policies and Procedures	Audit		
You're Welcome criteria	**User feedback**	**Mystery shopper**	**User involvement**		**Facilities audit**	**Training audit**	**Care Plan audit**
1. Accessibility	X	X			X		
2. Publicity	X	X					
3. Confidentiality and consent	X	X		X		X	
4. Environment	X	X			X		
5. Staff training, skills, attitudes and values	X					X	
6. Joined-up working		X		X			
7. Young people's involvement in monitoring and evaluation of patient experience	X	X	X				
8. Health issues and transition for young people	X			X		X	X
9. Sexual and reproductive health services	X	X		X		X	
10. Specialist child and adolescent mental health services (CAMHS).	X					X	X

APPENDIX TWO

Suggested text for inclusion in Service Specifications for Child/Young Person Specific Health Services and Interventions

Information/Data Required	Format & Method	Frequency
Completion of user feedback questionnaires. ▪ Number and percentage of service users and/or their parents/carers completing a questionnaire.	Quarterly reporting through monitoring and contract meetings	Quarterly update
Data from user feedback survey on: ▪ Accessibility of service ▪ Publicity/awareness of service ▪ Environment ▪ Awareness of confidentiality and consent ▪ Staff skills, attitudes and values	Findings to be broken by district/CCG, gender, age, ethnicity. Reports to be produced through monitoring and contract meetings.	Quarterly update
Number and percentage of young people surveyed who thought the service 'did a good job'.	Findings to be broken by district/CCG, gender, age, ethnicity. Reports to be produced through monitoring and contract meetings	Quarterly update
Service user feedback action plan based on the findings of the user feedback surveys.	Action plan to be submitted annually through monitoring and contract meetings.	Annual action plan

Nottinghamshire County Council

Report to Health and Wellbeing Board

2nd October 2013

Agenda Item: 6

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

HEALTH AND SOCIAL CARE INTEGRATION TRANSFORMATION FUND

Purpose of the Report

1. The report provides an update on the Health and Social Care Integration Transformation Fund, and requests approval from the Board to establish a working group to make the required arrangements for the oversight and use of the pooled Integration Transformation Fund budget in Nottinghamshire.

Information and Advice

2. In the 2013 Spending Round, the Government announced a £3.8bn pooled budget for health and social care services, building on the current NHS transfer to social care services of £1bn. The Spending Round document stated that 'the Government will introduce a £3.8 bn pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people'. This is set against the context of a reduction in overall local government expenditure of approximately 2.3%.

3. The Integration Transformation Fund (ITF) will be a pooled budget which will be deployed locally on social care and health, subject to the following national conditions which will need to be addressed in the plans:
    - plans to be jointly agreed;
    - protection for social care services;
    - as part of agreed local plans, 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends;
    - better data sharing between health and social care, based on the NHS number;
    - ensure a joint approach to assessments and care planning;
    - ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
    - risk-sharing principles and contingency plans if targets are not met – including redeployment of the funding if local agreement is not reached; and
    - agreement on the consequential impact of changes in the acute sector.

4. Whilst the ITF does not come into full effect until 2015/16 the intention is for CCGs and local authorities to build momentum during 2014/15, using the £200m due to be transferred to local government from the NHS to support transformation. There will be an expectation of joint 2 year plans with outcome measures for 2014/15 and 2015/16, which must be in place

by March 2014. Plans for use of the pooled budgets must be agreed by CCGs and local authorities and signed off by the Health and Wellbeing Board.

5. Details of the funding are shown in the table below. The June 2013 Spending Round set out the following:

2014/15	**2015/16**
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8 billion pooled budget to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the ITF will be created from the following:

£1.9 billion existing funding continued from 14/15 - this money will already have been allocated across the NHS and social care to support integration	• £130 million Carers' Breaks funding • £300 million CCG reablement funding • c. £350 million capital grant funding (including £220m of Disabled Facilities Grant and funding for IT projects to facilitate secure sharing of patient data between NHS and local authorities) • £1.1 billion existing transfer from health to social care
Additional £1.9 billion from NHS allocations	• funding to cover demographic pressures in adult social care and some of the costs associated with the Care Bill • £1 billion performance related, with half paid on 1 April 2015 (most likely based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in year performance)

6. As identified in the table, £1 billion of the ITF in 2015/16 will be dependent on performance. Local areas will need to set and monitor achievement of outcomes during 2014/15 in relation to the conditions of the Fund laid out earlier in the report, as the first half of the £1 billion - paid on 1 April 2015 - is likely to be based on performance in the previous year.

7. Local discussions have taken place with the Nottinghamshire Strategy Group culminating in a proposal to create a working group to plan for deployment of the Fund. The County Council, CCGs, District Councils and NHS England Area Team have been asked to nominate representatives for the group which will report to the Health and Wellbeing Implementation Group. The group will be chaired by the County Council Chief Executive, Mick Burrows.

8. The group will need to ensure that all inter-related programmes/strategies are aligned to plans for deployment of the Fund; including the NHS Call to Action; development of the local Health and Wellbeing Strategy; CCG strategic commissioning intentions and the County Council's budget proposals.

Other Options Considered

9. Not applicable.

Reason/s for Recommendation/s

10. Plans for use of the Fund must be agreed through partnership working between CCGs and local authorities in order to meet the conditions required, and to ensure the pooled budget is targeted to the best effect for the local population.

Statutory and Policy Implications

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

Implications for Service Users

12. Integration of health and social care services is an opportunity to improve the quality of experience and the outcome for service users. In '*Integrated care and support: our shared commitment*' integration was helpfully defined by National Voices – from the perspective of the individual – as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me".

Financial Implications

13. The financial implications are referred to in paragraphs 5 and 6 of the report.

Equalities Implications

14. Equality issues will be taken into account as part of the planning process undertaken in the working group. Better integration of services should mean that people receive a more consistent service across the county.

RECOMMENDATION/S

That the Board:

1) Approves the establishment of a working group to identify the arrangements necessary for oversight and use of the pooled Health and Social Care Integration Transformation Fund budget.
2) Receives a follow up report in January 2014 detailing draft plans for approval.

David Pearson
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Associate Director of Public Health

Jennie Kennington
Senior Executive Officer

Constitutional Comments (NAB 12/9/13)

15. The Health and Wellbeing Board has authority to approve the recommendation set out in this report by virtue of its terms of reference.

Financial Comments (KAS 13/9/13)

16. There are no financial implications contained within the report.

Background Papers and Published Documents

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

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

Nottinghamshire County Council

Report to the Health and Wellbeing Board

2nd October 2013

Agenda Item: 7

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

UPDATE ON HEALTH AND SOCIAL CARE INTEGRATION 'PIONEERS'

Purpose of the Report

1. The report will provide an update of the outcome of the Nottinghamshire integration 'pioneers' bid.

Information and Advice

Background

2. A report was presented to the June Health & Wellbeing Board outlining the background to the Health & Social Care Integration Pioneers project, requesting support for a joint submission for Nottinghamshire.

3. A multi-agency working group was established to prepare the bid, which was submitted on 28 June 2013, following consultation with key partners. The final submission is included as **Appendix One**.

4. Over 100 expressions of interest were received by the national Integrated Care and Support Pioneer Team. This showed a very high level of commitment to service improvement, meeting the challenge of designing coordinated services around the needs of patients and service users.

5. Unfortunately, following review by an expert panel against defined criteria, the Nottinghamshire submission was not shortlisted for further consideration. However, positive feedback was received on the quality of the bid and the vision detailed in the plan.

6. The Panel provided the following specific feedback on the application:

    a. The Panel considered that the application demonstrated interesting ideas which could be feasible. However, the Panel considered that the application lacked clarity on how it would work in practice as a multi partner programme, and therefore it does not sufficiently demonstrate the scale necessary to be a national pioneer.

7. The team were impressed with the range of ambitious plans and initiatives already underway and are therefore very keen for Nottinghamshire to remain involved and to be part of a network of support, sharing the learning taking place in the area. As a result the NHS Improving Quality (NHSIQ), which is hosting the Integration Care and Support Exchange (ICASE), will keep us informed of learning and development opportunities connected to the Pioneers programme.

8. As a first step, a toolkit has been commissioned by the team to support business planning and delivery locally. Nottinghamshire has also been asked whether we are willing to contribute to its development.

9. The expectation is that all localities will make progress in planning and delivering better integrated care and support over the coming years, irrespective of whether they are a part of the pioneers programme, supported in particular by the recently announced Integration Transformation Fund that will be shared between the NHS and local authorities. Proposals within the pioneer application will be useful when local planning in relation to this Fund gets underway across partners.

10. The Health and Wellbeing Board is asked to note the outcome of the Health & Social Care Integration Pioneers submission, and recognise the opportunities for continued engagement in the programme's learning, to assist us in the development of our Health and Wellbeing Strategy and local delivery plans.

Statutory and Policy Implications

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

Implications for Service Users

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

Equalities Implications

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

RECOMMENDATION/S

The Health & Wellbeing Board are asked to:

1. Note the content of the report and the outcome of the Integration Pioneers Bid.

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

For any enquiries about this report please contact:
Jennie Kennington, Senior Executive Officer

Constitutional Comments (NAB 12/9/13)

14. The Health and Wellbeing Board has authority to consider the recommendation set out in this report by virtue of its terms of reference.

Financial Comments (KAS 13/9/13)

15. There are no financial implications contained within the report.

Background Papers
Letter Inviting Expression of Interest for Health & Social Care Integration 'Pioneers.'

Nottinghamshire Health & Wellbeing Board report 'Health & Social Care Integration Pioneers' 5 June 2013.

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

INTEGRATED NOTTINGHAMSHIRE

Integrated Nottinghamshire

Pioneer Submission

Improving lives in Nottinghamshire:
One vision, local solutions, individual lives

In Nottinghamshire, we have a clear vision for Integrated Care.

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Our Vision

We treat citizens as people, not cases:

- by removing false divides between physical, psychological and social needs; and
- by bringing compassion to the fore.

Services will be re-focused on the whole person. People and systems providing care will:

- Be joined together to see the whole picture when a person is in need of support;
- Support citizens to thrive, creating independence not dependence;
- Be tailored to overall need - hospital will be a place of choice, not a default; and
- Not incur delays, people will be in the best place to meet their needs.

Our ambitious citizen perspective

- I wish to retain my independence
- I receive care as close as possible to my home
- All services that I use are seamless
- My needs are assessed so that support is there when I need it
- I am supported throughout my recovery

The Future of Nottinghamshire

We aspire for an Integrated Nottinghamshire; a county where health inequalities do not exist and all people:

- Live longer, healthier and happier lives;
- Feel respected and valued and are able to contribute to their communities;
- Can access the services they need to live independently for longer; and
- Have greater choice and control over their lives.

Integrated Nottinghamshire brings the experience of our citizens to the forefront of everything we do. We will tackle the growing pressures of ageing populations and increasing numbers of people with complex, long term conditions by radically challenging how health and social care currently works. We will build resilience by enabling people to be real partners in their own physical and mental health, moving from a dependency model to one of co-production. We will remain sensitive to the unique differences and needs within each locality but ensure alignment and delivery of the combined outcomes frameworks across the NHS, Public Health and Social Care.

Nottinghamshire has proven success in delivering holistic approaches to care. With an outstanding track record of working collaboratively and demonstrating sound governance we will quickly mobilise our aspirations for change and improvement.

The scale of challenge is not underestimated. Analysis of our health and social care economy suggests that if we continue to deliver care in the way we currently do we will be facing a gap of almost £150m by 2018. Yet interventions have been identified that will significantly close the gap, requiring significant integration of services at pace and scale.

What we want as Pioneers

- An opportunity to accelerate the learning and evidence base we are building from our existing integrated models of care on a county-wide and national footprint;
- Assistance developing new commissioning models for health and social care, including the recommissioning of our integrated urgent care front door;
- Advice on how to develop our workforce to best serve the needs of our citizens;
- Support to establish a proven model that contributes towards national A&E challenges; and
- To support Sherwood Forest Hospitals NHS Foundation Trust to build on the Keogh Review and help other providers achieve Foundation Trust status.

What we offer as Pioneers

Nottinghamshire is uniquely placed as a Pioneer of Integrated Care.

- We are delivering at a scale that will make a real impact to our citizens;
- We have excellent clinical and citizen engagement and are already building a social movement around integrated care;
- We have well developed CCGs with a strong history of transformational change;
- We have a diverse population that represents the challenges faced throughout England;
- We already have plans to address pressures on acute care; and
- The timing is perfect: our journey has already begun.

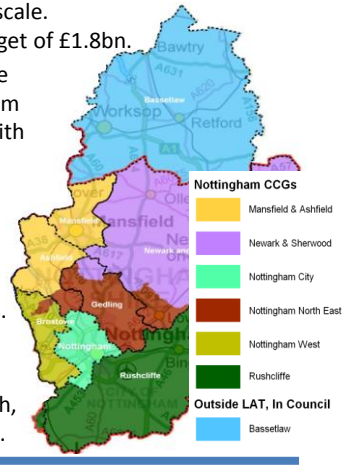
Who we are

The size of our county means we are delivering integrated care at scale. Together we support a population of 1,086,600 and manage a budget of £1.8bn.

We are complex and diverse. We deliver innovative integrated care which overcomes the challenges many others will face. A microcosm for the country, we manage urban deprivation to rural isolation, with a difference in life expectancy of 13 years across the county.

Together, we are demonstrating the partnership working required to tackle our greatest health and social care challenges. We are made up of seven CCGs, three acute trusts, one integrated mental health and community provider, one community provider, a city council, a county council and seven district/borough councils.

We are also working collaboratively with our academic partners to ensure a sound evidence base and an evaluation programme. We bring a strong record of conducting high quality health research, and of supporting the use of research to improve health outcomes.



We understand our integration challenges and have a plan for change.

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Our Burning Platform

It is widely recognised that in Nottinghamshire the current health and social care system is unsustainable without transformational change. Our health and social care economy is facing a very clear set of challenges. Some of these are universal to commissioners and providers throughout England and urgently need pioneers to develop solutions. Others are specific to Nottinghamshire and take into account our local communities and organisations. Our most pressing challenges are:

- An ageing population, with more people needing more care. Over the next 20 years, the number of people in Nottinghamshire aged 66-84 and 85+ is expected to increase by around 36%-49%, with an average increase of 2,800 and 950 people respectively per year;
- A rising birth rate, placing increasing demand upon services;
- Increasing numbers of young people with learning disabilities reaching adulthood – 128 in 2013/14 at a cost of £3.6m to the County Council;
- Extreme winter pressures, creating significant demand for acute hospital beds;
- Rising citizen expectations around the quality and location of care;
- Financial constraints as health care sees only small budget increases, while social care sees decreases;
- Saving requirements for adult social care of approximately £11m, requiring a fundamental review of the social care offering;
- Challenging fixed points in the system, such as the PFI arrangements at King's Mill Hospital.

If you do just one thing, get those who know what they are doing to work better together
National Child & Adolescent Mental Health Review

Even without these changes in the health and social landscape, we still face the challenge of providing better and more seamless healthcare that is tailored to the individual, and is proactive and preventative. At the moment we are not achieving this. Our citizens have told us that our services are currently:

"Every so often I get carted off to hospital"
Patient

- Disease specific: people are often under the care of three or more teams;
- Fragmented: poor communication between teams means information is lost;
- Confusing: it is not always clear what services are available;
- Limited: long waiting times and lack of out of hours services mean that often there is no option but to call 999; and
- Reactive: services respond to crises rather than preventing them.

Our Burning Ambition

It is our ambition to provide an integrated care experience for our citizens. Doing nothing is not an option: we need to transform the health and social care system in Nottinghamshire, in accordance with our design principles:

"Achieving integrated care would be the biggest contribution that health and social care services could make to improving quality and safety"
National Voices

1. Our citizens and staff shape our vision;
2. We act as one community to promote the health and wellbeing of the citizens of Nottinghamshire. We work together, invest together, manage risks together and learn together;
3. We move care closer to home and achieve better value for care provided, where appropriate;
4. We prevent illness or crises where possible and transfer resources (people, physical assets and finance) from reactive services to proactive services to support this;
5. We provide single points of access for citizens, and integrated provision of services;
6. We enable the system to cope with growing demand within expected resource constraints; and
7. We design interventions that will make significant contributions towards public health and social care outcomes.

A Campaign Approach to Change

Central to our design is a social movement approach to integration. The Strategy and Implementation Group for Nottingham South (SIGNS), inspired by the narrative from National Voices, provides a shared set of principles that will both shape the transformation and build public support for the change:

Together, we focus on the needs of our citizens
- We enable our citizens to remain independent
- We integrate around our citizens

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

Together, we simplify how our system works
- We work to achieve and then exceed our shared standards
- We assess citizens' needs to ensure early identification and intervention, rapid and flexible response, and reablement support

We have a strategy for integration…

Our integrated care aspirations are articulated through our strategy for integration. By delivering in our localities we will achieve the care outcomes that integrate Nottinghamshire.

An Integrated Nottinghamshire without boundaries or divides

An integrated system that achieves an overall benefit of improved patient experience and quality, whilst ensuring the long term sustainability of health and social care in Nottinghamshire.

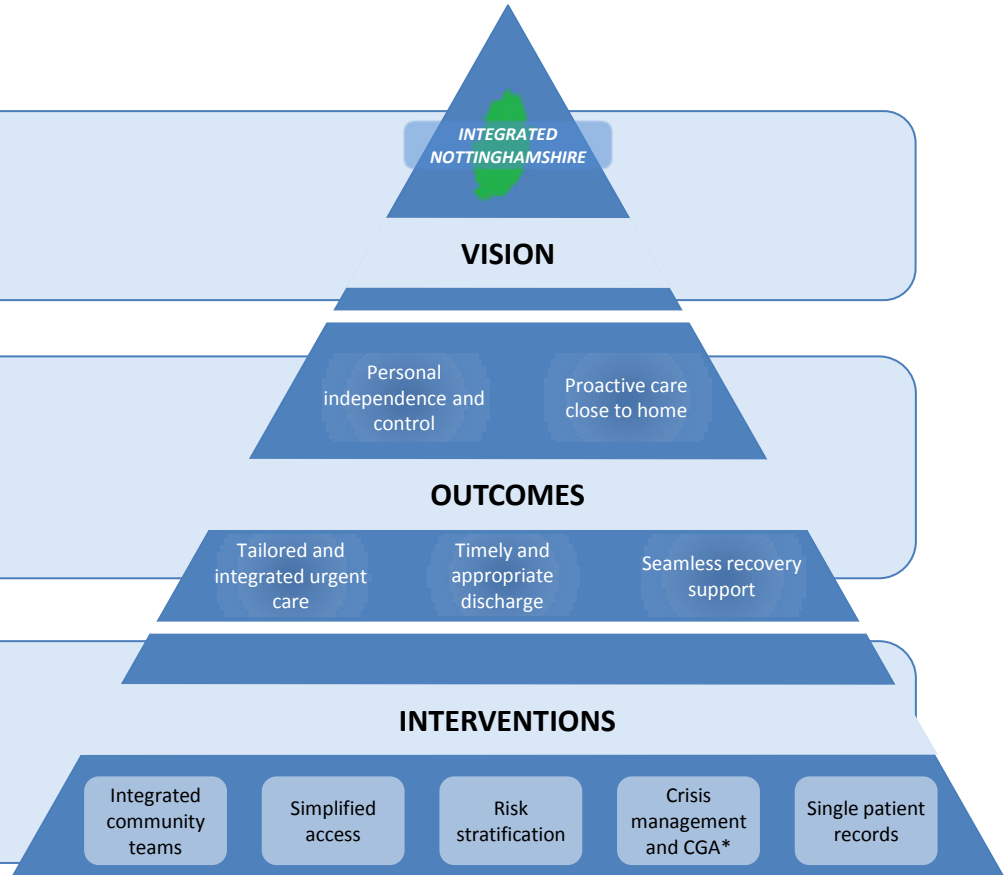
Achieving outcomes for our citizens

- I am supported to thrive
- I choose care that is right for me and I am in control of my health
- Urgent care is there for me in a crisis and recognises my needs
- I am supported to recover in my home

Integrated as one, delivering in localities

Our integration vision will be achieved by delivering targeted interventions at both the county-wide and locality level (Bassetlaw, Mid-Notts, and City & South). These will be driven by an overarching model of care, tailored to the needs of local health and social care.

Our Strategy for Integration



In practice: Mid-Notts Clinical Navigator
The delivery of the Clinical Navigator intervention in Mid-Notts will provide a local service that has been developed and owned by stakeholders in the region. It is shaped by the overall strategy and contributes to tailored and integrated urgent care, so supporting the overall benefit of an integrated health and social care system.

In practice: Virtual Wards
The development of 'virtual wards' in the City & South began in 2009 in Rushcliffe CCG. They contribute to proactive care closer to home by identifying those who are most at risk and treating them before a hospital admission is necessary. Our 'Integrated as one, delivering in localities' approach has allowed other CCGs to learn from Rushcliffe's example so that virtual wards are now being put in place across the region.

*Comprehensive Geriatric Assessment

…and are building an integrated model of care.

We have an overarching model of care built around the principles of 'Support to Thrive', 'Choose to Admit', 'Transfer to Assess' and 'End of Life Care' that we use to drive our county-wide and locality based interventions.

Support to Thrive

Citizens are supported to thrive in order to maintain independence, health and wellbeing. Where care is required it is provided in the community and in the comfort of peoples' homes.

For people at high risk of admission / crisis, the first step is again to effectively provide support in the community. For example, the PRISM (Profiling Risk, Integrated care, Self Management) programme in Mid-Notts uses risk profiling software to identify those at high risk of admission / crisis. Multi-disciplinary community based teams then provide proactive support.

If community, social or primary care is needed there is horizontal integration to provide a seamless transition between services such that citizens do not know if they are receiving an NHS, local government or community based service.

Choose to Admit and Transfer to Assess

We seek to reduce crises through early intervention and proactive care. However, inevitably crises will occur. Where the need for acute care emerges, people are managed in ways that suit them best.

The requirements of citizens are assessed, for example, through Comprehensive Geriatric Assessments (CGAs). This identifies problems early and makes sure the right treatment with the right care plan is in place.

People are not admitted to hospital simply because other services are not available. They can choose when and where to receive their care and support services, such as home aids and transport that fit around their needs.

Urgent care services are integrated, with a single front door and appropriate crisis response. For example, through our clinical navigator in Mid-Notts, a telephone advisory service helps health professionals to make the best decisions about where to direct patients.

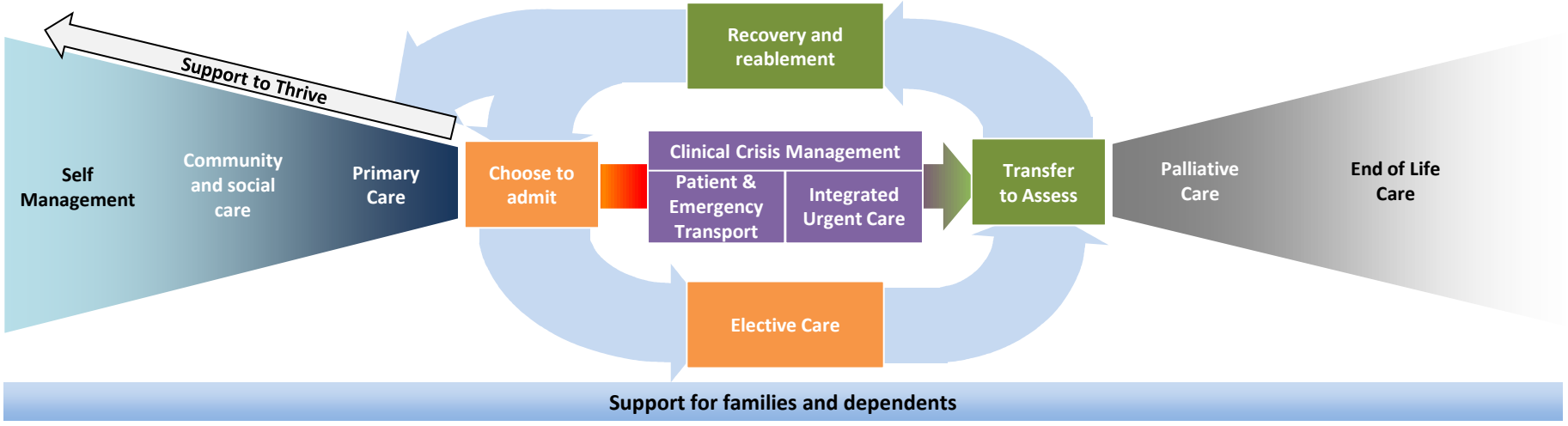
People leave hospital as soon as their health is stable enough for them to do so. Their needs upon leaving are organised by staff on their ward and there is ongoing care out of hospital to aid recovery, supporting people to thrive.

End of Life Care

We provide palliative care for those who are nearing the end of their life, putting in place the support structures both for them and for their families and dependents.

We have a defined End of Life Care pathway and are working with care home providers to ensure that staff are fully trained to provide the care and support our citizens require.

The Gold Standards Framework (GSF) Centre are running several quality improvement programmes in Nottinghamshire, training generalist frontline staff that care for those in the final years of life. This is reducing emergency admissions and deaths in hospital, but more importantly, is empowering staff and enabling more people to die in their own home.



We have strong examples of where we are implementing our strategy, both county-wide and in our three localities.

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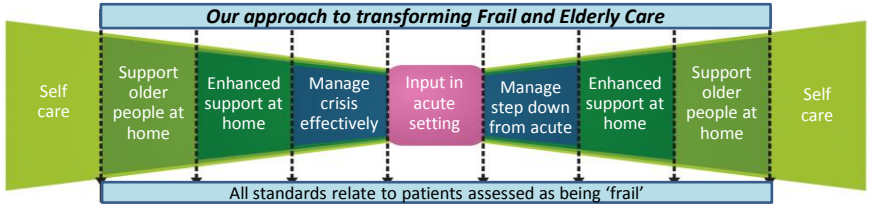
Our Integrated Model of Care combines county-wide transformation with locally tailored interventions. There are a number of interventions that will act across the county and provide large scale transformation for our citizens. However, we also understand the importance of local ownership and so are tailoring our strategic approach to address both the specific needs and specific challenges of each region. Some of the key interventions currently underway across the county and in each locality are outlined below.

Nottinghamshire-wide: Frail and Elderly Care

Frail Elderly Care has been identified as a clear priority for integrated care. There is an Integrated Commissioning Board for older people across the county with a joint commission strategy already established. We have a carers strategy at a county level with additional regional commitments, for example, additional funding from Bassetlaw to enhance carers services in the district.

We have a county-wide agreed approach to transforming frail and elderly care, based upon our Integrated Model of Care. It provides a set of thresholds and time based standards to assess citizens for risk and manage their care appropriately. Our approach has received commendation from David Oliver, former National Clinical Director for Older Peoples' Services and is already being delivered throughout the county.



Nottinghamshire-wide: Assistive Technology

We began the implementation of Flo Simple Telehealth across the whole health and social care pathway in Nottinghamshire in November 2012. It uses patients' own mobile phones and inexpensive biometric devices to monitor people at home. By March 2013 there were 250 people using telehealth; we aim to increase this to over 2,400 people in 2013/14 and for Flo to be 'business as usual' by March 2014.

Benefits are already being realised, including increased patient compliance and self-management. This is reducing the strain on NHS resources by decreasing face to face contacts, increasing clinical productivity and reducing travel time, while also increasing patient vital signs monitoring. Patient satisfaction is very high, with 100% of people evaluated keen that Flo becomes part of their usual care delivery.

Bassetlaw: Reablement Service

Bassetlaw's reablement services are already building a solid foundation for the implementation of Integrated Care. These services have been jointly commissioned by Local Authorities and CCGs working closely with local resources. As the new model of reablement is established it will be reviewed to prevent duplication and gaps between services.

A joint care strategy group representing all partners has now been in place for two years to co-ordinate this work and monitor and evaluate the impact on outcomes.

Mid-Notts: Integrated Care Blueprint

Mid-Nottinghamshire now has a Blueprint for Integrated Care in place, which aims to deliver 14 targeted interventions throughout the localities. These have been agreed across providers and commissioners following analysis and baselining. The interventions fall into four workstreams: Proactive Care & Long Term Conditions, Urgent Care & Crisis Response, Elective Care, and Women & Children. Together they are predicted to deliver up to £35m of savings for the localities, as well as driving citizen-focussed care and system-wide quality benefits.

One of the key interventions is a crisis hub / clinical navigator. This will provide a point of contact for healthcare professionals seeking the most appropriate route for their patients. It will cover all services available (acute, community care, social care and primary care).

City & South: Adult Integrated Care

In Nottingham City and the south of the county, inventions are focussed on transforming local services so that they are person, rather than condition led. This is shaped by a shared narrative, 'Ada and Maureen's story', to explain why integrated care matters in a way that everyone can relate to.

Services will be led by Care Delivery Groups (CDGs) made up of groups of GP practices and neighbourhood teams comprising multi-disciplinary health and social care staff. Eight CDGs will operate across the city, with resources tailored to the specific needs of each area. Teams will provide 24/7 access to support, integrating primary and secondary services and providing rapid response where appropriate.

The CDGs will also be supported by a care coordinator to release clinicians to focus on direct patient contact and support.

We have the governance and infrastructure in place to deliver as a Pioneer and have a track record of transformation….

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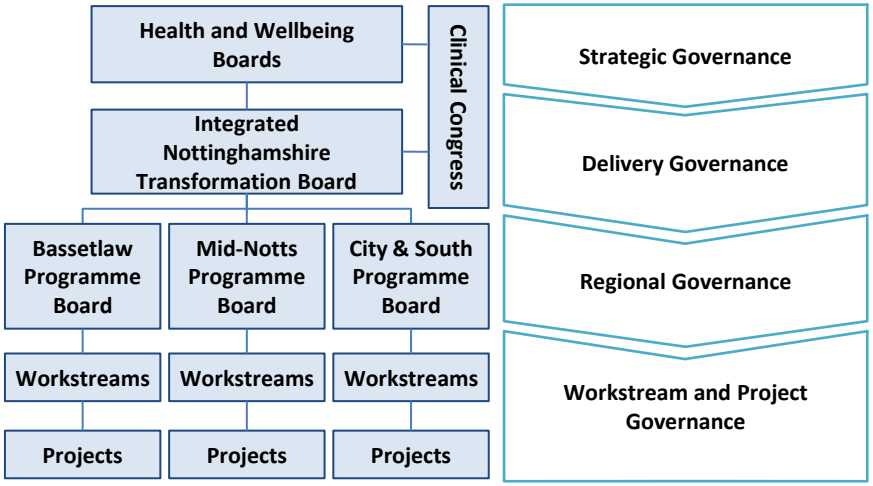
Delivering the Transformation

We have earmarked non-recurrent funding for Integrated Nottinghamshire, so are able to mobilise immediately. We have the capacity and governance in place and stakeholder buy-in to develop very detailed delivery plans from our existing roadmap.

Integrated Nottinghamshire Governance

Our governance model reflects the way that integrated care will be delivered within Nottinghamshire, and includes representation from all of our major health and social care stakeholder groups.



Productive Notts: Getting the governance right

Our 'Productive Notts' (now Integrated Notts) programme has been identified as a leading example integrated care practice by the Local Government Association.

Productive Notts was formed as a partnership of health care organisations in 2009 and was extended to include local authorities in 2011. It took a county-wide approach to addressing the issues of frail older people, led through intensive stakeholder engagement and culminating in an event attended by 80 staff from across the county.

Productive Notts established the foundations for the excellent working relationships that were essential for developing integrated care and to set up county-wide programmes on Assistive Technologies (Flo), Information Sharing (Connected Nottinghamshire) and Frail Older People, as well as delivering over £60m of savings.

Sharing our learning

We know that any intervention into health and social care must be based upon a sound evidence base. We have a strong history of working with organisations to develop evidence and ensure our programmes are based on the latest findings. For example, Newark and Sherwood's long term conditions QIPP programme is built upon Sir John Oldham's evidence based integrated care approach.

However, we also recognise that integration is an ongoing process and we are committed to being at the forefront of this in Nottinghamshire and beyond. We have a track record of developing and implementing innovative integrated care, and of sharing our learning from this. For example, we took part in the DH/DCLG leadership pilot on integration and we are now speaking nationally on PRISM, cited at the NHS Confederation Conference.

Mid-Notts were learning partners with the NHS Institute in preparation for authorisation and we have incorporated the NHS Change Model into our projects and Organisational Development Plan. Nottingham City is also part of the East of England King's Fund learning network on integrated care, which will enable the sharing of good practice developed locally and the opportunity to incorporate continued learning from across the country into programme planning.

We work collaboratively with our academic partners, providing system wide support to our CLAHRC, the East Midlands Leadership Academy, and the Institute of Mental Health. These relationships offer knowledge transfer from research and other academic material, support networking beyond the locality, and assist with implementation and evaluation.

Our Successes so far

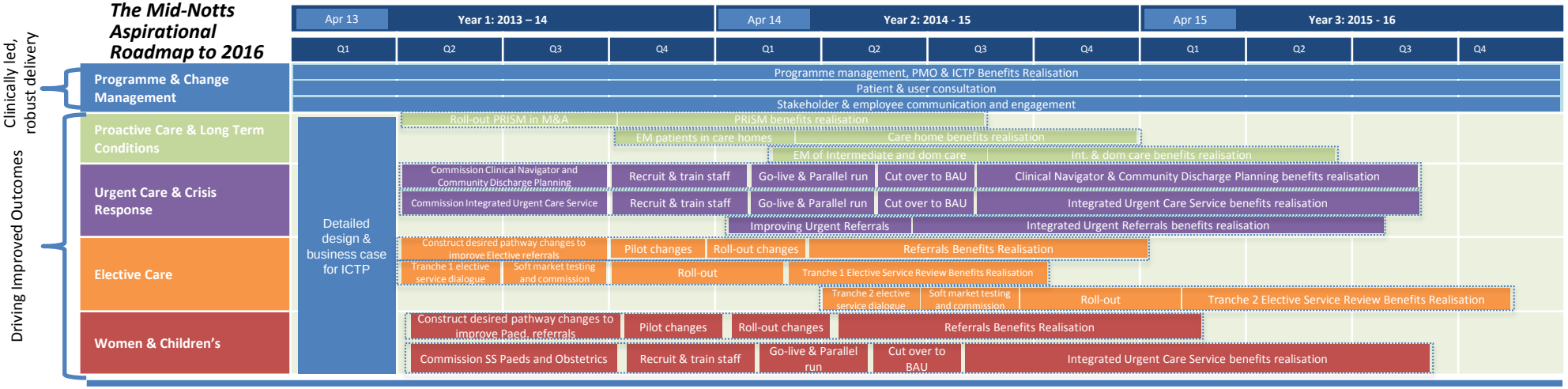
Joint commissioning strategies, aligned budgets: Dementia End of Life Care Reablement	**Joint commissioning:** Improving Lives in Nottinghamshire	**Jointly funded and commissioned integrated provision:** Mental Health Intermediate Care Service (MHICS)
Joint training and working: Roll out of Gold Standard Framework for end of life care	**Integrated provision with Third Sector Partners:** Working with Macmillan on long term conditions	**Joint working with Pharma:** Joint improvement projects in COPD, diabetes, falls and bone health
Large scale strategic development: Joint services centres to support integrated working	**Joint strategy and implementation plan:** Assistive Technology (Flo), Connected Nottinghamshire	**Multi-agency groups:** Frail Elderly Strategy Groups for Mid and South Notts Urgent Care Boards

…so we understand the critical factors that make change successful.

We recognise that integrating care presents significant transitional and operational challenges. In order to realise our overarching benefit of an Integrated Nottinghamshire, there will be a number of critical success factors:

1. **Clinical and Organisational Leadership**
   Leadership is the single biggest contributory factor to the success or failure of a complex change programme. Our governance structure, led by the Health and Wellbeing Boards, will ensure the integrity of the programme and drive benefits for citizens.
2. **Strong and Deliberative Engagement**
   Engagement with all our stakeholders is key to making sure that there is a strong sense of ownership of the change. We have dedicated groups in place to facilitate this, including our Citizens' Panels and engagement workstreams.
3. **Business Case & Benefits Lead Approach**
   A key tool the system will use to underpin the change will be a robust detailed business case. This will enable Integrated Nottinghamshire to be rigorous in its pursuit of both financial benefits and outcomes for citizens.
4. **Programme Management**
   We understand the necessity of rigorous programme management and have already made sure this is in place across the county, so we know how we will deliver our plans, manage our risks and evaluate our outcomes. As an example, the Mid-Notts aspirational roadmap to 2016 is outlined below.
5. **An Integrated Delivery Team**
   Our delivery teams include representation from major stakeholder groups, programme management, design, clinical leadership, information, estates and workforce transformation.
6. **Innovative Finance and Contracting**
   We are considering how to use contracting mechanisms to promote provider collaboration to ensure optimum outcomes for citizens that are also good value for money. We are already experimenting with alternative incentivisation models and as a pioneer would look to work within new models such as Capitated and Outcome-Based Incentivised Contracts (COBIC).
7. **Timely access to Data and Systems**
   All of the interventions proposed require technology enablement. We are already working on sharing data and providing single records for health and social care through Connected Nottinghamshire. Our ambition is to have a system that will enable us to share information and learning, assess citizens for risks and enable seamless care.
8. **Workforce and Culture**
   We are committed to delivering a workforce that meets the needs of patients through innovation, inclusiveness and engagement. Strategic direction is provided by the East Midlands Local Education and Training Board (LETB) and Training Council (LETC). Our culture is also one that is hungry for change. Our staff and our citizens see the value of what we are doing and are proud to be a part of such an important transformation.

The Mid-Notts Aspirational Roadmap to 2016



June 2013

Our citizens and staff shape our vision with us.

Engagement will be essential if we are to genuinely integrate services across the county and to achieve a smooth and efficient transition to new ways of working. Our engagement will be based around : 1) Engaged citizens and communities, 2) Collaborating commissioners and providers, and 3) Engaged workforce.

Engaged citizens and communities

Engaging our citizens and communities before, during and after integration is vital to the success of Integrated Nottinghamshire. We have already developed shared stories to help everyone understand why it is important that we change. We engage our citizens throughout the design of our Integrated Care interventions and also throughout delivery. An example of this would be the Communications and Engagement Forum and Citizens' Panel within the Mid Nottinghamshire Integrated Care Programme.

Patient and carer voices will also steer evaluation and ongoing development of Integrated Nottinghamshire. We propose to manage this by recruiting and working with a team of 'patient leaders and carer champions' who would act as a critical friend to review operational and strategic aspects of the programme. This team would ideally be supported and housed within local HealthWatches, and should be encouraged to maintain an independent view.

Collaborating commissioners and providers

Genuine collaboration between the county's major stakeholder groups is going to be essential for success. We want to use the Pioneer programme to develop a clear and consistent message about why change is important. We will develop the recent 'making it real' audit conducted by Nottinghamshire County into an action plan across the county. The principle of collaborating commissioners and providers (whilst adhering to the principles of competition and market forces) will be at the heart of the Integrated Nottinghamshire governance model (page 6) and the design and commissioning of our interventions.

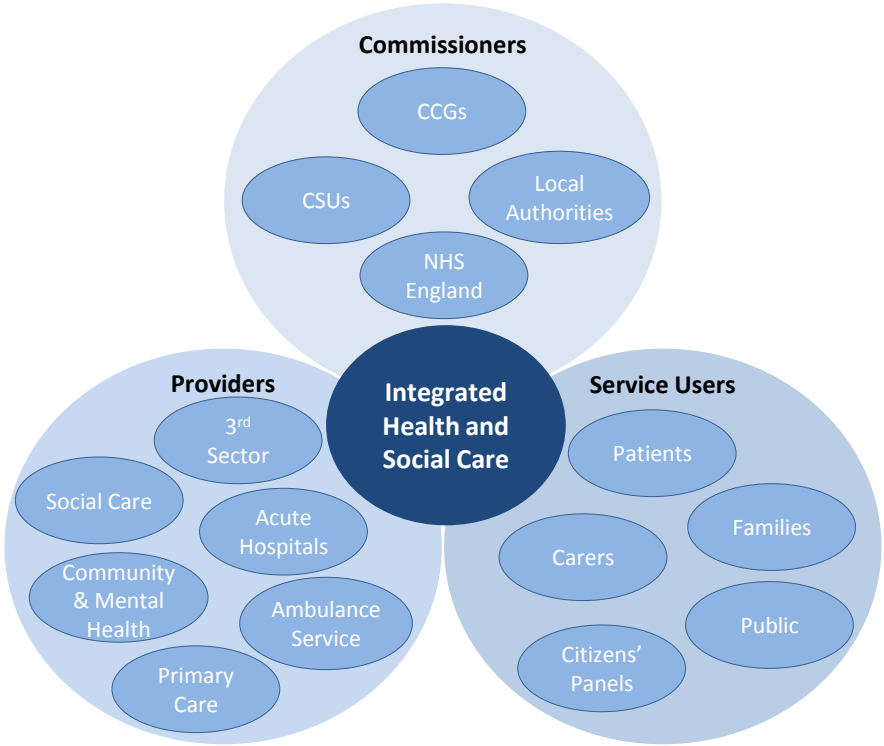
Engaged workforce

Given integration is knocking down traditional organisational barriers, our changes are likely to create significant workforce changes. This can lead to considerable uncertainly for our staff. We will engage our workforce throughout the programme through clear and consistent communications, driven by the Health and Wellbeing Board, and ensure that change is developed in partnership with them. For example, our Integrated Frail and Elderly Model of Care was designed in consultation with over 220 staff across the county.

"I feel so proud to be a part of this project – I think it's probably the most important thing I've ever been involved in as a nurse; the knock on effects for future practice are going to be enormous."
Luella Robb, Practice Nurse Clipstone Health Centre

We believe that change creates exciting opportunities for health and social care professionals in the county and we want them to be proud to work in the country's leading Integrated health and social care economy.

The Integrated Care Stakeholder landscape



Wider Integration

In Nottinghamshire, voluntary organisations, the County Council, District Councils and Public Health are working together to build stronger communities, develop 'social capital' and reduce the demand on traditional health and social care services. For example, the County Council Trading Standards teams are based within the Adult Social Care, Health and Public Protection department. Through schemes such as "*Buy with Confidence*" they play a significant role in protecting the vulnerable and helping people to feel safe within their own homes and communities, while also providing education and support to help people maintain their independence.

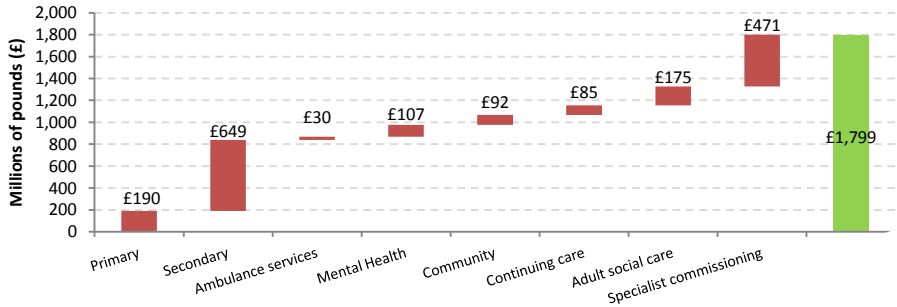
Whilst our model is clinically lead, a financial and analytical case is a critical component of our delivery approach.

INTEGRATED NOTTINGHAMSHIRE

Our Health and Social Care Economy

Our initial estimates are that the total cost of the health and social care economy in Nottinghamshire is £1,800m. An indicative breakdown between different aspects of care is set out in the graph below, though we note that not all of this spend will be in scope for integrated care reconfiguration.

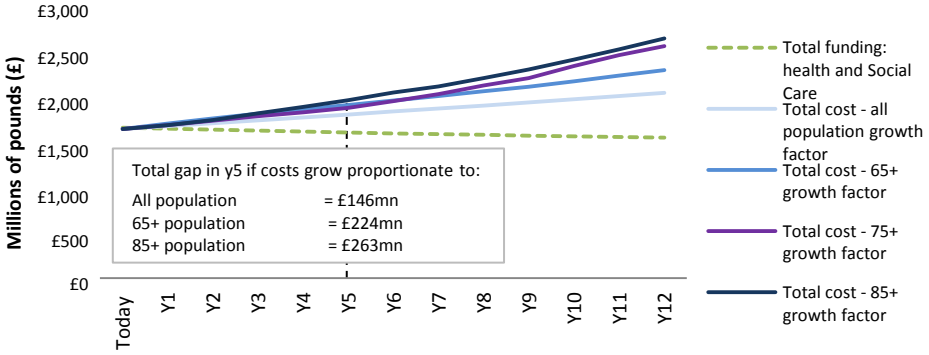
Current health and social care economy spend, by type of care



The scale of our financial challenge

The scale of challenge is not under-estimated. Analysis for the county has shown that, taking into account funding levels, population growth and inflation, the financial gap could increase to at least £146m in 5 years if services were to stay as they are. This could be even higher depending on the impact of demographics on healthcare costs (e.g. if healthcare costs rise in line with the over 85 population the gap in five years exceeds £260m).

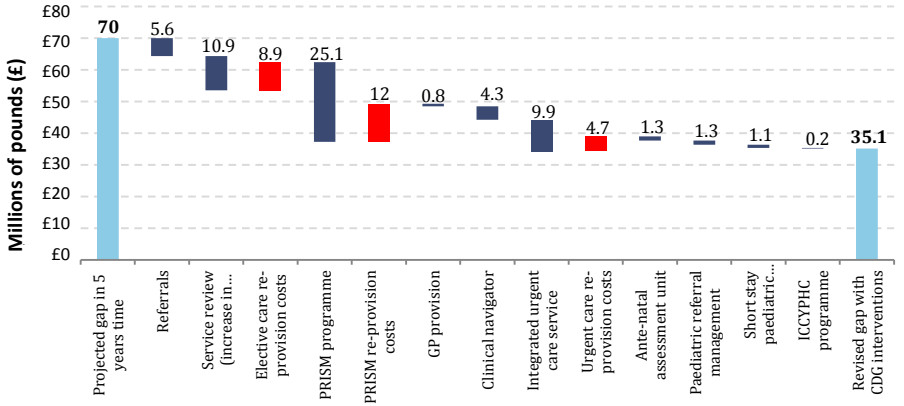
Gap between funding and costs of care



Closing the Gap

We are confident that our current and planned Integrated Nottinghamshire interventions will significantly close our financial gap. An example of this is the analytical case we have put together in our Mid-Notts Blueprint, that identifies £35m in savings. These savings will be used either to address the funding gap or be reinvested in new models of care.

Impact of Mid-Notts interventions on the projected gap



Holding ourselves to account

The Integrated Nottinghamshire governance structure and the Health and Wellbeing Boards will hold our transformation to account. We will regularly evaluate programme delivery and financial benefits realisation, ensure that there are high levels of satisfaction with services through patient, carer and staff feedback, and will manage a dashboard of system and quality (safety, experience and effectiveness) integrated care metrics.

- Non-elective admissions aged 65+ per 1,000 pop 65+
- Non-elective bed days aged 65+ per head of 1,000 pop 65+
- Non-elective re-admission rate within 28 days aged 65 and over
- Non-elective re-admission rate within 90 days aged 65 and over
- Excess winter deaths for over 65s
- No of delayed transfer of care days aged 18+ per 100,000 pop
- Registered deaths per 1,000 pop
- Proportion of local authority ASC spend on people aged 65+ on res/nursing care
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Proportion of people aged 65+ discharged direct to residential care
- Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+

Most importantly, we are clear what health and social care will feel like for our citizens in five years time.

Our vision, made reality

We have a clear idea of what we want to achieve and where we want to be in five years time. We have a strategy that shapes our plans and we have an integrated model of care through which to develop our interventions.

We have strong delivery teams that are already making change happen. They are supported by nationally recognised governance, an understanding of what makes change successful and an evidence base that builds on our local and national networks. Our track record gives us confidence we can and will transform health and social care for our citizens.

Most importantly, our vision is shaped by, and continues to be shaped by our citizens and our staff. Together we will work to deliver health and social care that is best for everyone; an Integrated Nottinghamshire where health inequalities do not exist and all people can live longer, healthier and happier lives.

Our ambitious citizen perspective

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

Engagement through social Media
See staff and patients' views at: www.youtube.com/watch?v=zXypXVN_Yjk

Health and social care in five years

By 2018:

- Access to services will be less complex through single points of access and use of web based information allowing self access;
- People will only tell their story once as assessment functions are joined up and information is shared across health and social care;
- Citizens will have greater choice and control over their lives and more self determination;
- People will have greater self awareness of how to improve their own health and well being through prevention and healthy lifestyles;
- Local communities and individuals will be healthier, live longer and more independently. They will be supported to live with risk and will be less reliant on statutory services;
- Hospitals and long term care will be last resorts and only when there is an absolute need that cannot be met outside of these environments; and
- Organisations will be joined up and will work together to share resources and learning, with one combined Health and Social care personal budget.

What people are already saying

Nottinghamshire County Council

Report to the Health and Wellbeing Board

2nd October 2013

Agenda Item: 8

REPORT OF SERVICE DIRECTOR, PERSONAL CARE AND SUPPORT YOUNGER ADULTS

THE NOTTINGHAMSHIRE RESPONSE TO 'TRANSFORMING CARE; A NATIONAL RESPONSE TO WINTERBOURNE VIEW HOSPITAL.

Purpose of the Report

1. To inform Board members of the local response to the Department of Health report, 'Transforming Care; A National Response to Winterbourne View Hospital', and the subsequent Winterbourne View Concordat.

2. To seek approval for the continued work to develop alternative services for people who are inappropriately placed in hospitals and the development of local services to prevent future inappropriate placements, together with an agreed shared funding responsibility.

Information and Advice

3. In May 2011 an investigation by the BBC Panorama programme revealed criminal abuse of people with learning disabilities at Winterbourne View, a Castlebeck assessment and treatment hospital near Bristol. As a result of criminal proceedings, eleven care workers admitted 38 charges of either neglect or ill-treatment of people with learning disabilities.

4. In December 2012, the Department of Health (DH) report **Transforming Care: A National Response to Winterbourne View Hospital** was published based on a number of reviews and investigations which had been undertaken by the Police, the CQC and local services. The report identifies a range of actions required at a national and local level to drive up the quality of support provided to people with learning disabilities, particularly those that are identified as having 'challenging behaviour' so they can receive high quality healthcare and be supported to live in the community. At the same time a national Concordat Program of Action was published backed up by a joint improvement programme led by The Local Government Association (LGA) and the NHS England.

5. The DH report found

   - **Patients stayed at Winterbourne View for too long and were too far from home** – the average length of stay was 19 months. Almost half of patients were more than 40 miles away from where their family or primary carers lived.

   - **There was an extremely high rate of 'physical intervention'** – well over 500 reported cases of restraint in a fifteen month period.

- **Multiple agencies failed to pick up on key warning signs** – nearly 150 separate incidents – including A&E visits by patients, police attendance at the hospital, and safeguarding concerns reported to the local council – which could and should have raised the alarm.

- **There was clear management failure at the hospital** – with no Registered Manager in place, substandard recruitment processes and limited staff training.

- **A 'closed and punitive' culture had developed** – families and other visitors were not allowed access to the top floor wards and patient bedrooms, offering little chance for outsiders to see daily routines at the hospital.
- The Review also exposed wider concerns about how people with learning disabilities or autism and with a mental health condition or challenging behaviours were being treated in England:
- **Inappropriate placements** – too many people are being placed inappropriately in hospitals for assessment and treatment, and staying there for long periods.

- **Inappropriate care models** – too few people are experiencing personalised care that allows them to be in easy reach of their families, or their local services.

- **Poor care standards** – there are too many examples of poor quality care, and too much reliance on physical restraint.

6. At the same time the DH established a national Concordat Program of Action backed up by a joint improvement programme led by The Local Government Association (LGA) and the NHS England. The programme of action proposed a series of measures to improve care for people with challenging behaviour;

    - any adult who is in a specialist autism or learning disability hospital setting will have their care reviewed by 1 June 2013; and

    - if they would be better off supported in the community then they should be moved out of hospital as quickly as possible, and no later than 1 June 2014

    - The Department of Health will examine how organisations and their Boards of Directors can be held to account for the provision of poor care or harm, and set out proposals in the Spring to strengthen the system where there are gaps.

    - the CQC will tighten inspection and regulation of hospitals and care homes for vulnerable groups, with more unannounced inspection and greater involvement of service users and their families; and

    - the CQC will hold organisations to account more vigorously for any failures to provide good quality care in line with the legal requirements.

    - new guidance will be published on training standards, codes of conduct, better commissioning practices and a code of ethics by various national bodies in 2013;

    - stronger rules on social services departments' responsibilities for safeguarding issues are included in the draft Care and Support Bill; and

- the Department of Health will work with professionals, providers, people who use services and families to develop and publish by end 2013 guidance on best practice so that physical restraint is only used as a last resort where someone's safety is at risk and never to punish or humiliate.

- the NHS and councils are expected to work more closely on joint plans in future, with pooled budgets to ensure adults with challenging behaviour get the support they need; and

- a new NHS and local government-led joint improvement team, funded by the DH, will help guide local teams, supported by a Concordat pledging commitment from over 50 national partners to raise standards.

- The DH will develop a range of measures and key performance indicators to help local councils assess the standard of care in their area; and

- The Learning Disability Programme Board, chaired by the Minister for Care and Support, will monitor progress and publish milestones.

7. The key message is that people should receive support locally, near to family and friends. Progress in this area will therefore be dependent on developing a range of responsive local services which can prevent admissions to hospital or other large institutional settings. All actions should be appropriately informed by the views and needs of people with challenging behaviour and their families.

8. The DH have directed that CCGs should work closely with local authorities to ensure that vulnerable people receive safe, appropriate, high quality care and that there is a substantial reduction in reliance on inpatient care for these groups of people. Where specialist support is required the default position should be to put this support into the person's home through specialist teams and services, including crisis support.

9. Within Nottinghamshire a joint health and social care project team working across all CCG areas has commenced work to meet the requirements of the programme. The project group are tasked with reviewing all patients who are in inpatient care, locked or unlocked rehabilitation, or Assessment and Treatment Units. Liaison has taken place with regional specialised commissioning services in relation to patients in low, medium and high secure services to facilitate discharge of patients in these settings to the community but it is recognised the responsibility for carrying out the assessments of these patients sits with specialised services.

10. The team are overseeing the delivery of person centred plans for each individual that include clear discharge plans. On the basis of this planning the team will recommend development of appropriate and sustainable community placements for the individuals identified. Supported living schemes are being progressed in Ashfield, Huthwaite, Hucknall, Mansfield, Newark and Worksop. The aim is to provide core and cluster flats where service users with challenging needs have independent accommodation with access to on-site support from suitably qualified staff. Where supported living is not deemed suitable for an individual, residential care options will be pursued.

11. The team are also tasked with Identifying current resources available locally to support the service users on discharge from hospital and develop a plan for additional resources required to meet the objective of supporting people with learning disabilities in the community in the longer term. This includes identifying the funding required to meet the above objectives including consideration of pooled budget arrangements

12. The table below indicates key actions required and the timelines outlined in final Department of Health Report: together with an update on local progress

	Key Action	**By When**	**Progress to date**
1	All Primary Care Trusts to develop local registers of all people with challenging behaviour in NHS-funded care	1st April 2013	Registers of patient identifiable information cannot be held by CCGs at present and so it has been proposed that the Healthcare Trust maintain the register of inpatients with Continuing Care needs maintaining the register for patients in the community.
2	Health and care commissioners, working with service providers, people who use services and families to review the care of all people in learning disability or autism inpatient beds and agree a personal care plan for each individual based around their and their families' needs and agreed outcomes.	1st June 2013	35 assessments and associated documentation to inform the future planning of services for individual patients – this has been completed and signed off by end of June 2013. Clear discharge plans developed for all patients not deemed to be ready for discharge prior to 1st June 2014
3	CCGs and local authorities will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area.	April 2014	The capacity within local services to provide on-going support and monitoring to these and other complex patients requiring support in the community is being scoped to ensure a decrease in the use of out of area hospital beds.
4	Everyone inappropriately in hospital will move to community-based support	June 2014	25 patients have been reviewed as being ready to return to the community by June 2014. For these people planning is being undertaken to provide them with accommodation and individual support to meet this timescale.
5	Health and care commissioners should use contracts to hold providers to account for the quality	From April 2013	Current commissioning and contracting arrangements will be reviewed to ensure that

	and safety of the services they provide		accountability for quality is clearly defined

13. The DH report makes clear that where commissioning and funding responsibility transfers from the NHS to local government, councils should not be financially disadvantaged. The NHS should agree locally how any new burden on local authorities will be met, whether through a transfer of funding or as part of a pooled budget arrangement. The strong presumption is in favour of pooled budget arrangements with local commissioners offering justification where this is not done. Pooled budgets can be established under Section 75 of the NHS Act 2006 where a Local Authority and CCGs consider that this would enable better integrated care and provide an efficient way of working.

14. Health and Wellbeing Board is asked to consider how financial responsibility should be shared. The options are

    a) A simple transfer of funding from CCGs to the Council equal to the current cost of services and any savings made by the CCG from no longer accommodating people in hospital and moving them to community settings.
    b) A pooled budget. This could be confined to the current cohort of people being reviewed, to all people with a learning disability who challenge services, or for all learning disability services across the county currently funded by health and social care commissioners.

15. A pooled budget could deliver certain opportunities: such as:

- Facilitating a co-ordinated network of health and social care services, eliminating gaps in provision;
- Ensuring the best use of resources by reducing duplication and achieving greater economies of scale (giving both partners a vested interest in ensuring spend is committed in the most effective way);
- Forecasting of need that takes place when constructing the pooled fund will enable money to be more effectively targeted, with less wastage, on delivering local services which fit needs.
- Generating economies of scale. For example pooled funding arrangements could encourage commissioning practices that promote the rationalisation of suppliers and drive down costs. Pooled funding might therefore drives economies through scale *and* through greater power in the market.

16. A pooled budget could also deliver certain challenges, for example;

- There may be considerable cost from administering joint budgets
- Even where there are joint budgets often organisations prefer to keep some separation over their own element of the budget, denying a true joining up of budgets.
- There is no definitive evidence that pooled budgets lead to improved outcomes for service users or any savings over the long term (and there may be costs in the short term)
- Budgets would need to be pooled across up to 6 organisations

17. A limited pooled budget just for people with challenging behaviour could be calculated by scoping the current spend of commissioners and this would facilitate the ending of perverse incentives to reduce spend that may impact negatively on the other partner.

18. In many areas pooled budgets have already taken place, although in some areas disaggregation has already taken place due to perceived costs associated with managing pooled budgets. However a fully joined up pooled budget does have the potential to deliver many of the potential advantages outlined above.

19. A national Programme Board Stocktake report was completed in July of this year (see attached at **appendix1**). The stocktake identified the most significant risk to completing the actions required relates to the very tight timescale for developing suitable accommodation options. Most of the reviews of the 25 people ready to leave by June 2014 have suggested that supported living is the most appropriate housing option. To house 25 people with challenging behaviour by June 2014 is a very difficult and complex task.

20. There are multiple issues around compatibility of service users, some service users are offenders who cannot live in certain areas, there is a lack of capital to develop housing, planning permission can delay or derail completely new schemes and there is a lack of willing housing providers. Even where these hurdles are overcome building or converting properties can take a long time.

21. Following the stocktake submission, Coun Bosnjak, Chair of the Health and Wellbeing Board wrote to Chris Bull, Chair of the national Improvement Programme to enquire if additional capital investment would be forthcoming to aid the development of accommodation.

22. A further issue which may cause delays in people moving to their preferred or most appropriate accommodation is the application of the Deprivation of Liberty safeguards. For some of the individuals assessed as being able to be supported in the community, a Deprivation of Liberty application would need to be made. This is likely to incur significant delays due to the need for an order being agreed through the Court of Protection. A similar recent case within the county took over a year to resolve through the Court.

23. There may be some service users who can move to appropriate accommodation but for whom the above factors lead to a delay in them moving beyond June 2014. In order to meet the June 2014 deadline of the service users leaving hospital they might be asked to move to accommodation that does not fully suit their needs. This decision should take into consideration the potential consequences of moving the patient to a less than ideal placement for a period as oppose to having an extended stay in hospital. Both courses of action will have costs and benefits that will require consideration. The Board may wish to consider whether it would prefer to see interim care and accommodation to be provided or delayed transfers from hospital in these circumstances.

24. The case scenario below provides an example of the nature of needs which are present with people currently being reviewed for a move from hospital accommodation.

Mr X had a difficult childhood that included emotional neglect and abuse. He did not always attend school. He has a moderate learning disability, including significant communication problems, as well as mental ill health.

After leaving school Mr X began to lead a chaotic lifestyle, abusing alcohol as well engaging in criminal activity such as theft, violence and using fake firearms to intimidate members of the public. He was accommodated in residential care but this broke down due to assaultive behaviour and issues around mental illness and criminal behaviour.

Mr X was subsequently put on a section of the mental health act and was eventually moved to a secure hospital to undertake a period of treatment and containment. Over a period of 5 years significant clinical assessment has taken place determine what factors maintain Mr X's behaviours of concern. A multi-element therapeutic approach has been used, where Mr X has engaged with occupational therapy, psychology, psychiatry, speech and language therapy and the direct contact of skilled nursing staff.

There has been significant improvement in Mr X's mental health, and he has been supported to develop daily living skills, such as cooking, general housework, shopping and planning and seeking help. He will require a further period of 6 months support to implement incremental access to the wider community to ensure his safety skills are in place and can be maintained before he moves back to the community.

Reason/s for Recommendations

25. This report outlines the work taking place to implement the required actions resulting from the DH report, Transforming Care, A National Response to Winterbourne View Hospital; and the Winterbourne View National Improvement Programme

Statutory and Policy Implications

26. 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.

Financial Implications

27. The current cost of providing care to people accommodated in locked rehabilitation hospitals is estimated to be £2,600 per week. The cost of people accommodated in low / medium secure settings is unknown, being funded as part of a regional block contract. The future care costs of accommodating people in community settings with appropriate care and support remains unclear and will not be fully known until each individual care and support plan has been completed at the point of discharge.

28. However, evidence from similar transfers of care previously undertaken such as the Campus re-provision programme would show that community alternatives are likely to be more costly

than the existing hospital based care. It is also estimated that whereas the current cost of care is 100% health funded, alternative provisions are likely to incur an element of social care funding requirements which again cannot be estimated until full assessments have been undertaken of Continuing Health Care needs. The guidance states that existing NHS funding should be fully reutilised for the provision of new services (this may not be possible for funding allocated to the regionally commissioned services) but It may be prudent to suggest that this is likely to be insufficient to meet future needs.

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board

1) note the content of the report.
2) approve in principle the establishment of a pooled budget to meet the needs of the people who will move from hospital to more appropriate community based support, subject to further work to scope the size of the pool, develop an appropriate management arrangement and develop risk sharing agreements.
3) agree to interim placements being made for individuals whose preferred accommodation and support cannot be provided within the prescribed time frame of 1st June 2014
4) agree to receive an update report in January 2014 to include progress on the development of pooled budget arrangements.

Jon Wilson
Service Director, Personal Care and Support Younger Adults
Adult Social Care Health and Public Protection Department

For any enquiries about this report please contact:

Ian Haines
Commissioning Officer,
Adult Social Care Health and Public Protection Department

Constitutional Comments (NAB 12.09.13)

29. The Health and Wellbeing Board has authority to approve the recommendations set out in this report by virtue of its terms of reference.

Financial Comments (KAS 23.9.13)

30. The financial implications are contained within paragraphs 27 and 28 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:

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

Winterbourne View Joint Improvement Programme

Initial Stocktake of Progress against key Winterbourne View Concordat Commitment

The Winterbourne View Joint Improvement Programme is asking local areas to complete a stocktake of progress against the commitments made nationally that should lead to all individuals receiving personalised care and support in appropriate community settings no later than 1 June 2014.

The purpose of the stocktake is to enable local areas to assess their progress and for that to be shared nationally. The stocktake is also intended to enable local areas to identify what help and assistance they require from the Joint Improvement Programme and to help identify where resources can best be targeted.

The sharing of good practice is also an expected outcome. Please mark on your return if you have good practice examples and attach further details.

This document follows the recent letter from Norman Lamb, Minister of State regarding the role of HWBB and the stocktake will provide a local assurance tool for your HWBB.

While this stocktake is specific to Winterbourne View, it will feed directly into the CCG Assurance requirements and the soon to be published joint Strategic Assessment Framework (SAF). Information compiled here will support that process.

This stocktake can only successfully be delivered through local partnerships. The programme is asking local authorities to lead this process given their leadership role through Health and Well Being Boards but responses need to be developed with local partners, including CCGs, and shared with Health and Wellbeing Boards.

The deadline for this completed stocktake is Friday 5 July. Any queries or final responses should be sent to Sarah.Brown@local.gov.uk

An easy read version is available on the LGA website

May 2013

Winterbourne View Local Stocktake June 2013			
1. Models of partnership	**Assessment of current position evidence of work and issues arising**	**Good practice example (please tick and attach)**	**Support required**
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	There is a Joint management Group across the local authority and lead Clinical commissioning Group. This group includes operational staff and commissioning officers		
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	There is good engagement from commissioned housing providers, and care support providers. Specialist external health consultants have been employed to undertake health elements of reviews. They have provided summaries regarding their findings which is being fed back to providers and informing commissioning. NHS regional specialist commissioners declined to engage with this method of external review or to have local authority involvement, and took a single agency approach. Two people have been identified from secure care that are ready for discharge to the community before June 2014.		
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	A Draft project plan has been written which is to be agreed by the integrated commissioning group. The development of alternative service provision has commenced		
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	The Integrated commissioning group (ICG) is overseeing project work. Regular reports are being made to the LDPB on progress		

1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	A Report on progress is to be presented at the September H&WB Board		
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	The Escalation process for conflict resolution is to report to the ICG or in urgent cases to the Chief Operating Officer of the Clinical Commissioning Group (CCG) &Local Authority Service Director.		
1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	Local accountabilities are understood by organisations and partnerships. There is less clarity at regional and national levels. There will be on-going dialogue with regional commissioning teams.		
1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	Ordinary Residence issues are already arising, there are currently two individuals identified as becoming ordinary resident within the county as a consequence of this work. There may be further financial and management issues in relation to patients from other authorities who will become County residents. There are risks that other authorities may place people in independent living in the county who will then become ordinary resident, and also that individuals may be placed in residential care within the county but who in the future may be subject to a treatment order and then become the aftercare responsibility of the authority		Support for placing authorities to retain responsibility
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	The ability to procure accommodation in a timely manner is the biggest risk to placing people in the community. Capital for development of accommodation services will be required which is not readily available at this time. Requests for capital funding to support the programme will be made to the local authority and CCG, however national		Capital for development of suitable accommodation and alternative support options

	allocations would help programme delivery.		
2. Understanding the money			
2.1 Are the costs of current services understood across the partnership.	Current spend is known for people placed by local commissioners; we are seeking to understand secure care costs which are part of a regional block contract and managed by NHS England .		
2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care.	A Financial strategy is to be developed and agreed by the H&WB Board by September '13.		
2.3 Do you currently use S75 arrangements that are sufficient & robust.	. No s75 agreement is in place locally		
2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	There is no pooled budget in place locally		
2.5 Have you agreed individual contributions to any pool.	N/A		
2.6 Does it include potential costs of young people in transition and of children's services.	N/A		
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	To be determined by the strategic integrated commissioning group		
3. Case management for individuals			
3.1 Do you have a joint, integrated community team.	The Project Team is working with local services to review and assess individuals excepting low secure patients who are responsibility of regional commissioners.		
3.2 Is there clarity about the role and function of the local community team.			
3.3 Does it have capacity to deliver the review and re-provision programme.	The team has the capacity to undertake reviews, assessments and develop support plans.		
3.4 Is there clarity about overall professional leadership of the review programme.	Professional leadership is through the project steering group.		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	All patients have named workers and advocacy arrangements in place where required		

4. Current Review Programme			
4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	All reviews were completed by the end of May. Commissioning and Operational staff are meeting to clarify actions, lead workers for each person and commissioning requirements.		
4.2 Are arrangements for review of people funded through specialist commissioning clear.	There is limited understanding of the needs of people reviewed by specialist commissioners Specialised commissioners have undertaken their own review process. Local commissioners have recently met with specialised commissioning colleagues to discuss the results of these reviews to facilitate planning for individuals.		Clarity around role and expectations of specialised commissioning in relation to Winterbourne actions.
4.3 Are the necessary joint arrangements (including people with learning disability, carers, advocacy organisations, Local Healthwatch) agreed and in place.	All individuals and their carers/advocates were invited to participate and contribute to the review process.		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	We have registers in place however recent guidance around CCGs and commissioners holding personal identifiable information has meant we can no longer hold this information. We are actively considering how and if this information should be held in the future		Clarity around commissioners and CCGs sharing and holding personal identifiable information
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	Recent national policy prevents CCGs from holding or sharing personally identifiable information therefore CCGs cannot hold, manage or co-ordinate registers We had a local register of information that was submitted to EMIAS in November 2012 however CCGs cannot maintain these registers due to the prohibition on holding personal identifiable information. Further work is therefore required to develop a suitable process for maintaining the		Policy on CCGs having access to personally identifiable information

	register.		
4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	All reviews have included service users, carers and advocates		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	External Consultants were employed by health to carry out reviews in conjunction with local practitioners. The Joint steering group (made up of local clinicians and commissioners) scrutinised each review carried out by the Consultants..		
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	Very good information was completed by specialist behavioural support consultants.		
4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	All reviews have been completed		
5. Safeguarding			
5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol.	Safeguarding is discussed with providers as part of the contract monitoring process and providers are required to let commissioners know of any safeguarding concerns when they occur. In addition there is the expectation that local areas will let commissioners know of any safeguarding concerns as appropriate (as per good practice guidance)...		
5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	Support providers are given full assessment and risk management info and supported to understand the implications of this. Case managers are employed for out of area inpatient placements to monitor placements and ensure appropriate plans are in place for each patient.		

5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	CQC do not routinely inform LA or CCGs of inspection outcomes except where enforcement actions are required. There are quarterly information sharing meetings with CQC. And we act jointly where appropriate to address concerns		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	LSCBs and NSAB are not regularly updated about review arrangements – The HWBB commissioning structure oversees this work and it is reported to partnership Board. Work of this nature requires clear accountability and reporting and should not be subjected to different lines of accountability, however reports will be made to the respective safeguarding Boards for information as appropriate.		Clarity about accountability and reporting arrangements
5.5 Have they agreed a clear role to ensure that all current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	Out of area placements are monitored through Contract Review meetings and through individual CPA meetings which are attended by Case Managers and Care Co-ordinators. Any safeguarding issues are highlighted and addressed through these routes.		
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings.	All providers are expected to have robust safeguarding arrangements in place and this is monitored through contract review meetings. .		
5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments.	The CSP and safeguarding Adults Board has undertaken work to consider the outcomes from serious case reviews and taken action to address issues of bullying and hate crime		
5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	Yes :		EMIAS AUDIT REPORT
6. Commissioning arrangements			
6.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	Individual outcomes and requirements are being collated to develop overall commissioning plans		
6.2 Are these being jointly reviewed, developed and delivered.	Care pathways are being developed jointly. Framework is required to develop funding		

	agreements and alternative future support arrangements.		
6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services.	Number of people placed out of area is known, all jointly funded people are commissioned by LA.		
6.4 Do commissioning intentions reflect both the need deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	Future commissioning intentions are yet to be developed. This will be overseen by the integrated commissioning group		
6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	Regional commissioners have not engaged fully with local services. We are continuing to seek agreement with regional commissioners		
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	Future funding arrangements are yet to be assessed and agreed across the partnership.		
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	Local advocacy contracts are in place and additional funding is available for this work.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	Current project plan is being developed.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	Local services cannot guarantee that all persons will be re-provided by 01/06/14 within current resources and available services. Our ambition is to develop and provide accommodation and support in the least restrictive environment, however for some individuals appropriate interim arrangements may need to be made.		Is the requirement to move people from inpatient settings or to provide the most appropriate future care arrangements
6.10 If no, what are the obstacles, to delivery (e.g. organisational, financial, legal).	Supported Living accommodation cannot be developed within the timescale and legal issues re: DoLs may prevent SL opportunities, e.g. a recent case in the CoP took over a year to reach decision. Development of specialist accommodation and the capital finance to do so will restrict options. which		

	may lead to interim placements being made		
7. Developing local teams and services			
7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings.	As above In each review it has been identified whether the person will need support over and above what a local team would usually provide to inform CCG commissioning.		
7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements.	Local advocacy contracts are maintained and reviewed, not out of county arrangements subject to other LA arrangements.		
7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	BIAs will be involved on an individual basis as required as part of the provision process.		
8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies			
8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally.	Local services are utilising a scenario generator to determine future crisis, community and emergency support arrangements.		
8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.)	We have specialist Community Assessment and Treatment Teams whose role is to work with providers and patients to avoid hospital admission where appropriate and possible. Additional local services such as step up / step down, enhanced SL options are being considered for development alongside enhanced community based support services		
8.3 Do commissioning intentions include a workforce and skills assessment development.	To be completed as per the delivery plan		
9. Understanding the population who need/receive services			

9.1 Do your local planning functions and market assessments support the development of support for all people with complex needs, including people with behaviour that challenges.	Information is contained in JSNA and Health needs assessments and will be included within the market position statement for social care Current market development and procurement activity, being designed to meet needs.		
9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	Yes		

10. Children and adults – transition planning			
10.1Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults.	The needs of young people in transition are yet to be factored into future planning requirements and further work is required to develop this.		
10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	This will be modelled as part of the delivery plan going forward based on local population and health needs assessment		
11. Current and future market requirements and capacity			
11.1 Is an assessment of local market capacity in progress.	Market analysis is underway – early indications suggest insufficient capacity in specialist residential and SL environments. Planned tender for SL services will address some issues of enhanced services.		
11.2 Does this include an updated gap analysis.	This will be completed following market analysis		
11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	The LD Steering Group has been set up in order to validate and plan next steps for the reviews of in patients . The group includes clinicians and commissioners and has been key in ensuring appropriate plans are developed for patients who are currently in hospital		

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name……Jon Wilson, Service Director……

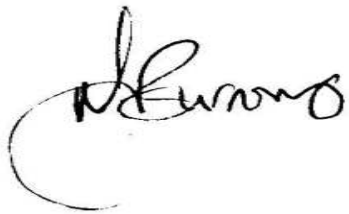
Organisation……Nottinghamshire County Council……..

Contact……0115 9773985……

Signed by:

Chair HWB ……

LA Chief Executive …



CCG rep…

Nottinghamshire County Council

Report to Health and Wellbeing Board

2 October 2013

Agenda Item: 10

REPORT OF CORPORATE DIRECTOR, POLICY, PLANNING AND CORPORATE SERVICES

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

3. The attached work programme has been drafted in consultation with the Chair and Vice-Chair, and includes items which can be anticipated at the present time. Other items will be added to the programme as they are identified.

Other Options Considered

4. None.

Reason/s for Recommendation/s

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

Statutory and Policy Implications

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

RECOMMENDATION/S

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

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

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

Constitutional Comments (HD)

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

Financial Comments (PS)

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

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All

Health and Wellbeing Board & Workshop Forward Plan

	Health & Wellbeing Board (HWB)	HWB Workshop (closed sessions)
4 September 2013	**Meeting Rearranged**	
2 October 2013 **(**Rearranged from 4th September**)**	**Young People Friendly Health Services in Nottinghamshire** (Kate Allen / Irene Kakoulis) **Children who go missing from home or care** (Anthony May) **Health & Social Care Integration Fund** (David Pearson) **Integrated Pioneer Bid** (David Pearson) **Nottinghamshire Response to "Transforming Care: A National Response to Winterbourne View Hospital".**(Jon Wilson) **Verbal update on findings of Substance Misuse consultation** (Chris Kenny)	**Cancelled**
6 November 2013	**Health Checks** (John Tomlinson) **Clinical Commissioning Group Commissioning Intentions – All Nottinghamshire CCGs** (TBC) **Homelessness** (Barbara Brady) **CAHMS Needs assessment** (Kate Allen) **Nottinghamshire Safeguarding Children Board Annual Report 2012/13** (Steve Edwards) **Health & Wellbeing Strategy 2014-17** (Cathy Quinn)	

	Health & Wellbeing Implementation Group report (David Pearson)	
4 December 2013		**Health & Wellbeing Strategy, integration and aligning local priorities**
8 January 2014	**HealthWatch** (Joe Pidgeon) **Integrated Commissioning Function – commissioning priorities** (Kate Allen) **Public Health Nursing, Healthy Child Programme & Family Nurse Partnerships** (Kate Allen) **Integration Transformation Fund Plans –** (Cathy Quinn) **Roles and Responsibilities for NHS England** (Helen Pledger) **Mid Notts Integrated Care Transformation programme Update –** (Lucy Dadge) **Health Protection Arrangements** (Jonathan Gribbin / Vanessa McGregor) **Autism Self assessment** (Cath Cameron-Jones)	
5 February 2014		
5 March 2014	**Breast Feeding** (Kate Allen) **Publication of Public Health Annual Report** (Chris Kenny) **Learning disability self assessment** (Cath Cameron-Jones TBC)	
2 April 2014		

Proposed Future Items (& suggested date)

Public Meeting	**Workshop**
JSNA annual report (Chris Kenny) – spring/summer 14, then annual each spring. • Nottinghamshire Child & Family Poverty Strategy annual performance update (Derek Higton/Justine Gibling) • Role of NHS England • CCG collaborative commissioning arrangements • CAMHS needs assessment • Health Inequalities • Role of Police & Crime Commissioner • Workplace Health • Dental public health • Accidental injury prevention • Campaigns to prevent cancer and long-term conditions • Interventions to reduce and prevent birth defects • Learning Disabilities • End of Life • Housing • Use of social media to portray health messages • MASH report • Older people • LD / ASD • Education and aspirations	• SHA review outcomes – scrutiny of QOF data / Quality of Primary Care services (May/July) • QIPP • Links with scrutiny • Vulnerable Children & Disability • Homelessness