Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 02 September 2015 at 14:00

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

AGENDA

Notes

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

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

Customer Services Centre 0300 500 80 80

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

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.

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

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 3 June 2015 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Joyce Bosnjak (Chair)
Reg Adair
Martin Suthers OBE
Muriel Weisz
Jacky Williams

DISTRICT COUNCILLORS

	Jim Aspinall	-	Ashfield District Council
A	Susan Shaw	-	Bassetlaw District Council
	Vacancy	-	Broxtowe Borough Council
	Henry Wheeler	-	Gedling Borough Council
A	Debbie Mason	-	Rushcliffe Borough Council
	Tony Roberts MBE	-	Newark and Sherwood District Council
	Andrew Tristram	-	Mansfield District Council

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group
A	Dr Steve Kell OBE	-	Bassetlaw Clinical Commissioning Group (Vice-Chairman)
	Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
	Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
	Dr Paul Oliver	-	Nottingham North & East Clinical Commissioning Group
	Dr Judy Underwood	-	Mansfield and Ashfield Clinical Commissioning Group

LOCAL HEALTHWATCH

Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

Vacancy	-	North Midlands Area Team, NHS England

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Chris Cutland	-	Deputy Police and Crime Commissioner

OFFICERS IN ATTENDANCE

Kate Allen	-	Public Health
Caroline Baria	-	Adult Social Care, Health and Public Protection
Paul Davies	-	Democratic Services
Sarah Fleming	-	Better Care Fund Programme Manager
Irene Kakoulis	-	Public Health
Nicola Lane	-	Public Health
Cathy Quinn	-	Public Health

CHAIR

The appointment by the County Council on 14 May 2015 of Councillor Joyce Bosnjak as Chair of the Health and Wellbeing Board was noted.

VICE-CHAIR

Dr Steve Kell was elected Vice-Chair of the Board for 2015/16.

MINUTES

The minutes of the last meeting held on 1 April 2015 having been previously circulated were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Steve Kell, Councillor Debbie Mason, David Pearson, and Councillor Susan Shaw.

DECLARATIONS OF INTEREST BY BOARD MEMBERS AND OFFICERS

None.

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Dr Kenny reported that discussion was still in progress with NHS England about their representation on the Board.

RESOLVED: 2015/023

That the membership of the Board, as set out above, be noted.

ANNUAL SUMMARY OF THE NOTTINGHAMSHIRE COUNTY COUNCIL PUBLIC HEALTH COMMITTEE 2014/15

Dr Kenny introduced the report, which summarised the activities of the Public Health Committee during 2014/15. Board members expressed disappointment that progress had been slow at building links with local authorities to provide Public Health advice to spatial planning. Dr Kenny explained that progress had begun, and it was intended to report more fully to the Board later in the year. He reminded members that the Board's role was to coordinate activity at a strategic level, with spending decisions being taken by the various commissioning organisations.

RESOLVED: 2015/024

That the report on the work of the Public Health Committee be noted.

BETTER CARE FUND PERFORMANCE AND UPDATE

Sarah Fleming introduced the update report on the Better Care Fund (BCF). Consultation on the BCF pooled budget had identified support for the proposal. The first quarterly performance exception report had been circulated. The report also proposed amendments to Bassetlaw CCG's BCF plan. It was not expected that the Mid Nottinghamshire or Greater Nottingham areas would be amending their plans. It was pointed out that at Nottingham University Hospitals, the trajectory in relation to total non-elective admissions had been well exceeded.

Concerns were raised about waiting times to access to Disabled Facilities Grants. It was explained that the BCF Programme Board would be looking into the implementation of DFGs in more depth.

RESOLVED: 2015/025

1) That the outcome of the public consultation on the s75 pooled fund be noted.

2) That the readiness assessment detailing the current state of readiness to deliver the BCF plan in 2015/16 be noted.

3) That the performance exception report be noted.

4) That the quarterly national reporting be approved.

5) That the amendments to the NHS Bassetlaw CCG component of the BCF plan be approved.

HEALTHY CHILD PROGRAMME AND PUBLIC HEALTH NURSING: UPDATE REPORT

Kate Allen introduced the report on commissioning arrangements for the Healthy Child Programme and Public Health nursing, proposals to integrate health visiting and school nursing services into a Healthy Child Programme, and a proposed expansion

of the Family Nurse Partnership. She responded to questions and comments from Board members.

- She clarified that the budget for school nursing was around £3m, and for health visiting and Family Nurse Partnership was around £11m. She confirmed that NHS providers would be able to bid for the new services.

- It was pointed out that Phase 1 of the Troubled Families Programme had produced a surplus which had been reinvested in other early intervention activities.

- It was commented that while both primary and secondary schools taught PHSE, secondary schools varied in the amount of PHSE delivered. Dr Allen referred to the Healthy Schools Programme, and the possibility of obtaining some national funding for emotional wellbeing in schools.

- Extension of the existing contracts was supported from a CCG perspective, as it gave more time to align other commissioning plans. Dr Allen stated that it was intended to involve CCGs in preparation of the new specifications.

- Board members emphasised the value of good working relationships in order to make the best use of resources. Dr Allen indicated that building relationships would form part of the specification.

RESOLVED: 2015/026

1) That the current and future proposed commissioning arrangements for the Healthy Child Programme and Public Health nursing for 0-19 year olds be noted.

2) That the proposals to integrate health visiting and school nursing services to provide a joined-up Healthy Child Programme for Nottinghamshire be noted.

3) That the planned expansion of the Family Nurse Partnership programme be noted.

BREASTFEEDING: UPDATE ON PREVALENCE, TARGETS, LOCAL PLANS AND THE DEVELOPMENT OF A BREASTFEEDING FRAMEWORK FOR ACTION

Kate Allen introduced the report on the benefits of breastfeeding, performance in Nottinghamshire against breastfeeding targets and the development of a Framework for Action for breastfeeding. Councillor Wheeler introduced work by Gedling Borough Council to promote the UNESCO Baby Friendly Initiative.

In the discussion which followed, it was explained that men should be encouraged to overcome their prudishness about breastfeeding. This could be achieved by working with young men to break down stereotypes, and working with fathers right from the start of pregnancy. Gedling Borough Council was commended for its success. It was explained that the statistics for breastfeeding were based on national performance indicators. However it would be possible to include local performance indicators in the

new contracts for the Healthy Child Programme. Reference was made to the value of properly trained advocates who would be capable of facilitating changes in behaviour.

The Chair encouraged Board members who wished to be involved in preparation of the Framework for Action to contact Kate Allen.

RESOLVED: 2015/027

1) That the information in the report about breastfeeding in Nottinghamshire be noted.

2) That Board members encourage the support of local initiatives to promote breastfeeding.

3) That the development of a joint Nottinghamshire and Nottingham City Breastfeeding Framework for Action be supported, and any interested Board members be involved in preparation of the Framework.

HOW YOUNG PEOPLE FRIENDLY ARE OUR HEALTH SERVICES? NOTTINGHAMSHIRE MYSTERY SHOPPER REPORT 2015

Irene Kakoulis presented the report about the mystery shopping exercise undertaken by a group of young people in 2014. The mystery shoppers had assessed GP surgeries, contraception and sexual health services and pharmacies against the Department of Health's quality criteria for young people friendly health services ("You're Welcome"). Board members were encouraged to view the video about the project, and to attend the related network event on 13 August 2015.

Board members commended the mystery shopping exercise, and believed it would be helpful to extend its coverage. Some CCGs carried out their own mystery shopping. It was suggested that young people should be encouraged to participate in patient participation groups at surgeries. While the NHS Choices website had information aimed at young people, it was regarded as important to keep these web pages up to date.

The view was also expressed that young people lacked the confidence to present their own needs to their GP other than in relation to sexual health or contraception. Similarly, guidance from the Youth Service tended to be in relation to these services rather than the full range of health issues.

RESOLVED: 2015/028

1) That the findings and recommendations of the Nottinghamshire Mystery Shopper project be noted.

2) That the proposed next steps for commissioners of services be supported, to ensure that health services are young people friendly through the consistent use of "You're Welcome" by providers.

3) That an event for young people be held under the auspices of the Board to present the mystery shopping findings and discuss their priorities in relation to

health and wellbeing with members of the Health and Wellbeing Board and stakeholders.

4) That the proposal be supported that the Nottinghamshire Young People's Health Steering Group has strategic ownership of the Mystery Shopper programme and leads on the implementation of agreed recommendations.

CHAIR'S REPORT

As well the data on local authority health profiles available on the Public Health England website, it was pointed out that data at ward level could be found on the Public Health Observatory website.

Workforce planning and the NHS, and workforce pressures locally, was suggested as a possible topic for a Board meeting or workshop.

The £55m fund established by the Department of Health to improve the health of homeless people was noted, and local organisations encouraged to submit bids.

RESOLVED: 2015/029

That the Chair's report be noted.

WORK PROGRAMME

RESOLVED: 2015/030

That the work programme be noted.

The meeting closed at 4.20 pm.

CHAIR

Nottinghamshire County Council

Report to Health and Wellbeing Board

2 September 2015

Agenda Item: 6

REPORT OF THE CHAIR OF HEALTHWATCH NOTTINGHAMSHIRE

HEALTHWATCH NOTTINGHAMSHIRE ANNUAL REPORT

Purpose of the Report

1. To provide the Health and Wellbeing Board with an update on progress from Healthwatch Nottinghamshire.

Information and Advice

2. Healthwatch Nottinghamshire has published its annual report for the 2014/15 period. A summary of the main achievements for the period include:

- Publishing its first statutory Annual Report
- Holding its first annual events, 'Healthwatch Happenings' in three locations across the county
- Organising a successful Carers' Conference, attended by 150 local carers and professionals
- Undertaking its first Insight Project into the experiences of patients using the Arriva Transport Solutions renal transport service at Nottingham's City Hospital
- Continuing to recruit and train volunteers, including the first group of Enter and View volunteers
- Receiving over 500 responses from young people who completed a survey of their experiences of Health and Social Care services
- Considering a wide range of issues reported by the public at our Prioritisation Panel
- Continuing to circulate a monthly newsletter and regular 'Have Your Say' reports showing what has happened with issues reported to us
- Developing its Coffee and Chat model of engagement with the public and delivered a series of coffee and chat sessions in different parts of the county

- Launching a new website
- Commissioning bespoke software to help collect and analyse data about people's experiences of services
- Escalating issues to Healthwatch England that needed a national response

3. A full copy of the report is attached as Annex 1.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. Not applicable.

Statutory and Policy Implications

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

RECOMMENDATION

1) That the Board note the report and annual report and the progress made by Healthwatch Nottinghamshire.

Joe Pidgeon
Chair of Healthwatch Nottinghamshire

For any enquiries about this report please contact:
Nathan Hutchinson, PR & Communications Officer
tel: 0115 963 5179
email: nathan.hutchinson@healthwatchnottinghamshire.co.uk

Constitutional Comments (SG 19/08/15)

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

Financial Comments (MM 20/08/15])

8. There are no financial implications arising from this report.

Background Papers and Published Documents

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

- None

Electoral Divisions and Members Affected

- All

Healthwatch Nottinghamshire

healthwatch Nottinghamshire

Annual Report 2014/15

Contents

Note from Joe Pidgeon, Chair of Healthwatch Nottinghamshire Board

This second year of our existence has seen a surge of activity across the full range of our statutory duties. It has been a successful, productive and exciting year as a result of which the public, NHS patients, users and carers have been increasingly served and assisted by the presence and help provided by Healthwatch staff.

Underpinning all has been the work of our brilliant Chief Executive, establishment of a full team of 10 staff, a complete Board of 8 members, and a growing group of volunteers, all of whom combine high quality with a determined and committed spirit. There has been innovative and extensive engagement with children and young people that bears comparison with anything yet achieved nationally.

At a local level our Community and Partnership Workers and Volunteer Co-ordinator have successfully dug deeper into their respective communities of interest and geography. The development of a comprehensive volunteering strategy has borne fruit in our first Enter and View work.

As with last year, there is still much to do to increase the awareness of the role and work of Healthwatch. But progressively the word is getting out there by means of media exposure, an ever-expanding database of interested people, through the work of our dedicated staff team, and through more imaginative ways of getting us known to the Nottinghamshire public.

As a result of the above initiatives across the County an increasing number of issues are coming in to Healthwatch. The receiving, recording and analysis of this information is crucial. Our ability to do this has improved hugely. This has been the result of the work of our Evidence and Insight Manager and Information and Admin worker. We are sad to be losing the latter, Charlotte Daniel, who has been so key in helping us to progress.

This has also been the year when the newly formed Prioritisation Panel consisting of 7 trained volunteers has proved invaluable in helping us to decide how to respond to the many issues coming in.

Mention should also be made of the helpful role of our 16 person Advisory Group made up of representatives from the County's major stakeholders that relate to health and social care. Its task it is to scrutinise and support the work of the Board to ensure its wider accountability to the community and its effectiveness. We work very closely with Healthwatch Nottingham and we continue to share two posts. We are active in our contacts with other local Healthwatch across the East Midlands.

But the future remains challenging. The new Government has not yet informed local Healthwatch of their funding position after March 2016. The level of funding we receive in future years will inevitably raise the question of how we prioritise in order to be effective in meeting statutory requirements.

Notwithstanding those challenges ahead, the work of the past year has meant that the Board, the Chief Executive and the staff team are positive and confident in their readiness and robustness to take Healthwatch Nottinghamshire forward.

About Healthwatch

Healthwatch Nottinghamshire is an independent organisation that helps people get the best from their local health and social care services.

We listen to local people's experiences of services in Nottinghamshire, and use the evidence we gather to bring about real changes in how services are designed and delivered.

Healthwatch Nottinghamshire is here for all of the people in the county, children, young people and adults, and works across all health and social care services. This allows us to create an overall picture of the quality of local services so that we can see what is working well, and what could be improved. We are part of a national network, with a local Healthwatch in every local authority area in England.

Our vision/mission

Our mission is to involve local people to help improve health and social care services for the people of Nottinghamshire.

Our vision is that Healthwatch Nottinghamshire puts local people's experiences at the heart of service design and delivery, leading to continuous improvements in the quality of treatment and care they receive.

Our strategic priorities

Our strategic priorities are to ensure that:

- People's views and experiences of health and social care services are sought and understood
- The view and experiences of people who use local services and the people who care for them are presented to, and influence, local decision makers
- Healthwatch Nottinghamshire is a well-run and a sustainable organisation which continues beyond its current contract

Pictured: Jane and Deb using our five star rating system to collect people's experiences

Engaging with people who use health and social care services

Understanding people's experiences

Healthwatch Nottinghamshire Community and Partnership Workers and our volunteers are out and about in Nottinghamshire, making contact with local people and the groups that support and represent them. We want to make sure that children, young people and adults know that they can have their say about health and care services and are given every opportunity to do so. We meet up with groups and individuals in a range of health, care and community settings and invite them to tell us about their experiences. We organise our own events and we attend events organised by other organisations.

During 2014-15 we met up with over 4500 people at 374 activities across the county.

As a local Healthwatch, we need to ensure that particular groups of people in our communities are able to have their say. These are children and young people, older people over 65 and people who are disadvantaged, vulnerable or whose voices are seldom heard. During 2014-15, 40% of our engagement activities were targeted at people from these groups and their experiences made up 49% of the experiences we gathered.

Have Your Say Points

Healthwatch Nottinghamshire Have Your Say points have been established in various locations across the county, including in council offices, hospitals and community buildings. The aim of the Have Your Say points is to provide information about Healthwatch Nottinghamshire and also to encourage people to feedback their views and experiences of services to us.

During this year we have reviewed our Have your Say points and concluded that the points work best when Healthwatch staff or volunteers are available to give people information and support them to have their say. Have Your Say points have worked well in rural areas in Bassetlaw, where local volunteers at Clarborough and Welham and Misterton have been active in encouraging local people to have their say.

Recently staff of the mobile post office that travels around rural Bassetlaw have also become Healthwatch volunteers taking information out to people in four villages across the north of the district.

Pictured: Setting up a Have your Say Point

Coffee and Chat

We have been developing our Coffee and Chats as a way of meeting up with people in a relaxed way to talk about their experiences of health and care services. We provide coffee and cake in a local venue, such as a library or garden centre, and invite people to come along.

In Rushcliffe we have organised Coffee and Chat sessions in partnership with Rushcliffe Clinical Commissioning Group (CCG) and Rushcliffe CVS. Over 100 people came along to three events held in towns and villages across the borough and told us about their experiences of local services. The CCG will be using the findings of the report in its future plans and the report has also been circulated to local providers.

We have also developed a 'pop up' coffee and Chat, where we go along to meetings of groups (with cake) to invite members to talk about their experiences. Pop ups have been held at a number of groups including:

- Brinsley Movement for All
- Beeston Sing and Smile Group
- Broxtowe Chinese Early Years Group
- Rushcliffe Mental Health Carers Group

"It is always good to feel our views and ideas are valued and taken seriously. The friendly way you gathered our views was entirely in line with our own evaluation methods as even those who might not be comfortable speaking in front of a group were able to participate"

Anne Sheldon, Brinsley Movement For All, Group Leader

Pictured: Coffee and Chat session

Children and Young people having their say

One of our Community and Partnerships workers works exclusively with children and young people across the county.

During 2014-15, 53 engagement activities were delivered for children and young people, in schools, youth centres and at events for children and young people. During the year we asked children and young people to rate their experiences of health and care services, and gathered over 1000 service ratings. We produce a quarterly report summarising the feedback from children and young people, which is circulated to providers and commissioners.

During our engagement activities with young people (11-18) in 2014, we asked them to complete a questionnaire about their views and experiences. This questionnaire has been completed by 394 young people. We are currently working with students from Nottingham Trent University to analyse the data. The results will be fed back to providers and commissioners and will help us to prioritise work with young people in the future.

"You really have gained some excellent feedback from children and young people and we have used the information for a number of pieces of work including the development plans for a schools and health hub to promote PSHE and policy development."

Irene Kakoullis, Integrated Children's Commissioning Hub, Nottinghamshire County Council

Children and Young People from the Gypsy, Roma, Traveller Community

Healthwatch Nottinghamshire worked with local organisation Gypsylife to find out more about the health and care experiences of young people from the Gyspy, Roma, and Traveller (GRT) community. Gypsylife took the Healthwatch Nottinghamshire young people's questionnaire out to 66 GRT young people aged 11 to 19. We then compared the findings with answers given by young people in general. We found that GRT young people used up to 13 children's health and social care services, compared to the general young population who used up to 23 services. When asked to comment on how satisfied with a service they were, we found that a higher percentage of GRT young people gave services a poor rating (both satisfaction and how young person friendly the service was) than the general young population. This information was passed on to the CCGs and the Integrated Children's Commissioning Hub to be used in future planning and commissioning of services.

Working Age People

Healthwatch Nottinghamshire is part of the Working Voices project group in Bassetlaw, which is co-ordinated by the local CCG. The local Community and Partnerships worker has been part of the Working Voices team which is engaging with local employers and attending work places to speak to the local workforce and find out their views about local health services and plans for the future. The Working Voices project hopes to engage with as many Bassetlaw people as possible to hear their views on local NHS services and future health care plans. This pilot project is going to be continued and developed offering an additional route for communicating and engaging with people who are in full time work, and who may not normally have time to come to engagement events.

Healthwatch Nottinghamshire has not yet specifically targeted people who work or volunteer in Nottinghamshire but do not live in the county in its engagement activities.

Older people over 65

During the year Healthwatch delivered 11 events aimed at older people, and also attended 42 events arranged by other organisations. These included:

- Breathe Easy Group Celebration event organised by the British Lung Foundation.
- Larwood Flu Fayre
- Gedling Veterans Armed Forces event
- Afternoon Tea at Edwinstowe run by Newark CVS
- Keep Well Keep Warm organised by Ashfield Voluntary service.
- Older Persons Advisory Group

Pictured: Have Your Say at Breathe Easy Celebration Event

People living in Care Homes

Since Healthwatch started operating in 2013, there have been concerns about the quality of care in care homes across the county, but we were not hearing directly from residents of care homes or their relatives and carers about their experiences of care. We have developed a programme of work to raise awareness of Healthwatch in care homes and to ensure that any experiences reported to us are reported and acted on.

Jointly with Healthwatch Nottingham we have developed information about Healthwatch for people in care homes and their relatives and carers, which has been sent or delivered to all the care homes in the county. Healthwatch is now routinely invited to relatives' meetings when there are problems with quality of care at care homes so that we can tell them about Healthwatch and how to contact us. We have also adapted the coffee and chat model for care homes and have trained a group of volunteers to go to care homes and talk to residents and their relatives and carers about their experiences of health and care services.

Adult Mental Health

Healthwatch Nottinghamshire has heard from a number of people who had poor experiences of accessing mental health services across the county. At the end of 2014 we undertook a scoping project to find out more about people's experiences of mental health services and to see how these varied across the county. We collected over 100 pieces of feedback from people with experience of using mental health services and we have produced an Insight Brief with the findings. Crisis services were highlighted as the main area of concern for both service users and carers, with 59% of the comments about this area being negative. As a result, one of Healthwatch Nottinghamshire's priorities for further work in 2015-16 is an Insight Project about access to mental health crisis services from both a service user and carer perspective. We have also signed up to the Nottinghamshire Mental Health Crisis Concordat so that our work on mental health crisis is co-ordinated with work by undertaken by other bodies in the county.

New website

In November we launched our new website. This includes a Feedback Centre where people can directly log their experiences of local health and care services and can leave a rating. We hope that over time more people will leave their experiences in this way so that information can be shared with providers and commissioners and contribute to improving the experiences of other people. The information collected through the website will be combined with the information we collect from other sources and feed into a new database and analytics system which will help us to spot problems and trends at an early stage.

Raising Awareness of Healthwatch

We continue to promote Healthwatch in a number of different ways and we are grateful to many local organisations who also support us by actively promoting who we are and what we do.

No. PR & Comms activities	101
No. Newsletters published	14
No. Website hits	17514
No. Tweets published	1191
No. Articles in the media	36
No. Radio/TV interviews	12
No. People receiving the newsletter	1345

We have continued to share a regular column in the Nottingham Post with Healthwatch Nottingham and the two Healthwatch now also have a regular slot on our local community television channel, Notts TV.

We know we still have a long way to go to raise awareness about Healthwatch across all of the communities in the county. In our Annual Survey we asked people if they thought that the majority of local people know about Healthwatch. Only around 20% said that they thought this was the case.

Pictured: Rushcliffe Sunday Funday

Enter and View

Enter and View is a statutory power that local Healthwatch can use to visit health and care providers' premises to find out how services are experienced by patients and service users at the point of delivery. Trained volunteers visit services and talk to patients, service users and carers about their experiences of using the services and then report back on what they have found.

The Healthwatch Nottinghamshire Board decided early on that its Enter and View powers would be used in response to issues or concerns raised by local people (see page 23). The Prioritisation Panel is able to recommend to the Board that an Enter and View visit is undertaken as one of the outcomes of its discussion of the issues that have been reported to Healthwatch.

During 2014-15 we recruited 7 Enter and View representatives. References are taken up and a Disclosure and Barring Service check is carried out for all representatives, who undergo a core training programme.

The core sessions look at the role and responsibilities of the Authorised Representative in detail, where and when we can use the powers and cover subjects such as safeguarding, equality and diversity, confidentiality, reporting processes and how to deal with situations that may arise. We also include a Dementia Friends session for all our Representatives.

The Enter and View volunteers' first project was the Insight Project into the experiences of patients using the Renal Transport Service to travel to and from the Renal Unit at Nottingham City Hospital. The Prioritisation Panel received a number of comments from patients about the impact of the transport service and felt that an in depth study would be beneficial to better understand patients' experiences and identify possible solutions. (see page 16) The Insight Report has been well received by commissioners and providers and a detailed action plan has been drawn up by the provider to address the recommendations in the report, which is being monitored by the commissioners.

Pictured: Volunteer Training Session

2014/2015 - At-A-Glance

During April 2014 to March 2015 we collected **543** detailed comments about local health and social care services.

Of these comments...

34% were **positive**

5% were **neutral**

56% were **negative**

5% were **mixed**

The services that were talked about most were...

1. **Mental Health.** 14% of comments were about mental health of which 74% were negative
2. **GPs.** 14% of comments were about GPs of which 65% were negative.
3. **Social Care.** 8% of comments were about social Care of which 70% were negative.
4. **Hospitals.** 50% were about hospitals of which 49% were negative

Themes that were discussed across all services included:

1. **Treatment and Care** (125 comments)

57% 3% 36% 4%

2. **Access to service** (123 comments)

11% 10% 75% 4%

3. **Staff** (112 comments)

71% 2% 22% 5%

Providing information and signposting for people who use health and social care services

Healthwatch Nottinghamshire is not directly commissioned to provide an Information and Signposting service to individual members of the public.
We have developed good working relationships with information and signposting services provided by providers and commissioners so that we can direct people to sources of information and advice about services, as appropriate. However, we do provide information and advice people during the course of our regular engagement activities. An example of this was a member of the public who told us how hard she found the long walk from the front entrance of her local hospital to the ward to visit her husband. When we reported this to the hospital, they told us that visitors could request the help of a porter with a wheelchair to get to the ward. We reported this back to the person concerned, but also made other organisations aware and included the information in local newsletters, so that other people in the same situation know that they can ask for assistance if they need it.

Pictured: Panel receiving questions at Carers' Conference Event

Information for Carers

In May 2014 Healthwatch Nottinghamshire hosted the county's first Carers' Conference on behalf of Nottinghamshire County Council and the local NHS Clinical Commissioning Groups. Over 145 local carers and professionals attended the event. The event was free to attend and we offered replacement care costs and help towards travel if needed. Workshops were delivered on issues of interest to carers, including specific aspects of the Care Bill, welfare rights and carers' health.

Carers also had the chance to put their questions and comments to an expert panel of senior people from the NHS, the County Council and carers' organisations. The market place of local organisations helped carers to identify and access help and support they needed. Comments provided by carers when we asked what they will do differently as a result of attending the conference included:

"I will be able to get the help and support I need to look after my mom better"

"Attend a course on Dementia I found out about today. Take a carer and her wife to it. Access two other courses for carers I found out about today e.g. caring with confidence and looking after me.

Dementia Team and Dementia Friends

Healthwatch Nottinghamshire has joined the Dementia Action Alliance. As part of our action plan we have developed a small Dementia Team of staff and volunteers to ensure that Healthwatch is gathering and responding to the experiences of people with dementia and their relatives and carers across the county.

One of the Healthwatch Nottinghamshire volunteers has taken on the role of Dementia Champion and attends a number of meetings and events on our behalf.

The Dementia Team has also received training from the Alzheimer's Society to become Dementia Friends Champions. All of our staff, Board and volunteers receive Dementia Friends training and we have also offered Dementia Friends training for members of the public alongside some of our engagement activities.

Influencing decision makers with evidence from local people

Producing reports and recommendations to effect change

Healthwatch produces the following reports on a regular basis:

- Have Your Say Report – feedback about the issues raised with Healthwatch and the actions taken
- Children and Young People's engagement report

These reports are widely circulated to providers, commissioners and the public. These give opportunities for information to be shared and responded to:

We reported that at one of our engagement activities with children, it was suggested that it would be good for children if they could have a friend to sleep over when they are in hospital. One of the hospital trusts got in touch with Healthwatch to say that they thought this was a great idea and they would see if they could put it into practice.

Putting local people at the heart of improving services

Healthwatch Nottinghamshire's mission is that the views and experiences of local people should be at the centre of decisions about local services.

This drives our own work, and it also central to our relationships with commissioners and providers. 83% of providers and 93% of commissioners who responded to our annual reflection survey indicated that they value the work of Healthwatch Nottinghamshire.

Almost three quarters of providers stated that we are making a difference to their work and two thirds of providers feel that our work is making a difference for local people. All of the providers who responded said that they would recommend that other organisations work with Healthwatch Nottinghamshire.

Focus on ……Insight Project on Renal Transport

During 2014 a number of people reported poor experiences of using the Renal Transport Service provided by Arriva Transport Solutions to travel to and from the Renal Unit at Nottingham City Hospital. The Healthwatch Nottinghamshire Prioritisation Panel gave this issue a high priority and decided that this issue should be looked at in more detail and it became the subject of our first Insight Project.

All of the providers and commissioners involved, Arriva Transport Solutions, Nottingham University Hospitals Trust, Mansfield and Ashfield Clinical Commissioning Group and Greater East Midlands Commissioning Support Unit, welcomed the initiative and supported the planning of the project. The Insight Project Team consisted of our newly trained Enter and View representatives and some of the Healthwatch Nottinghamshire staff team.

The Insight Project Team went along to all of the dialysis sessions for a week in November to talk to patients about their experiences of patient transport. We also circulated questionnaires for people to complete and some patients completed a transport diary.

During the project we:

- Undertook Interviews with 45 people who use the transport service, collecting over 12 hours of feedback.
- Gathered diaries of journeys from 7 patients covering 50 journeys.
- Collected 50 completed surveys from renal dialysis patients.
- Collected surveys from 17 members of the renal unit staff for their experiences of the service.

Pictured: Insight report

The report was published in March 2015 and the findings have been presented to the Joint City/County Health Scrutiny Committee, the Nottingham University Hospitals Trust Quality Committee and the Derbyshire and Nottinghamshire Quality Surveillance Group. Arriva Transport Solutions have developed an action plan to respond to the findings of the report and are meeting regularly with the commissioners. We plan to return to the Renal Unit in the autumn to see if the patients have seen any difference in their experience of the transport service

"It takes so much of your time, for some people, this just becomes your life, just this, and it doesn't have to be, it's just a little part of your life, not the whole of your life. Transport doesn't help make it a little bit of your life."

Renal dialysis patient

Promoting the Involvement of Local People in Commissioning, Provision and Management of Local Services

Healthwatch Nottinghamshire is frequently asked to participate in committees and boards for both providers and commissioners. Such requests are considered carefully, but generally we do not feel it is right for Healthwatch, as an independent body, to be a member of boards or committees and involved in making decisions about the future of local services. Where appropriate we do attend board and committees as a 'participating observer' and we have developed a guidance document about our role to help members to decide if attendance from Healthwatch is appropriate. We are clear that an invitation to Healthwatch to attend a board or committee is not a substitute for involving patients, service users, carers and the public, and that our role is to provide scrutiny of plans to involve local people in a meaningful way.

Healthwatch Nottinghamshire Champions on local committees and boards

Healthwatch Nottinghamshire Champions are volunteers who are members of committee or boards, but also represent Healthwatch at meetings. All the CCGs in Nottinghamshire have a body that represents the views of patients and local people to the Governing Body and each has a Healthwatch Champion who feeds information into the group and back to Healthwatch.

"I have been part of the peoples council since it was formed, it was established to provide assurance to the NNE CCG Governing Body that all decisions made by the NNE CCG have been informed by the appropriate level of input from patients carers and the community, we are there to ensure that the proper level of care is given to patients carers etc. I hope that I help by using my personal knowledge and experience over the years of how the NHS has helped me and other people that I know when discussing these changes and practices. At the moment I am involved with putting together a patients' charter of what we should expect our care to be".

Doreen Williams - Healthwatch Champion on Nottingham North and East CCG's Patient Council:

Consultations with the public about the shape of future services

As part of our information role, we monitor opportunities for the public to contribute to consultations about changes to services, and to commissioning decisions, and promote these through our newsletter, website and at events. We are increasingly being asked by commissioners to comment on plans for consultations and engagement events and we have been able to influence methods of consultation and timescales to try to ensure that people have a real opportunity to have their say.

We contributed to the recent Commissioning for Better Outcomes Peer Review of Adult Social Care, which recommended that the Council should extend involvement of Healthwatch Nottinghamshire in all commissioning areas.

Pictured: Carers' Conference workshop

Involving local people in Mid Nottinghamshire Transformation Programme

In mid-Nottinghamshire the NHS and County Council have developed a blueprint for transformation of health and social care services called 'Better Together'. Healthwatch Nottinghamshire has been involved with the programme in a number of ways; through attendance at the Transformation Board and the Communications and Engagement Group and through the involvement of a Healthwatch Champion in the Citizen's Board for the programme. Through all of these groups, staff and volunteers have been able to influence the amount and type of local people's involvement in the programme. This has included in the development of the outcomes framework for new contracts.

"As part of the NHS forward view, the Better Together Programme has been chosen as one of only 29 vanguard sites across the country. We are all very pleased about this because it demonstrates that the Department of Health has recognised the Programme as a forerunner in the improvement of services moving forward. By being part of this important group, I am able to contribute my opinion in all the discussions from an independent patient perspective, so putting patient care at the heart of the decisions made."

Jane Stubbings is a Healthwatch Nottinghamshire Champion on the Better Together Citizen's Board:

Contributing to Health Scrutiny

"I believe that we have had a productive and collaborative relationship with Healthwatch, they have been of great support to the Health Scrutiny Committee and I hope they feel that we have reciprocated that in our working with them, I look forward to continuing and building on our working relationship."

Councillor Colleen Harwood, Chairman - Health Scrutiny Committee, Nottinghamshire County Council

Healthwatch Nottinghamshire attends the two Council Health Scrutiny committees in the County to contribute local people's views to the work of the committees. The role of Health Scrutiny is to strengthen the voice of local people in the commissioning and delivery of health services. Health commissioners and providers have to present substantial variations to local health services to the Health Scrutiny Committees, who will look at how local people are involved in decisions about such changes. Healthwatch Nottinghamshire has contributed to discussions about patient transport, the plans for the future of both Adult and Child and Adolescent Mental Health Services, the need for better communication with the public about the plans for transformation of local services, and presented the outcome of the Renal Transport Insight Report.

Being part of the Health and Wellbeing Board

Joe Pidgeon, Chair of the Healthwatch Nottinghamshire Board, represents Healthwatch Nottinghamshire on the Health and Wellbeing Board. Information and evidence gathered by Healthwatch has been used by Joe to contribute to discussions, these include:

- The September meeting was reminded that Healthwatch had asked the Health and Wellbeing Implementation Group to monitor the impact of the budget reductions on the health and wellbeing of local people. This was accepted and we expect to see this included in the future work of the Implementation Group.
- At the same Board meeting Healthwatch made the point that there needs to be better cross referencing of communications messages to the public about the links between the Health and Wellbeing Strategy and the work of the three Transformation Boards in the county. A number of new communication measures are now planned for the Board, including a new communications lead in Public Health, greater use of Twitter, and more media coverage.
- At the December Board meeting, future plans for Child and Adolescent Mental Health Services (CAMHS) were under discussion. One of the recommendations was that a report should come back to Board on the work planned and underway to promote mental resilience and prevent mental health problems in children and young people in Nottinghamshire. This endorsed the point Healthwatch had made about the importance of developing initiatives at primary and secondary school level.

Joe produces a regular blog about his experience of attending the Health and Wellbeing Board – 'Joe Blogs', which complements the report that is produced by Nottinghamshire County Council following each meeting.

The Health and Wellbeing Board was subject to a Peer Challenge review in February 2015. The national Peer Challenge Team concluded that excellent leadership is shown by the Healthwatch Nottinghamshire representation on the Health and Wellbeing Board.

Quality Surveillance Groups

Quality Surveillance Groups (QSG) were set up to bring together all commissioners and regulators of health and care, including Healthwatch, to share information and intelligence about quality and safety of services. One of the actions that the Prioritisation Panel can recommend is that an issue is escalated to the relevant QSG. Quality Surveillance Groups are organised by the NHS Area Teams, so currently staff from Healthwatch Nottinghamshire attend two separate QSGs, one for Nottinghamshire and Derbyshire (covering all of Nottinghamshire except Bassetlaw), and also one for South Yorkshire, which includes Bassetlaw.

The meetings take place bi-monthly and are also attended by the Clinical Commissioning Groups, the County Council, Public Health England, the NHS England Area Team and all of the regulators. At the meetings information is shared about all of the main providers of health and care services in the area and local Healthwatch intelligence is included, as appropriate. Healthwatch Nottinghamshire has escalated one issue to the Nottinghamshire and Derbyshire QSG following patient safety concerns raised during the Renal Transport project.

Focus on…….Volunteering with Healthwatch Nottinghamshire

From the outset, the involvement of local people as volunteers has been central to our work. There are a number of different roles for volunteers, depending on their skills, interests and availability. We are increasingly developing micro-volunteering opportunities for people who want to get involved but do not want a continuing commitment.

Volunteers are offered different levels of induction and training, depending on their roles. All volunteers are asked to feedback about the activities they undertake on behalf of Healthwatch. There is a monthly email bulletin to all volunteers and there is a dedicated area on the Healthwatch Nottinghamshire website and a Discussion Forum on the website which is open to all volunteers.

We currently have 49 volunteers working with us and have recently asked them about their experience of volunteering with Healthwatch Nottinghamshire:

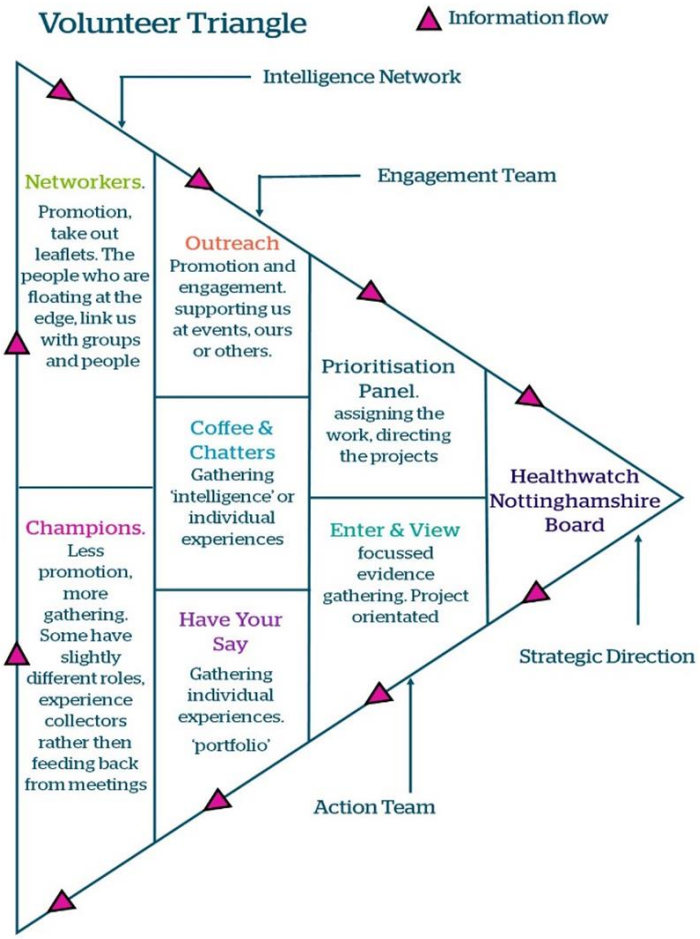
- 78% rated their induction as good or excellent
- 73% rated the training they received as good or excellent
- 78% rated their ongoing support as good or excellent
- 91% rated communication as good or excellent
- 90% said they felt valued by Healthwatch

All said they would recommend volunteering with Healthwatch to someone else.

We asked the volunteers what was the best thing about volunteering with Healthwatch Nottinghamshire:

"It is doing something useful for the communities in which we live. It gives me a personal satisfaction to know that the input I have often goes directly into improving services"

"The feeling that individuals can make a difference and speak up for those who feel unable to do so. It gives me a chance to share others views even if they are not my own"



Working with others to improve local services

Where appropriate, Healthwatch Nottinghamshire is keen to work with others to find out about people's experiences of health and care services and to ensure that these experiences are influential and make a difference.

Of the organisations who responded to our Annual Survey, 83% of providers and 93% of commissioners indicated that they value Healthwatch Nottinghamshire and almost three quarters of providers stated that we are making a difference to their work.

Two thirds of providers feel that our work is making a difference for local people.

We have undertaken a number of joint pieces of work with other organisations including:

- Rushcliffe Coffee and Chat events with Rushcliffe CCG and Rushcliffe CVS – the collected responses have been included in the work of the CCG and the South Notts Transformation Board
- Young Carers Bitesize events with Nottinghamshire County Council and the CCGs to find out more about the experiences of young carers in the County
- Recruitment of Cancer Champions with Macmillan – to recruit and train people to build links with local cancer groups

Pictured: BCVS Have Your Say Point Launch

Information about Electronic Prescriptions

Healthwatch Nottinghamshire was alerted to possible problems with the new Electronic Prescription Service by a member of the public who asked a relative to collect medication on her behalf and may have un-knowingly signed paperwork to change the patient's elected pharmacy, as the paperwork was not very easy to understand. A local Patient Participation Group (PPG) also raised a concern.

In July 2014 we worked alongside Healthwatch Nottingham, the Nottinghamshire Local Pharmaceutical Committee and the NHS England Area Team to ensure the public were informed of the advantages and disadvantages of the new Electronic Prescription Service. Working with NHS England we designed a poster which was distributed to all local pharmacies. We also provided further information through our website, participated in a discussion on Radio Nottingham with colleagues from the Local Pharmaceutical Committee to raise awareness of the campaign, and ensured that regular updates were provided through our newsletters.

"Our joint work with the Electronic Prescription Service (EPS) helped us understand the confusing environment the NHS is for the public so we were better able to advise pharmacies how they could better support their customer to make informed choices about EPS."

Nick Hunter – Chief Executive, Nottinghamshire LPC

Working with the Care Quality Commission

Healthwatch Nottinghamshire regularly shares information with the Care Quality Commission (CQC) locally. We have not escalated any issues to the CQC or made any recommendations that they should undertake special reviews or investigations.

We are now routinely asked if we have information to contribute to the planning of inspections of primary care services, hospitals and residential and home care. We are also invited to the monthly Information Sharing meeting where the County Council, CCGs and CQC share information about quality concerns in care homes and home care services.

Our CQC Primary Care lead convenes a quarterly meeting where Healthwatch Nottingham and Nottinghamshire can meet with CQC staff from all directorates and share information and plans.

Working with Healthwatch England

Healthwatch Nottinghamshire routinely sends reports to Healthwatch England about local issues and contributes to requests for information.

We contributed to the Healthwatch England Special Inquiry into discharge, focussing on the experiences of homeless people of being discharged from hospital, working with a local homelessness charity, Framework Housing Association, who were active in inviting feedback from their service users and the staff who work with them.

Escalation of issues to Healthwatch England – Personal Budgets and unregulated services

Healthwatch Nottinghamshire has escalated one issue to Healthwatch England during the year.

During 2014 we started to hear concerns from local people about a lack of quality assurance or regulation of some non-personal care services being purchased by people who receive a direct payment from the local authority.

Healthwatch Nottinghamshire heard about two cases where this gap in regulation had a severe impact on local vulnerable people. The services they had been using were not meeting their needs, but after raising concerns with the service directly, changes were not made and they were left with nowhere else to take their concerns.

The Healthwatch Nottinghamshire Prioritisation Panel discussed this issue and, following correspondence with Nottinghamshire County Council, decided to escalate the concern to Healthwatch England.

After gathering further evidence from other local Healthwatch, Healthwatch England Chief Executive, Katherine Rake, wrote a detailed letter to Jon Rouse, Director General of the Department of Health. In his response, Jon Rouse identified that local authorities' care planning should identify any individual problems with such services.

He also said that the Department of Health will be working on a new Personal Assistant Framework to address some of the risks for people employing their own staff using direct payments.

On occasions where we have specifically requested information from providers and/or commissioners, we have received a satisfactory response

How we make decisions

Local Healthwatch are required to have a procedure for making decisions and to involve local people in making decisions about Healthwatch priorities. Healthwatch Nottinghamshire has three bodies involved in the decision making process.

The Healthwatch Nottinghamshire Board

The role of the Board is to make decision about how Healthwatch Nottinghamshire plans and delivers its activities and makes the best use of resources. As Healthwatch Nottinghamshire is a registered company and charity, our Board members are both Directors and Trustees. All Board members are local people who are selected following an open recruitment process. Four new members have been recruited this year to join the existing four members.

The Chair of the Board is paid and dedicates at least three days each week to his role. The Board meets every eight weeks and the minutes of meetings are available on the Healthwatch Nottinghamshire website. Board members also represent Healthwatch Nottinghamshire at various meetings and committees.

Healthwatch Nottinghamshire Advisory Group

The Advisory Group was set up to support the work of the Board and the staff group. The Advisory Group is made up of people from a wide range of organisations and interest groups across the county, who can bring their knowledge and expertise to help in the development of Healthwatch Nottinghamshire. This includes people from user-led organisations, the Voluntary and Community Sector and health and social care providers and commissioners. The Advisory Group is involved in developing local policies and practice and has discussed and advised on a range of issues. These include: the setting up of the Prioritisation Panel; the development of the Information Sharing Protocol between Healthwatch and local providers and commissioners; developing our Enter and View policy and developing a local response to the Healthwatch England report on complaints. The minutes of the Advisory Group are available on the Healthwatch Nottinghamshire website.

The Prioritisation Panel

The Prioritisation Panel plays a key role in deciding what actions Healthwatch Nottinghamshire should take about the issues that are reported to it. The Panel is made up of local people, recruited through an open application process. There are currently seven members of the panel.

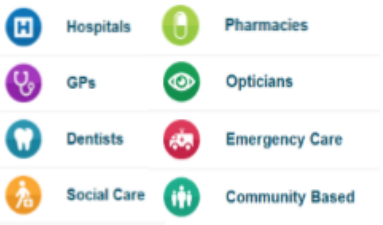
The panel meets monthly to provide an independent assessment of the information that has come in to Healthwatch Nottinghamshire. This could be patient experience gained directly through Healthwatch work, or information collated through other sources. Panel members assess the priority of issues using set criteria and they also make decisions about what actions should be taken and priorities for future work.

Actions may include whether we request further information, make a report or a recommendation, which premises to enter and view and when they should be visited. The meetings are open to the public and held in different locations across the county, so that local people can understand how we prioritise our work based on their needs and experiences. The minutes from meetings, outlining decisions made and the reasons for those decisions, are also published on our website.

Prioritisation Process

Tell us about your experiences of local health and social care services.

Have your say



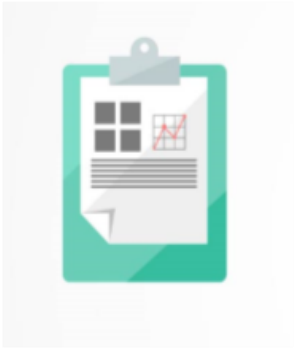
Shortlisting & Sharing

We carefully consider each comment, as well as looking for **trends and patterns.**

A shortlist of topics is prepared for discussion at our Prioritisation Panel. **All comments are anonymised** and shared with service providers and commissioners.

Prioritisation Panel

Our Prioritisation Panel is a small group of Healthwatch volunteers. They decide what to do next so that Healthwatch can **improve things** and **make a difference**.



Insight Projects

The Prioritisation Panel might ask us to begin an Insight Project on an important issue . A report will be written and recommendations made to the people who design and deliver local services.

See the impact...

Our regular 'Have Your Say Reports' keep you up to date with the work we do and the impact it has.

We also publish our Prioritisation Panel notes and Insight Project reports online.

Focus on…… the work of the Prioritisation Panel

Experiences taken to the Prioritisation Panel	**34**
Experiences prioritised as high	**6**
Experiences prioritised as medium	**23**
Experiences prioritised as low	**5**

Some of the issues that have been discussed at the Prioritisation Panel include:

Ophthalmology at Nottingham University Hospitals Trust (NUH)

In early 2014 we received a number of concerns from patients and carers about the Ophthalmology service provided at Queens Medical Centre in Nottingham. Following our contact with Nottingham University Hospitals Trust (NUH) over these concerns, we were invited to join their Head and Neck Patient Partnership Involvement Committee. A Healthwatch volunteer with personal experience over many years of one of the outpatient clinics in Ophthalmology and has attended the group throughout 2014-15, to represent the interests of patients in the service's plans to improve this service.

Access to GP services

The Panel has considered a number of comments from patients about difficulties and delays in getting an appointment with their GP. A report was produced summarising all the comments received, which was forwarded to the NHS England Area Team to contribute to the development of their Primary Care Strategy. Individual GP practices have let us know about their plans to improve access for their patients and we have asked local people to let us know how services are changing and if they improve.

Phlebotomy Services for Children

A carer contacted Healthwatch when she had tried to get an appointment for a blood test for her grandchild. She had been told she had to wait for up to 8 weeks for an appointment and her GP had advised her to go to A&E to get a test more quickly. She also found that there were a number of places that offered phlebotomy services for children, but not a central list. Healthwatch Nottinghamshire found that phlebotomy services for children are commissioned and delivered by a number of different organisations and, following our enquiries, the matter was discussed at the Children's Health Network. A list of sites offering phlebotomy services for children is now available and a report has recently been produced by commissioners making recommendations for improvements to the commissioning of services in the future.

CT Scanner at Newark Hospital

Healthwatch Nottinghamshire was alerted by a member of the public to the fact that Sherwood Forest Hospitals Trust, which runs Newark Hospital, had announced that it would not be replacing the CT scanner at the hospital, but would be purchasing a second scanner at Kings Mill hospital, which is over 20 miles away We approached the Trust and the commissioners to ask for more information about the implications for the health of local people of this decision and to raise concerns about how this change had been communicated. Concerns were also raised by the local MP, staff at the hospital and many local people and the Trust decided to review its decision and announced that it will replace the static scanner at Newark Hospital when it comes to the end of its life.

Our plans for 2015/16

The Healthwatch Nottinghamshire Business Plan for 2014-16 contains 10 outcomes that we aim to achieve through our work (see page 27). We will also be acting on the feedback that people have given us from our Annual Survey about where they think we are doing well and where we can improve.

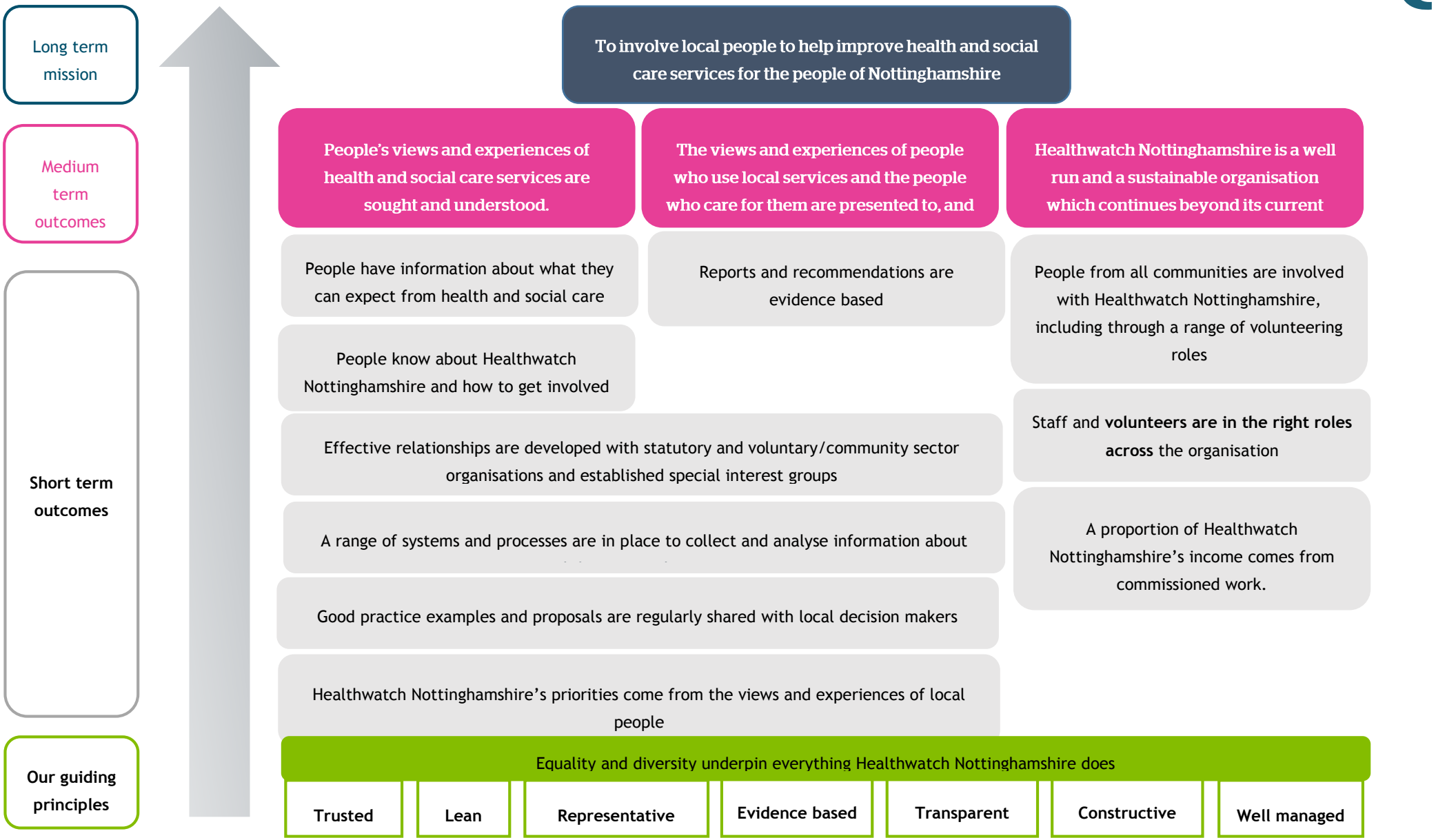
Our aims for 2015/16 are to:

- Continue to raise awareness of Healthwatch Nottinghamshire across all of the people and communities of Nottinghamshire, particularly those who have not yet heard about Healthwatch or feel they have had a chance to have their say
- Increase the number of comments and experiences reported to us, directly and through data sharing agreements with providers and commissioners
- Use the data we collect effectively through the introduction of our new software to highlight areas of concern and good practice
- Produce more reports from the information we have collected and analysed
- Continue to demonstrate actions and changes that have happened to services as a result of information and evidence provided by Healthwatch Nottinghamshire
- Continue to play an active role in the Health and Wellbeing Board and in Health Scrutiny to ensure that local people's views and experiences are central to the planning and review of services
- Develop further our plans for income generation to ensure the future sustainability of the organisation

From April 2015, the Prioritisation Panel has prioritised the following areas for more in-depth work, following reports made to Healthwatch by local people:

- Adult Mental Health crisis services
- Home Care
- Independent secure mental health hospitals
- Transition of young people from children's to adult services
- Dementia services information at the point of diagnosis

These priorities will be reviewed during the year once projects are completed and responses received from providers and commissioners.


Long term mission
To involve local people to help improve health and social care services for the people of Nottinghamshire
Medium term outcomes
People's views and experiences of health and social care services are sought and understood.
The views and experiences of people who use local services and the people who care for them are presented to, and
Healthwatch Nottinghamshire is a well run and a sustainable organisation which continues beyond its current
Short term outcomes
People have information about what they can expect from health and social care
Reports and recommendations are evidence based
People from all communities are involved with Healthwatch Nottinghamshire, including through a range of volunteering roles
People know about Healthwatch Nottinghamshire and how to get involved
Staff and volunteers are in the right roles across the organisation
Effective relationships are developed with statutory and voluntary/community sector organisations and established special interest groups
A range of systems and processes are in place to collect and analyse information about
A proportion of Healthwatch Nottinghamshire's income comes from commissioned work.
Good practice examples and proposals are regularly shared with local decision makers
Healthwatch Nottinghamshire's priorities come from the views and experiences of local people
Our guiding principles
Equality and diversity underpin everything Healthwatch Nottinghamshire does
Trusted
Lean
Representative
Evidence based
Transparent
Constructive
Well managed

Our financial report 2014/15

Funding for local Healthwatch comes from the Department of Health to the Local Authority. Our contract is with Nottinghamshire County Council and we received £385,000 to fund the work of Healthwatch Nottinghamshire in 2014/15. This was a reduction of 15% from the funding received in 2013-14. This reduction is part of a phased reduction of 30% in total funding for Healthwatch Nottinghamshire over 2014-2016.

Healthwatch Nottinghamshire income and expenditure 2014/15

Income	Cost (£)
Nottinghamshire County Council	385,000
Other income	11,162
Total	396,162
Expenditure	**Cost (£)**
People costs - staff, volunteers and board	255,434
Premises costs - e.g. rent, utilities, maintenance	17,881
Running costs - e.g. insurance, professional fees,	21,719
Office costs - e.g. phones, printing, stationery	12,059
Publicity and marketing	8,244
Events and activities	7,067
Set up and equipment	34,186
Depreciation	7,124
Sundries	155
Transfer to reserves	32,293
Total	396,162

The full accounts for Healthwatch Nottinghamshire for the year 2014/15 are available on the Healthwatch Nottinghamshire website

The Healthwatch Nottinghamshire Team

Board members

Alan Sutton (Treasurer/Vice Chair)
Emma Challans
Jim George
Jon Lancaster
Joe Pidgeon (Chair)
Juliet Woodin
Paula Noble
Shirley Inskip

Staff

Alison Duckers Community and Partnerships Worker – Children and Young People (left employment Jan 2015)

Andrea Sharp
Community and Partnerships Worker – Mid Nottinghamshire

Charlotte Daniel
Information and Administration Worker

Christine Watson
Community and Partnerships Worker – Bassetlaw

Claire Grainger
Chief Executive

Deb Morton
Volunteer Coordinator

Donna Clarke
Evidence and Insight Manager

Jane Kingswood
Community and Partnerships Worker – South Nottinghamshire

Loren Maclachlan
Administration Assistant

Nathan Hutchinson
PR & Communications Officer

Rebecca Whittaker
Community and Partnerships Worker – Children and Young People

Advisory Group

Alan Langton
Older Persons Advisory Group
Alex McLeish
Broxtowe Borough Council
Andrew Beardsall
Bassetlaw CCG
Craig Bonar
Ashfield District Council
Hazel Buchanan
Nottingham North and East CCG
Julie Andrews
Mansfield and Ashfield CCG
Liz Lowe
Rushcliffe CVS
Laura Skaife
Nottingham University Hospitals Trust
Nicola Lane
Public Health
Paul Sanguinazzi
Nottinghamshire Healthcare Trust
Pauline Kenton
Disability Nottinghamshire
Penny Spice
Adult Social Care, Nottinghamshire County Council
Sarah Collis
Self Help Nottinghamshire
Sue Fenton
Home Start Nottinghamshire
Val Gardiner
Newark and Sherwood CVS
Ann Berry
Children's Integrated Commissioning Hub

Prioritisation Panel

Jane Stubbings
Jennifer Doohan
John Kerry
John Todd
Mary Horsley
Trudi Cameron
Vanessa Cookson

Other Volunteers

Adrian Hartley
Alison Ellis
Barbara Preston
Barbara Venes
Brian Clarke
Carol Weller
Chris Herdman
Daphne Bone
Dean Thomas
Doreen Williams
Doreen Langford
Edwina Morris
Gail Maxfield
Helen Hopkinson
Helen Miller
Jill Pateman
Jim Radburn
Jo Millar
John Brealey
Julie Bryant
Katie Harlow
Maureen Morby
Maureen Tomlinson
Natalie Palmer
Pat Crowe
Peter Taylor
Rebecca Eteo
Sue Hall
Tom Wilson
Veronica Edkins

Enter and View Authorised Representatives

Adrian Hartley
Edwina Morris
Gail Maxfield
Jim George
Jon Lancaster
Julie Bryant
Sue Hall

Contact us

Get in touch

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Hucknall
Nottinghamshire
NG15 7HP

Phone number: 0115 963 5179

Email: info@healthwatchnottinghamshire.co.uk

Website URL: www.healthwatchnottinghamshire.co.uk

We will be making this annual report publicly available by 30th June 2015 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format please contact us at the address above.

Nottinghamshire County Council

Report to Health and Wellbeing Board

02 September 2015

Agenda Item: 7

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

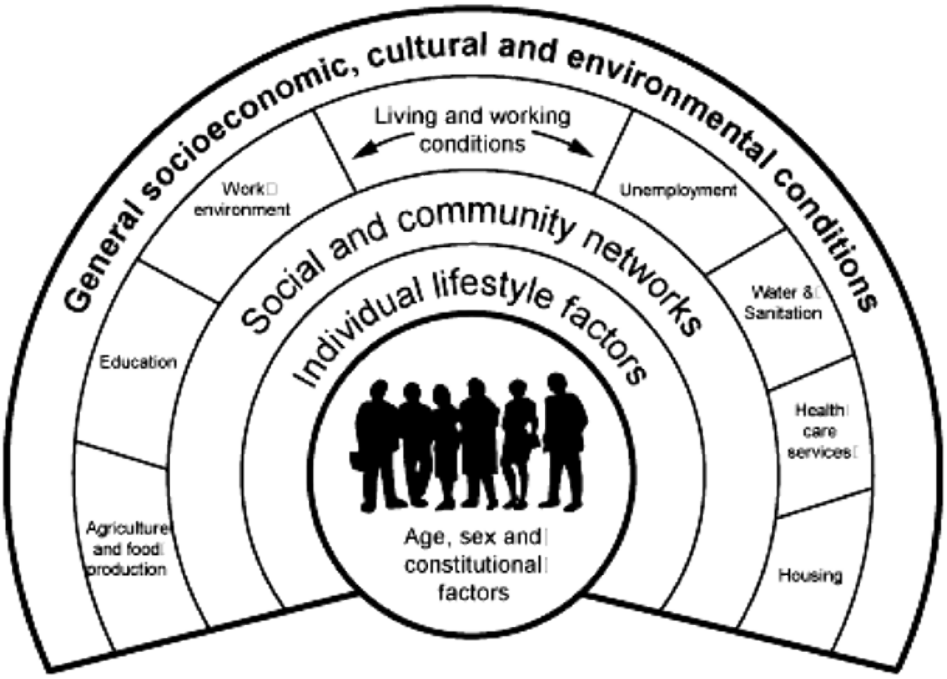
HEALTH INEQUALITIES

Purpose of the Report

1. This report sets out the current state of health inequalities in Nottinghamshire, to update the Board on Life Expectancy, and to set a baseline for Healthy Life Expectancy. It shows trends and provides benchmarks against the national averages. It describes the main underlying factors that contribute to health inequalities in Nottinghamshire County and actions being taken to address these, and it proposes areas where more effort is required. The Health and Wellbeing Board is requested:
   a. To continue support for programmes and initiatives which are already addressing the main contributors to inequalities in life expectancy and in healthy life expectancy. It is especially important to sustain these in times of austerity.
   b. To commit to driving up the quality of primary care through co-commissioning and for each Board member representing a CCG to endorse the development of a CCG strategy for improving the quality of primary care with Key Performance Indicators to demonstrate progress.
   c. To work in partnership to address hotspots where contributing factors to health inequalities intersect, geographically or within population cohorts.
   d. To embed consideration of impact on health equality within service commissioning, transformation and redesign, using the local Health Inequalities Framework.
   e. To hold a Health and Wellbeing Board workshop to agree priorities for improving Health Inequalities and develop multiagency action plans to address the leading causes of Health Inequalities, as an integral part of the Nottinghamshire Health & Wellbeing Strategy..

Information and Advice

2. Health Inequalities is a huge and complex topic within the area of population health and wellbeing. There are multiple determinants of health and wellbeing, all of which can contribute to health inequalities. One way of looking at Health Inequalities might be to review equality of access to the services that support health and wellbeing. However, this risks being overly simplistic, as many of the determinants and causes of inequalities overlap and interact. The diagram below represents the main groups of factors that determine health and wellbeing for individuals and populations.



3. This report will focus on the factors that have the greatest overall impact on health inequalities. It will summarise the authoritative evidence of what causes health inequalities and what needs to be done to address them at national and local levels, and it will provide a picture of Health Inequalities within Nottinghamshire, comparing the local picture with national data, where available, using two overarching indicators: Life Expectancy and Health Life Expectancy.

4. In November 2008, Professor Sir Michael Marmot was asked to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England. His report "Fair Society, Healthy Lives" centred on the themes of: social justice, the social gradient in health and health inequalities, fairness, economic context, social inequalities and climate change. The costs of inequalities were explained in terms of years of life lost, years of healthy life lost and economic costs.

5. Marmot concluded that reducing health inequalities would require action on six policy objectives (see table below) and that delivering these policy objectives would require action by central and local government, the NHS, the third and private sectors and community groups. The Marmot review identified that strategies to address health inequalities needed to tackle health risks (smoking, alcohol, obesity and drug use) and social determinants (early years, education, work, income and communities).

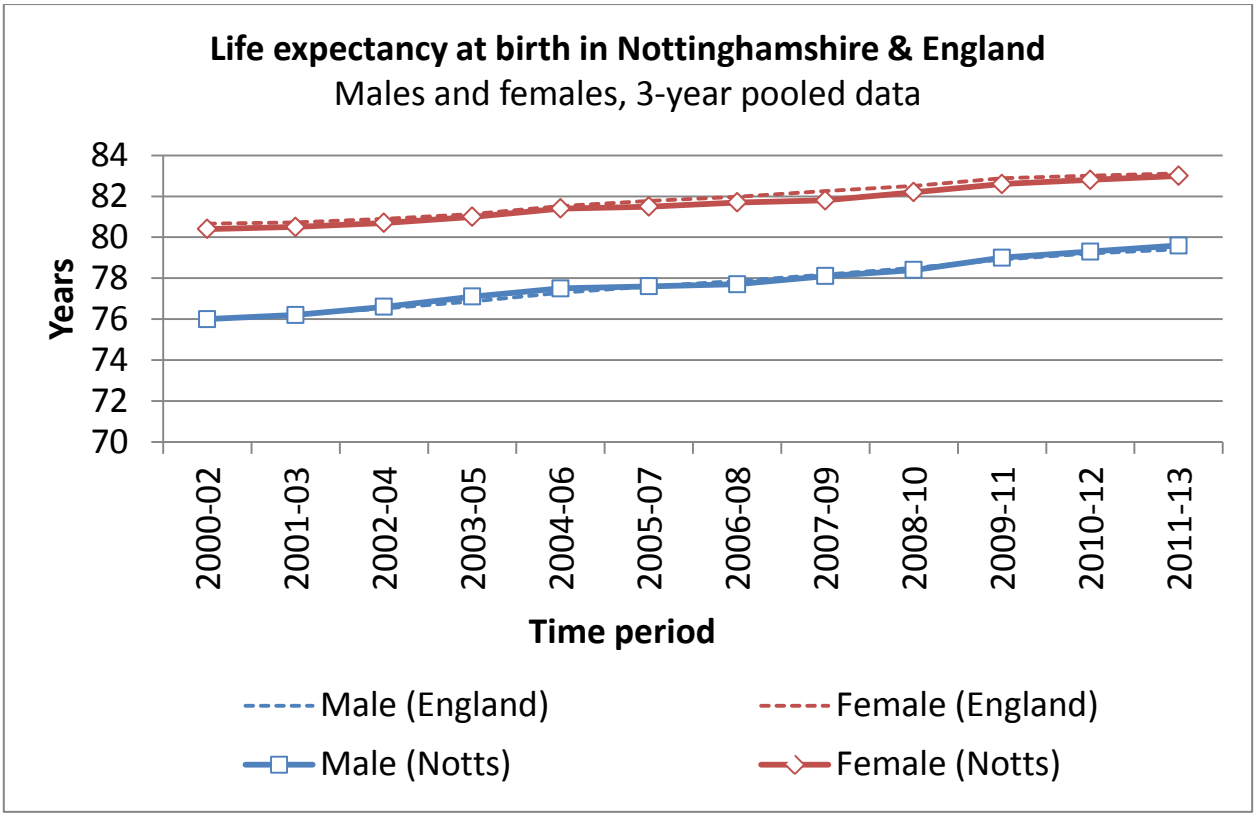
6. The Health and Wellbeing Board is therefore well placed to engage in participatory decision-making at local level to ensure that there are effective local delivery systems focused on health equity in all policies.

Marmot objective	Determinants	Local lead
i. Give every child the best start in life	Smoking in pregnancy Breastfeeding	Nottinghamshire County Council Nottinghamshire County Council
ii. Enable all children, young people and adults to maximise their capabilities and have control over their lives	Education	Nottinghamshire County Council
iii. Create fair employment and good work for all	Employment Living wage	Local Enterprise Partnership All members as employers and as advocates at national level
iv. Ensure healthy standard of living for all	Employment Living wage Housing, Planning	Local Enterprise Partnership HWB members as employers and as advocates at national level District & Borough Councils
v. Create and develop healthy and sustainable places and communities	Community Engagement Access to leisure facilities and green spaces	District & Borough Councils
vi. Strengthen the role and impact of ill health prevention	Access to and quality of primary care Healthy Lifestyles	Clinical Commissioning Groups Local Enterprise Partnership

Life Expectancy

7. Life Expectancy (LE) is the length of time that, on average, a new-born baby can expect to live. It has a slight bias towards earlier/younger deaths. Many factors determine LE, and significant variations are found based on sex, ethnicity and socio-economic status.

8. There is a 3.4 year difference in LE in Nottinghamshire between males (79.6 years) and females (83 years). Over time the LE gap between the sexes is decreasing, as male LE is improving faster than female LE, from a 4.4 year gap in 2000-02 to a 3.4 year gap in 2011-13.



Source: Public Health Outcomes Framework Data tool, Public Health England. Accessed April 2015

The table below summarises the main LE indicators, and these are shown in detailed charts in Appendix 1.

Indicator		Value (years)	Time period	Local trend	Benchmark to England
Gender gap in LE, Notts average		3.4, Female – Male	2011-13	Decreasing	Below (better)
LE gap by district	Females	2.7, Rushcliffe – Mansfield	2011-13	Increasing	0.1yrs below (better)
	Males	3.2, Rushcliffe – Ashfield			
LE change over time by district, greatest / least improved	Females	3.0, Ashfield / 2.2, Mansfield ie female LE has improved least over time in Ashfield and most in Mansfield	2000-13	Increasing	0.2yrs above (better)
	Males	4.4, Broxtowe / 2.9, Gedling ie male LE has improved least over time in Ashfield and most in Mansfield			
LE gap by MSOA	Females	12.4, Rushcliffe – Bassetlaw	2008-12	Not available	Local area indicator – national benchmark not applicable
	Males	11.2, Ashfield – Rushcliffe			
LE gap by deprivation	Females	7.8, Notts least – most deprived	2006-10	Not available	Local area indicator –
	Males	8.8, Notts least – most deprived			

quintile					national benchmark not applicable

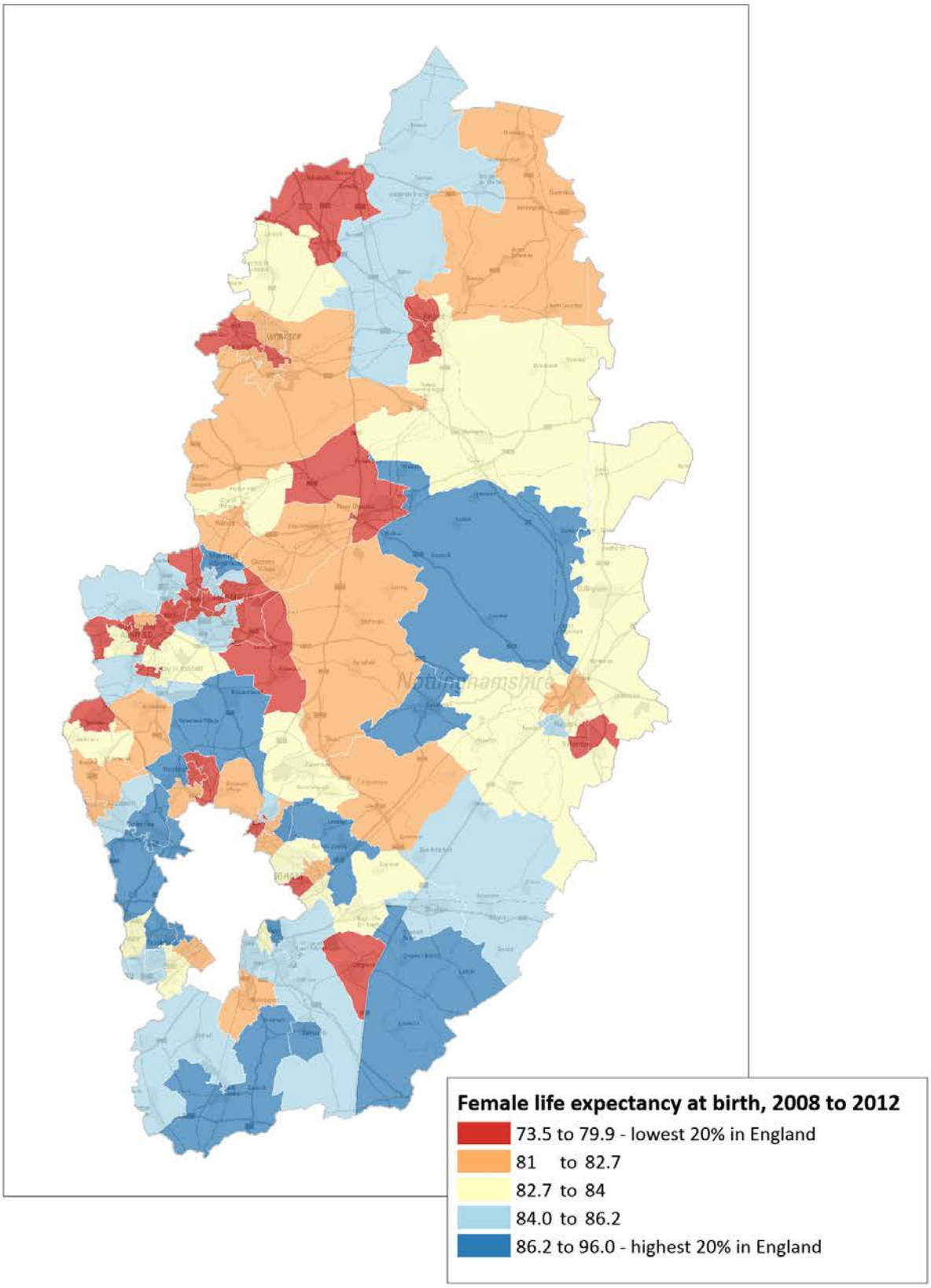
9. The gap in LE between males and females has remained consistently below and better than the national average. This gender gap was 4.7 years in England and 4.4 years in Nottinghamshire in 2000-2002 and by 2011-2013 it had decreased to 3.7 years in England and 3.4 years in Nottinghamshire.

10. LE is increasing over time in all districts. The geographical variation in LE across Nottinghamshire is shown in Appendix 1. LE is greatest in Rushcliffe (84.1 years for females and 80.8 for males), and least in Mansfield (81.3 years for females) and Ashfield (77.6 years for males). The gap in LE between the best and worst districts is staying the same for females and reducing slightly for males.

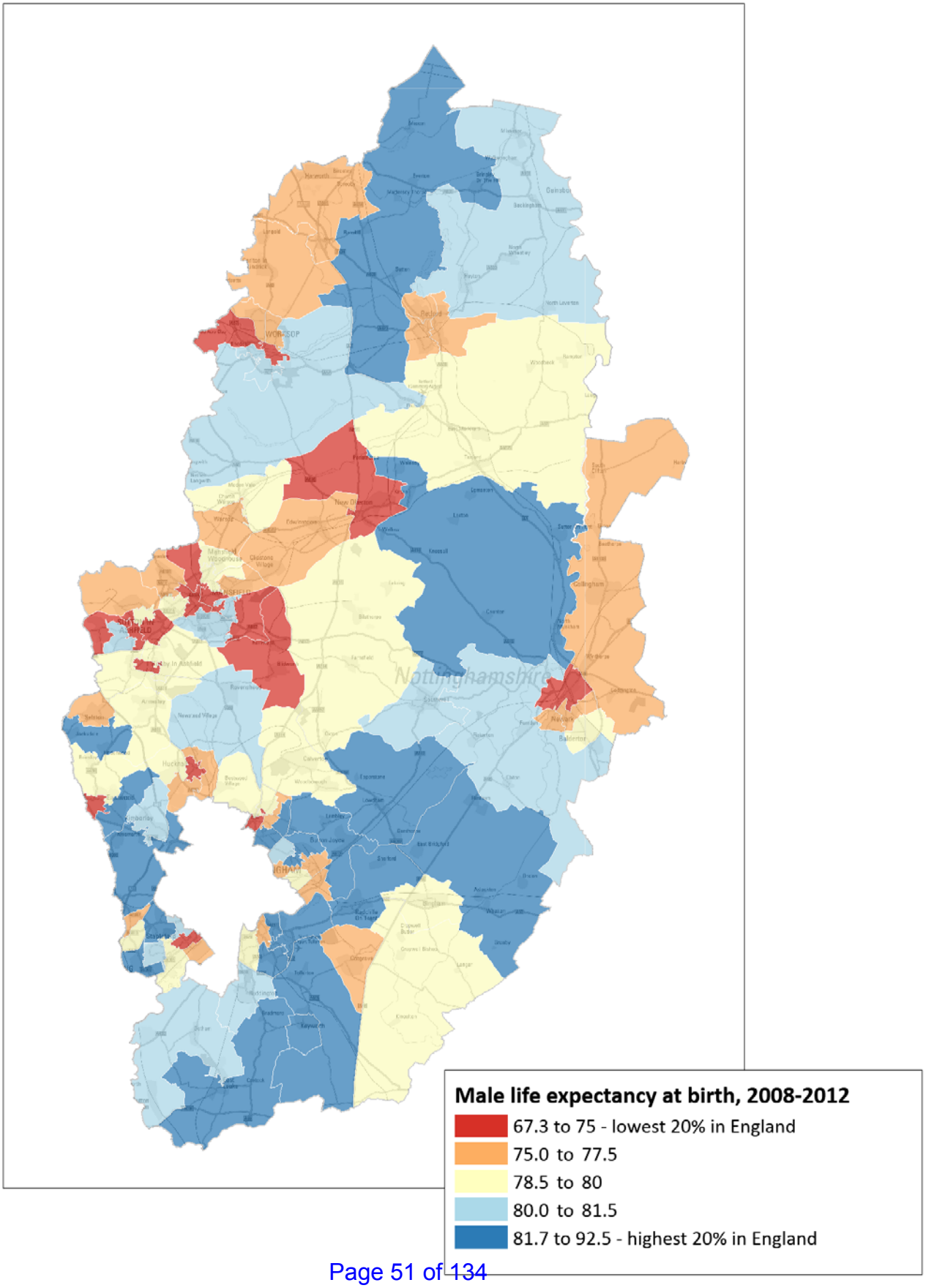
11. Bigger geographical differences in LE are seen at the level of Middle Super Output Areas (MSOAs, areas of between 5,000 and 15,000 people or 2,000and 6,000 households). For the period 2008-12, the difference in female LE between the best and worst MSOAs was 11.2 years, and in male LE the difference was 12.4 years.

12. Some of the differences in LE between groups of different ethnicities are due to genetic predisposition but this only accounts for a small fraction. Where variation is seen, this is therefore for the most part unwarranted. However, data are not available on the differences in LE between people of different ethnicities in Nottinghamshire because ethnicity is not recorded on death certificates.

13. The difference in LE between the most and least deprived deciles is 7.8 years for females and 8.8 years for males. The maps on the next two pages show where the “hotspots” are, with the areas with the lowest LE showing as dark red and the areas with the highest LE showing as dark blue. The boundaries show MSOAs. This closely follows patterns of deprivation and is unwarranted variation.

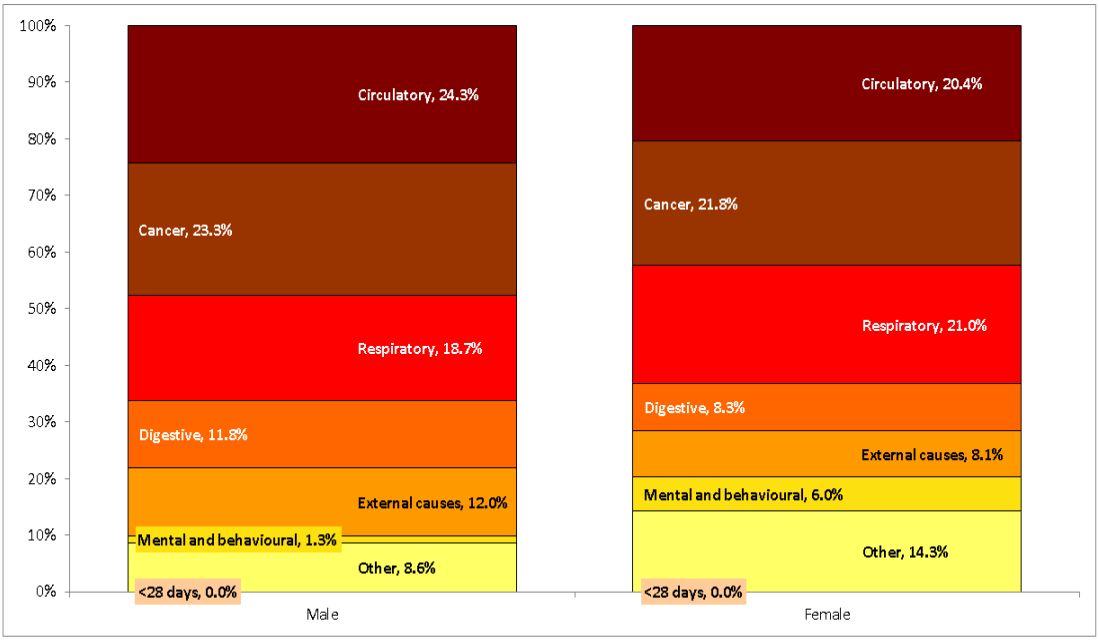

Female life expectancy at birth, 2008 to 2012
73.5 to 79.9 - lowest 20% in England
81 to 82.7
82.7 to 84
84.0 to 86.2
86.2 to 96.0 - highest 20% in England

14.


Male life expectancy at birth, 2008-2012
67.3 to 75 - lowest 20% in England
75.0 to 77.5
78.5 to 80
80.0 to 81.5
81.7 to 92.5 - highest 20% in England

15. The main contributors to the LE gap between males and females in Nottinghamshire are cardiovascular disease (CVD), cancer and respiratory disease. These three disease groups together account for 3.77 years of LE lost in males and 3.07 years lost in females, between the most and least deprived quintiles in Nottinghamshire i.e. between approx. 60-65% of the total difference.

Breakdown of the life expectancy gap between most and least deprived quintiles in Nottinghamshire, by broad cause of death, 2010-2012

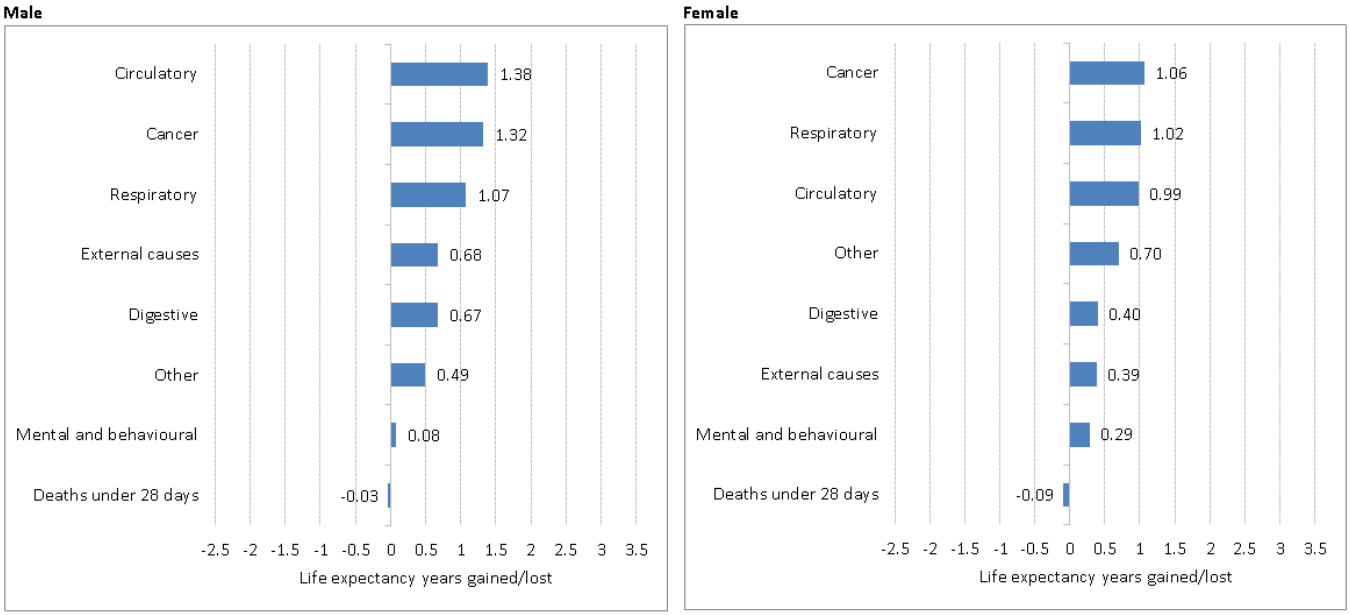


Footnote: Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide.

Table showing the breakdown of the life expectancy gap between Nottinghamshire most deprived quintile and Nottinghamshire least deprived quintile, by broad cause of death, 2010-2012

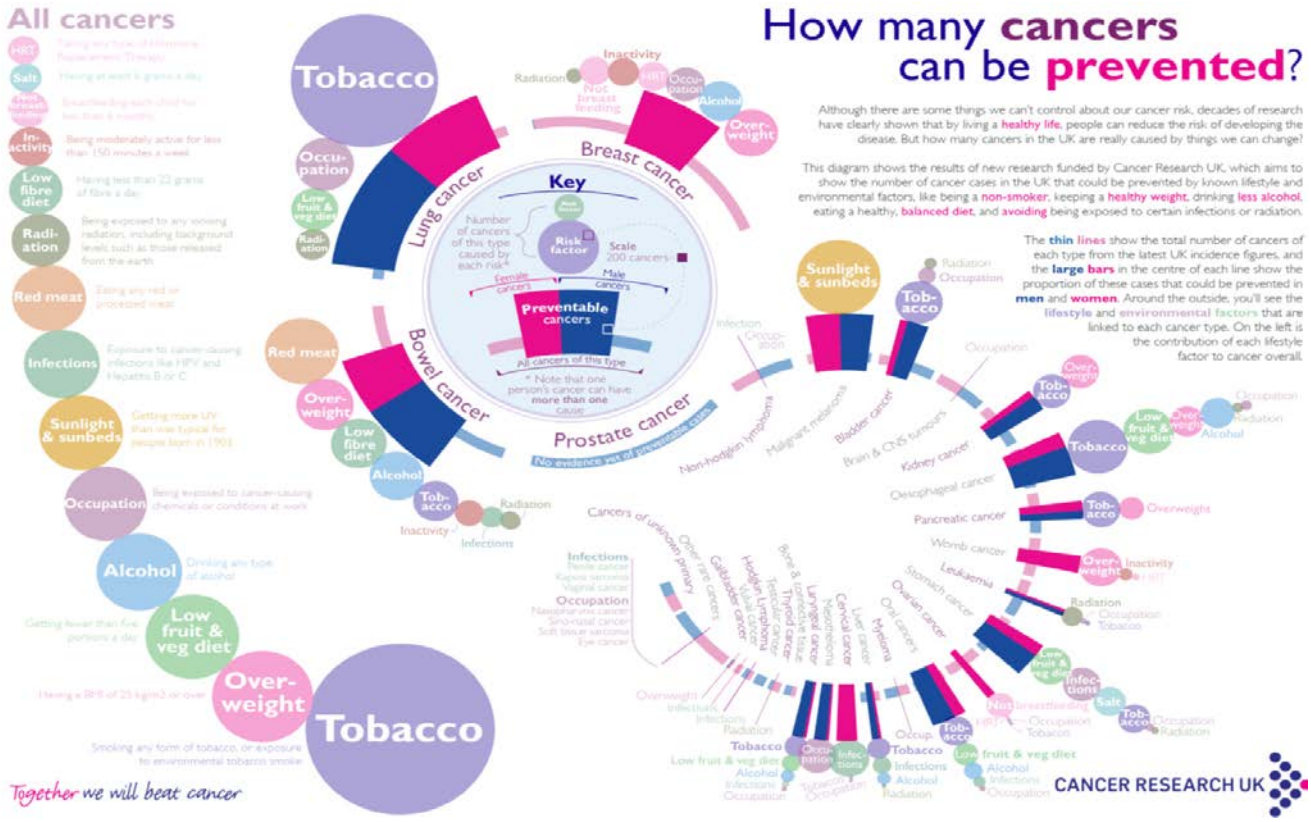
16. The charts below show how many years of life would be gained if the most deprived quintile in Nottinghamshire had the same mortality rates as the least deprived, for each of these contributors.

Life expectancy years gained or lost, by broad cause of death, 2010-2012



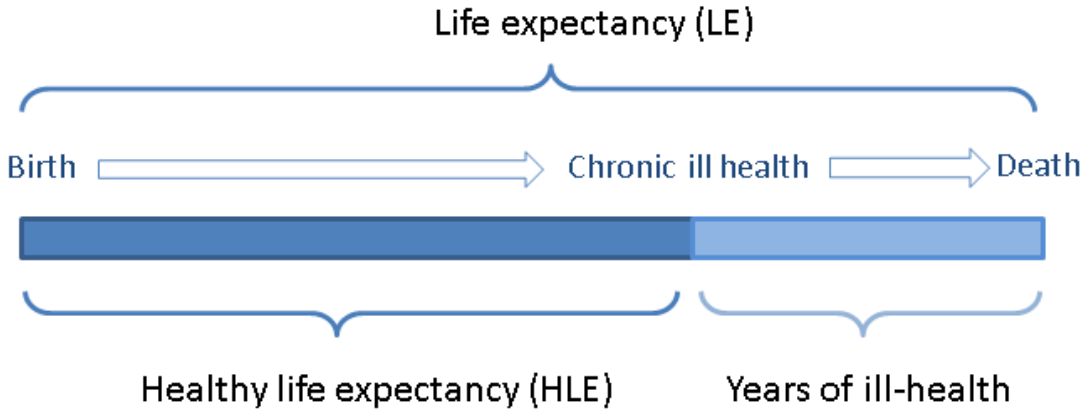
Footnote: Circulatory diseases includes coronary heart disease and stroke. Digestive diseases includes alcohol-related conditions such as chronic liver disease and cirrhosis. External causes include deaths from injury, poisoning and suicide

17. The main modifiable risk factor underpinning CVD, cancer and respiratory disease is tobacco use. This is illustrated in the cancer prevention chart below, in which tobacco is seen to be the single greatest contributor to cancer overall. Indeed research suggests tobacco explains half the difference in the LE gap. Alcohol and obesity can also be seen to feature prominently in many types of cancer, as they do for CVD.



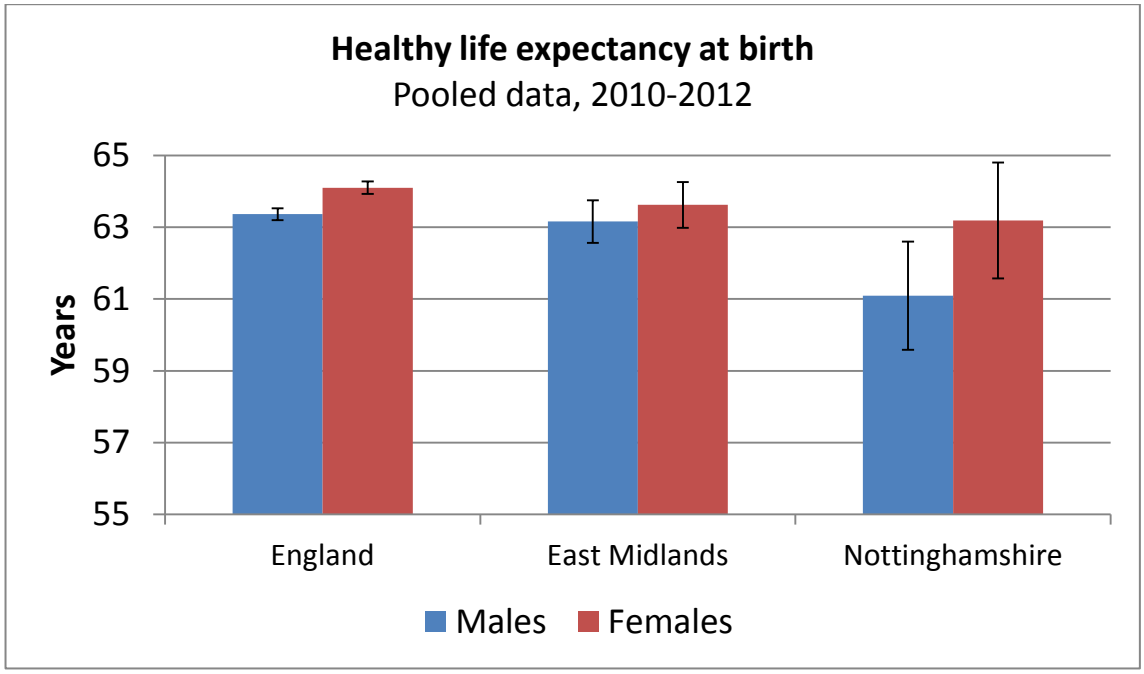
Healthy Life Expectancy

18. Healthy Life Expectancy (HLE) is an indicator that has not been reported in Nottinghamshire before. This report therefore sets a baseline for this measure. HLE is a measure of the average number of years a person would expect to live in good health based on current mortality rates and prevalence of self-reported good health. (Health-Adjusted Life Expectancy, Disability-Adjusted and Disability-Free Life Expectancy are similar measures but the methodology differs for each).



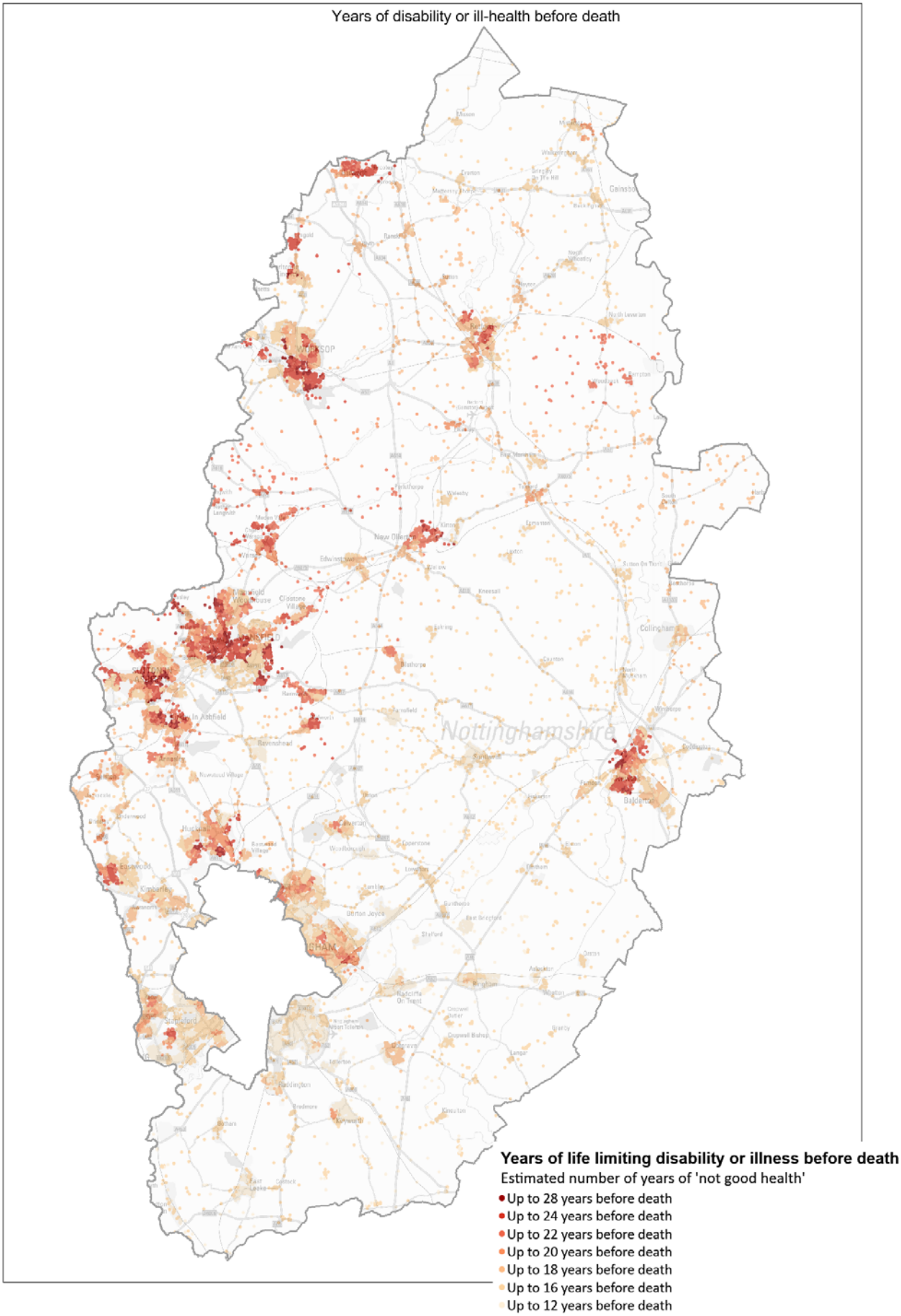
19. Many of the underlying factors and actions being taken to address HLE are the same as for LE, but some are different. For example Macmillan recently reported that for the first time as many people survive cancer as die from it, and so cancer survivorship has a greater impact on HLE than ever before due to the long term consequences of treatment such as lymphoedema, chronic fatigue, anxiety, pain, incontinence (National Cancer Survivorship Initiative).

20. It can be seen from the chart below that Nottinghamshire has a statistically significant worse HLE than the national average for males and, notwithstanding the wide confidence intervals, may have a worse HLE than the regional and national averages for both males and females.



Source: Marmot Indicators 2014, PHE London Knowledge & Intelligence Team

21. The map below shows the geographical variation in HLE, clearly demonstrating the "hotspots" where people are living longer with ill health. This closely resembles the LE maps presented in section 12, but this HLE map has greater granularity and identifies "hotspots" at the level of discrete estates, which could inform a multi-agency workshop to plan very targeted and specific action. See Appendix 1 for street level example.


Years of disability or ill-health before death
Nottinghamshire
Years of life limiting disability or illness before death
Estimated number of years of 'not good health'
Up to 28 years before death
Up to 24 years before death
Up to 22 years before death
Up to 20 years before death
Up to 18 years before death
Up to 16 years before death
Up to 12 years before death

22. The main contributors to poor HLE overlap with those for poor LE, however there are some conditions that do not significantly affect overall length of life but that contribute significantly to chronic ill-health, such as mental health disorders, injuries and musculoskeletal diseases. Local data are not available, however the Global Burden of Disease lists the greatest number of years lost to disability in the Western European Region as resulting from:

Years of healthy life lost due to disability (YLDs), 2010

Cause, by main group	Proportion of YLDs	Largest subset(s)
Musculoskeletal disorders	30.6%	22.5% low back / neck pain
Mental and behavioural disorders	14.1%	7.8% major depressive 3.6% anxiety disorders
Respiratory	5.6%	2.7% chronic obstructive pulmonary disease 2.2% asthma
Cardiovascular disease	5.6%	1.8% ischaemic heart disease 1.1% stroke
Falls	5.4%	N/A
Substance misuse	3.9%	1.7% alcohol 1.1% opioids
Injuries	3.4%	2.3% pedestrian / transport
Diabetes	2.9%	N/A
Migraine	2.9%	N/A
Cancers	2.7%	1.7% benign prostatic hyperplasia 0.3% breast cancer
Alzheimer's	2.5%	N/A
Neurological conditions	1.4%	0.6% epilepsy
Digestive diseases	1.1%	0.4% inflammatory bowel disease

Source: WHO Global Burden of Disease, accessed July 2015

ACTION

23. For any geographical area or population group there is no simple root cause of health inequalities but where underlying factors and causes intersect, this leads to "hotspots" and creates sharp gradients of health inequality that merit concerted action at a locality level by individual partners, multi-agency partnerships and / or by the Health and Wellbeing Board as a whole. There is always more that could be done. Areas of work that have the greatest potential to yield results would aim to:
    - Eliminate unwarranted variation in medical and clinical outcomes between primary care practices
    - Embed action to address health inequalities across all areas of the Health and Wellbeing Strategy
    - Ensure that area-based initiatives include actions to address the main underlying causes of health inequalities.

24. There is a role for all members of the Health and Wellbeing Board within these broad areas of work, but some are clearly better placed to lead on particular strands of work, and some areas of existing work warrant greater effort (see table below, showing areas where there is robust evidence to support improvements in LE – these will also have an impact on HLE).

Pregnancy / Early Years	Role: Local Authority	Role: Primary Care	More effort needed
Good antenatal / Obstetric care	Less	More	
Smoking and Obesity in Pregnancy	Equal	Equal	✓
Reduce Teenage Pregnancy	More	Less	
Family Planning	Less	More	
Breast Feeding	Less	More	✓
Vaccination	Less	More	
Children and Young People	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
Educational Attainment	More	Less	✓
Prevent uptake of smoking	More	Less	✓
Childhood Obesity	More	Less	✓
Adults and Older People	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
NHS Health Checks	Less	More	✓
Lifestyle – Smoking	Equal	Equal	✓
Lifestyle – Exercise	More	Less	✓
Lifestyle – Diet	More	Less	✓
Lifestyle – Alcohol	More	Less	✓
Road Traffic Accidents	More	Less	
LTC Management / Pathways / Self Management	**Role: Local Authority**	**Role: Primary Care**	**More effort needed**
Cardiovascular Disease & Diabetes (inc reducing BP, HbAIc, Cholesterol, detect AF)	Less	More	✓
Respiratory Disease / COPD (inc detect, diagnosis, manage)	Less	More	✓
Employment /Environment	**Role: Local Authorities**	**Role: Primary Care**	**More effort needed**
Wellbeing at Work scheme	More	Less	✓
LA and NHS as good employers (Living Wage)	Equal	Equal	✓
Living Wage advocacy	More	Less	✓
Cancer Prevention	**Role: Local Authorities**	**Role: Primary Care**	**More effort needed**
Lifestyle – Smoking *	As above for Adults & Older People * 30% of cancer is due to smoking, and 30% is due to diet		
Lifestyle – Diet *			
Lifestyle - Alcohol			
Cancer Early Detection & Treatment	**Role: Local Authorities**	**Role: Primary Care**	**More effort needed**
Screening	Less	More	
Education	Less	More	ongoing; national

			campaigns
Early Referral	Less	More	?
Effective Treatment	Less	More, + secondary care	?

25. Areas of work can also be identified to address inequalities in HLE, but there is less known about the evidence base. There is evidence to support the following:
    - Musculoskeletal health – workplace ergonomic assessment and training, NICE guidance for the management of low back pain (equal roles for local authorities and primary care)
    - Mental Health - building resilience and social inclusion, access to treatment/talking therapies and parity of esteem in primary care identification and early intervention (equal roles for local authorities and primary care)
    - Housing and Planning – links between health and housing are well established but less known about what works best, other than fuel poverty and winter deaths.

26. Clearly there are too many areas of work where more effort is needed, to be able to do justice to them all at the same time, so it would be advisable for the Health and Wellbeing Board to agree its priorities. The Health Inequalities Framework (Appendix 2) and the accompanying toolkit currently under development would be useful to facilitate this, using a workshop format. Although this framework was developed to support health service commissioning, it takes a systematic approach that is transferable to Health and Wellbeing Board strategic action planning.

27. Two key publications argue that healthcare professionals have a role in addressing the social determinants of health as well as individual lifestyle behaviours. A British Medical Association (BMA) publication sets out, very briefly, some of the evidence and examples of actions that doctors can take to affect the social determinants of health and reduce the social gradient. A report from the Institute of Health Equity at University College London (UCL) draws on examples of excellent practice and describes areas where greater action is necessary, making some practical suggestions about how to take forward action on the social determinants of health. Best practice identifies that the gap in health outcomes can be reduced through strengthening quality and capacity of primary care, and more targeted and systematic use of approaches to prevention, early diagnosis, medical drug treatment and condition management. Some areas to consider are:
    - fit for purpose premises
    - accessibility (location, opening hours)
    - quality of care (case finding, pathway management, prescribing, exception reporting, reduction of clinical variation)
    - practice management, staffing and capacity
    - workforce education and training.

28. Examples of existing services and initiatives to address the main factors that contribute to LE and HLE variations in Nottinghamshire include:
    - Combined – Tobacco Declaration; Lifestyle services; Change 4 Life; Healthy Options Takeaway Scheme; Wellbeing at Work Scheme; Daybrook Connecting Communities Programme, Nottinghamshire Obesity Strategy

- CVD – NHS Health Check Programme; Abdominal Aortic Aneurysm Screening, Stroke awareness campaign (Act F.A.S.T.)
- Cancer – Cancer Screening, Be Clear on Cancer national media campaigns
- Respiratory disease – Air quality management areas, Flu and pneumococcal immunisation, COPD pathways
- Early years – Sure Start services located in areas of deprivation, Child immunisation, Healthy Schools, Educational psychology service / Inclusion support, Nottinghamshire Child Poverty Strategy
- Long term conditions – Multidisciplinary locality teams and integrated services; Patient education programmes; Diabetic Eye Screening; Rushcliffe Primary Care Best Practice Specification
- Mental Health – Nottinghamshire Mental Health Strategy.

Other Options Considered

29. Not applicable.

Reason for Recommendation

30. It has been shown that there are already robust programmes, strategies and actions in place to deal with the main contributing factors to health inequalities between groups within the Nottinghamshire population. However, there are areas of potential concern such as areas where more effort is required to make a real impact on inequalities; “hotspots” where contributing factors intersect, and potential gaps that may merit more detailed consideration by the Board in future, especially for the contributors to HLE.

Statutory and Policy Implications

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

RECOMMENDATIONS

1) To continue support for programmes and initiatives which are already addressing the main contributors to inequalities in life expectancy and in healthy life expectancy. It is especially important to sustain these in times of austerity.
2) To commit to driving up the quality of primary care through co-commissioning and for each Board member representing a CCG to endorse the development of a CCG strategy for improving the quality of primary care with Key Performance Indicators to demonstrate progress.
3) To work in partnership to address hotspots where contributing factors to health inequalities intersect, geographically or within population cohorts.
4) To embed consideration of impact on health equality within service commissioning, transformation and redesign, using the local Health Inequalities framework.

5) To hold a HWB workshop to agree priorities for improving Health Inequalities and develop multiagency action plans to address the leading causes of Health Inequalities, as an integral part of the Nottinghamshire Health & Wellbeing Strategy.

Chris Kenny, Director of Public Health

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Constitutional Comments (SLB 31/07/2015)

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

Financial Comments (DG 05/08/2015)

33. There are no financial implications in this report.

Background Papers and Published Documents

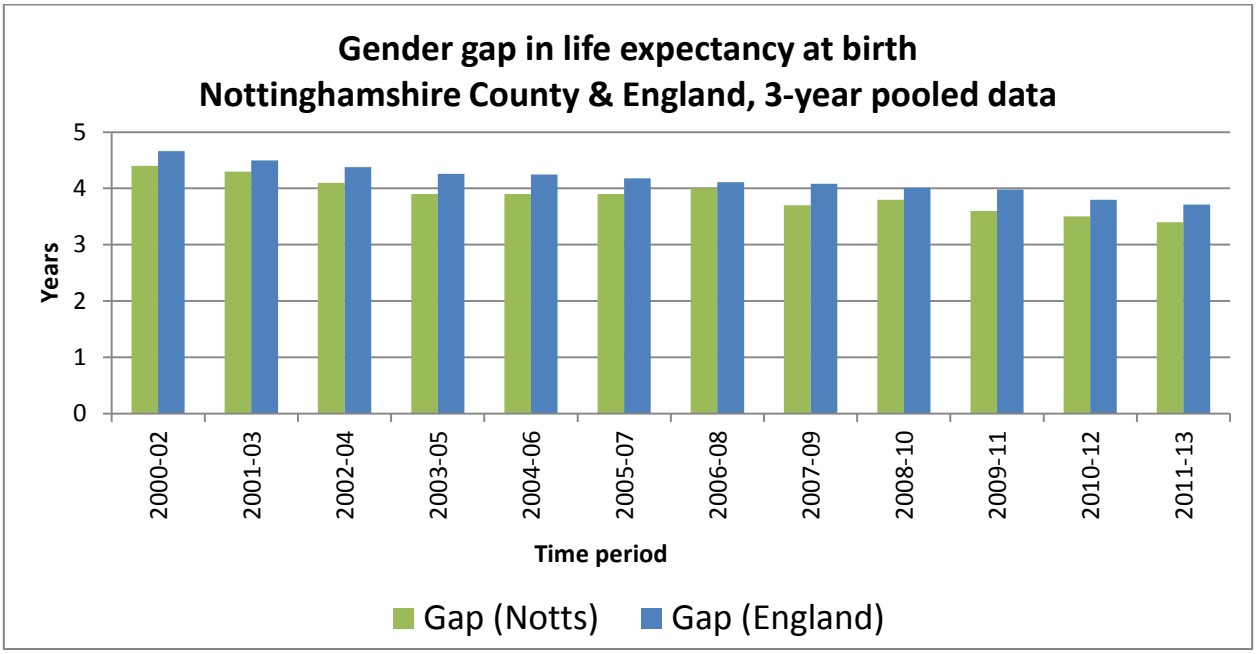
Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- None

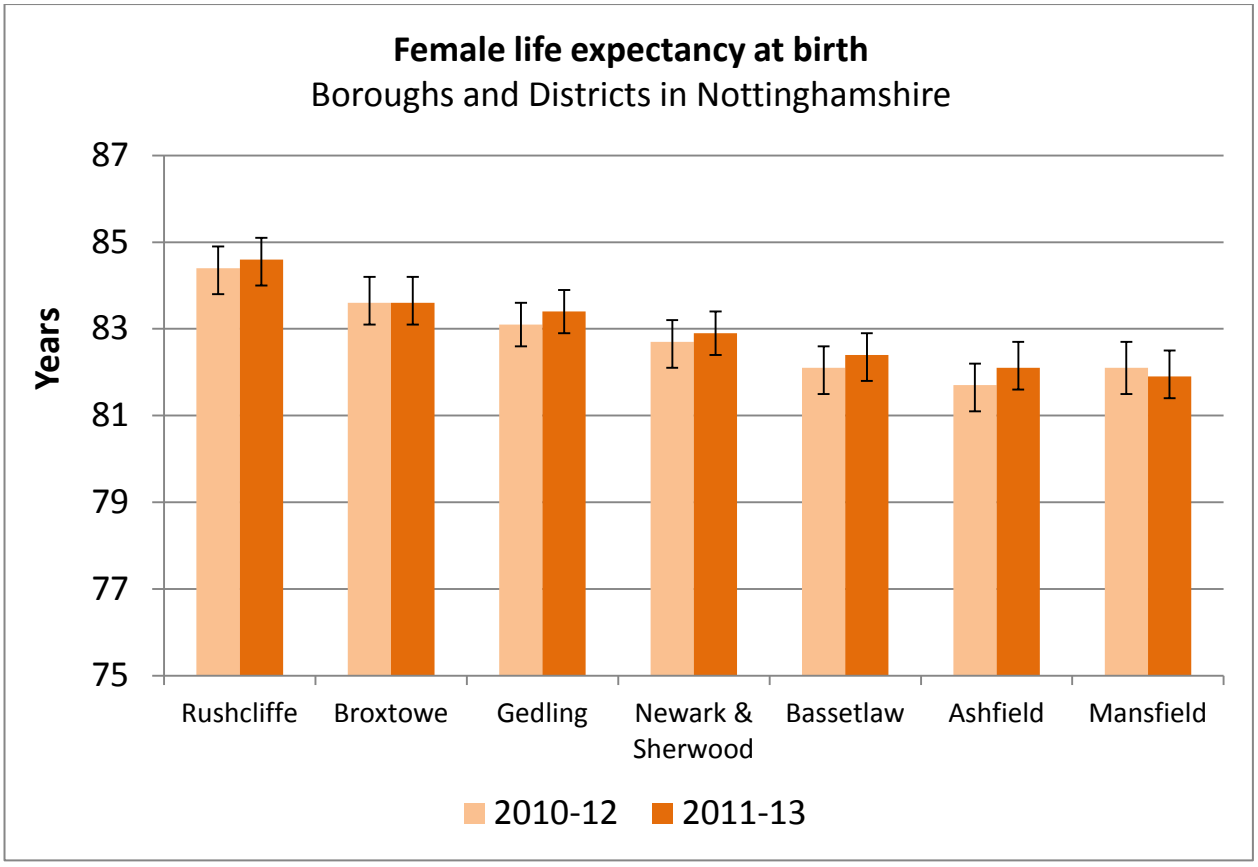
Electoral Divisions and Members Affected

- All

Appendix 1



Source: Public Health Outcomes Framework Data tool, Public Health England. Accessed April 2015



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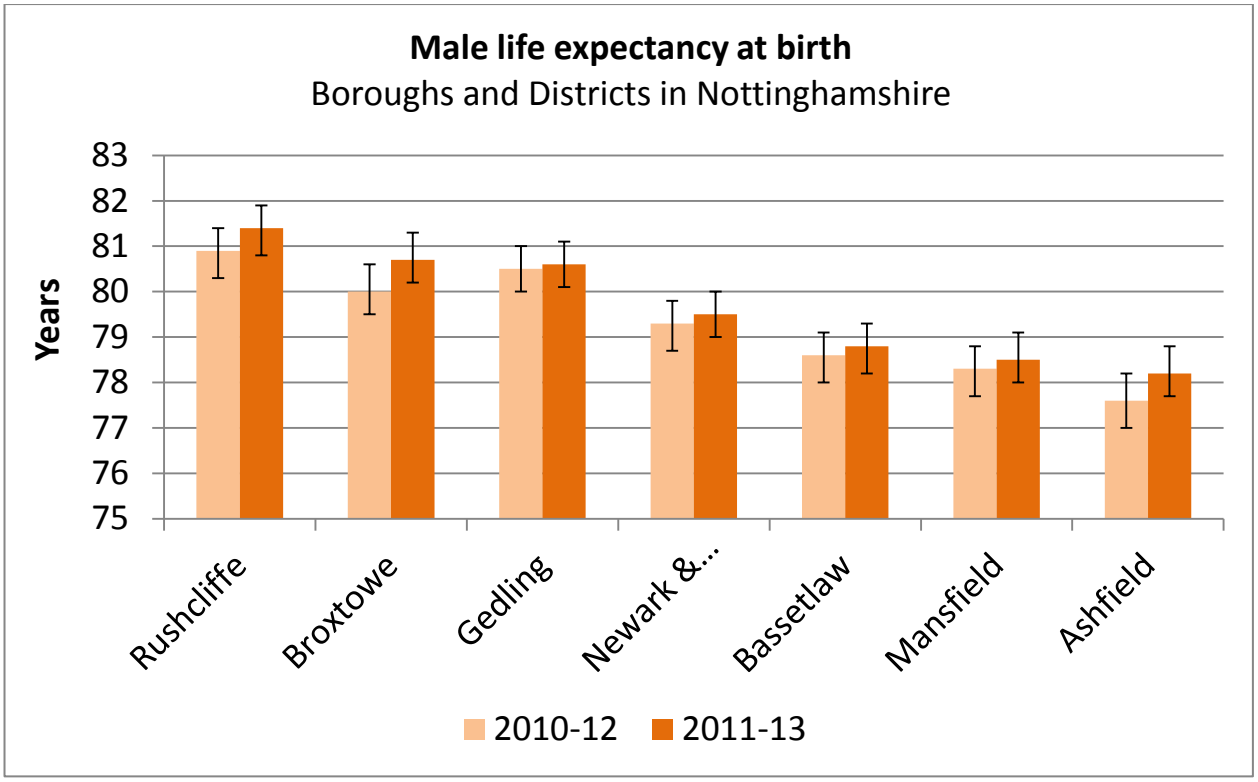

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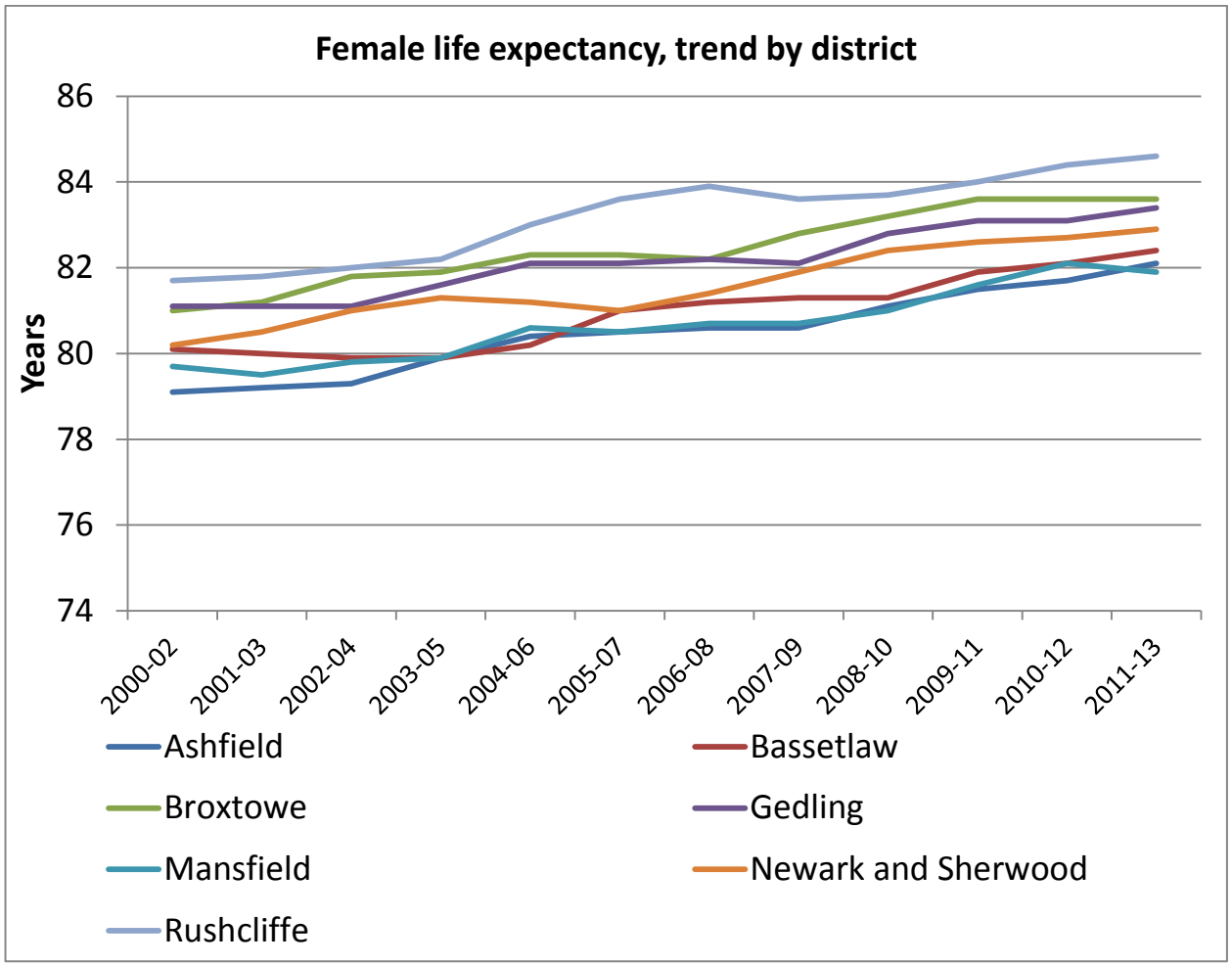

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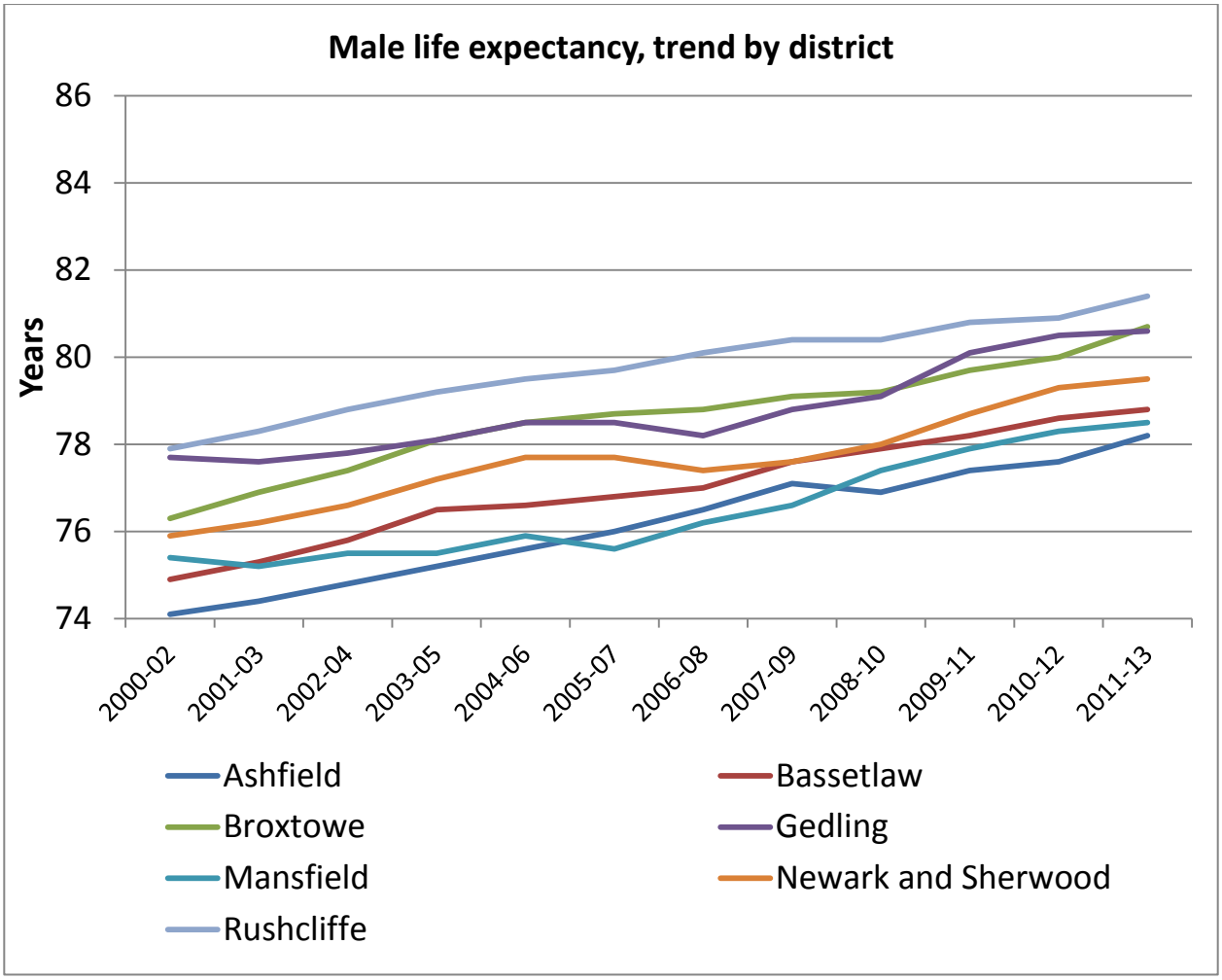

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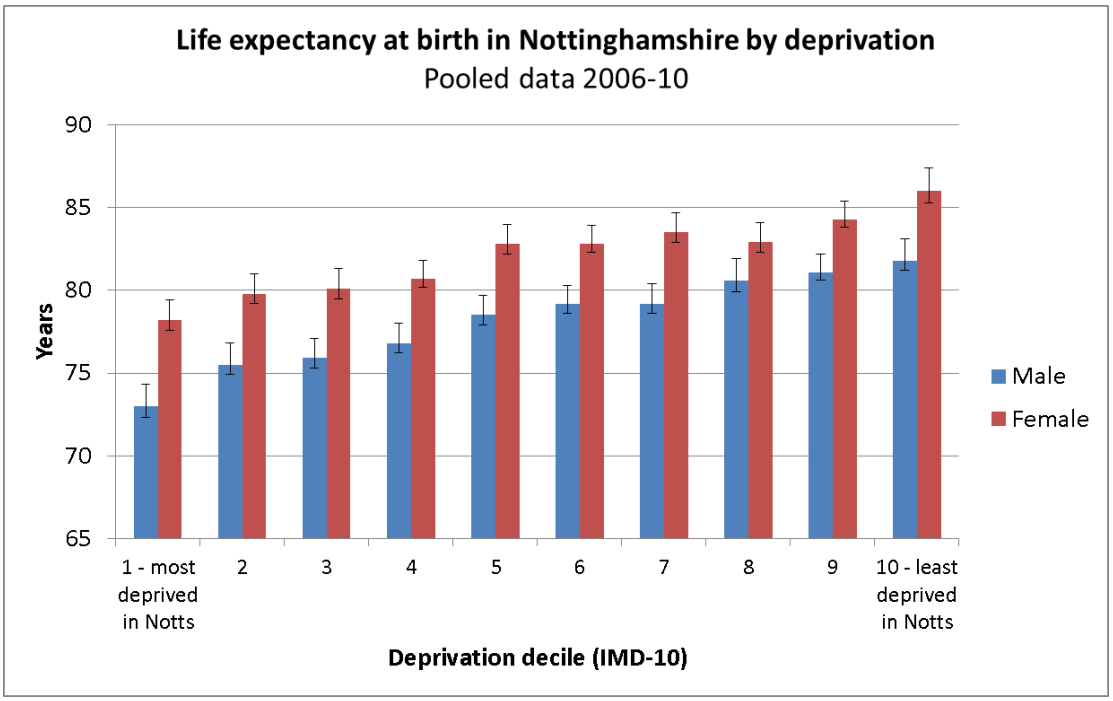
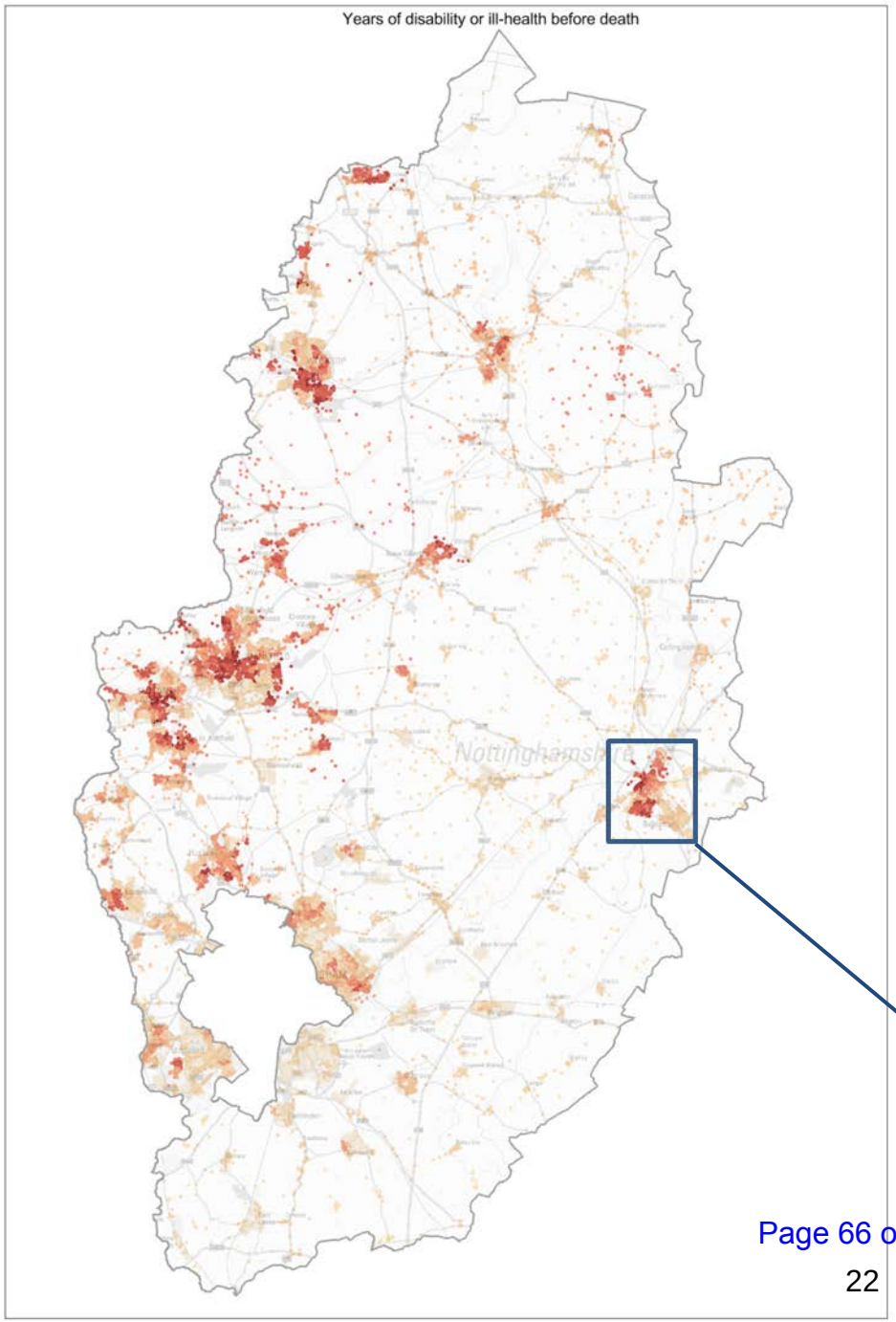


Source: The Public Health Observatories in England, based on analysis of ONS mortality data and population estimates



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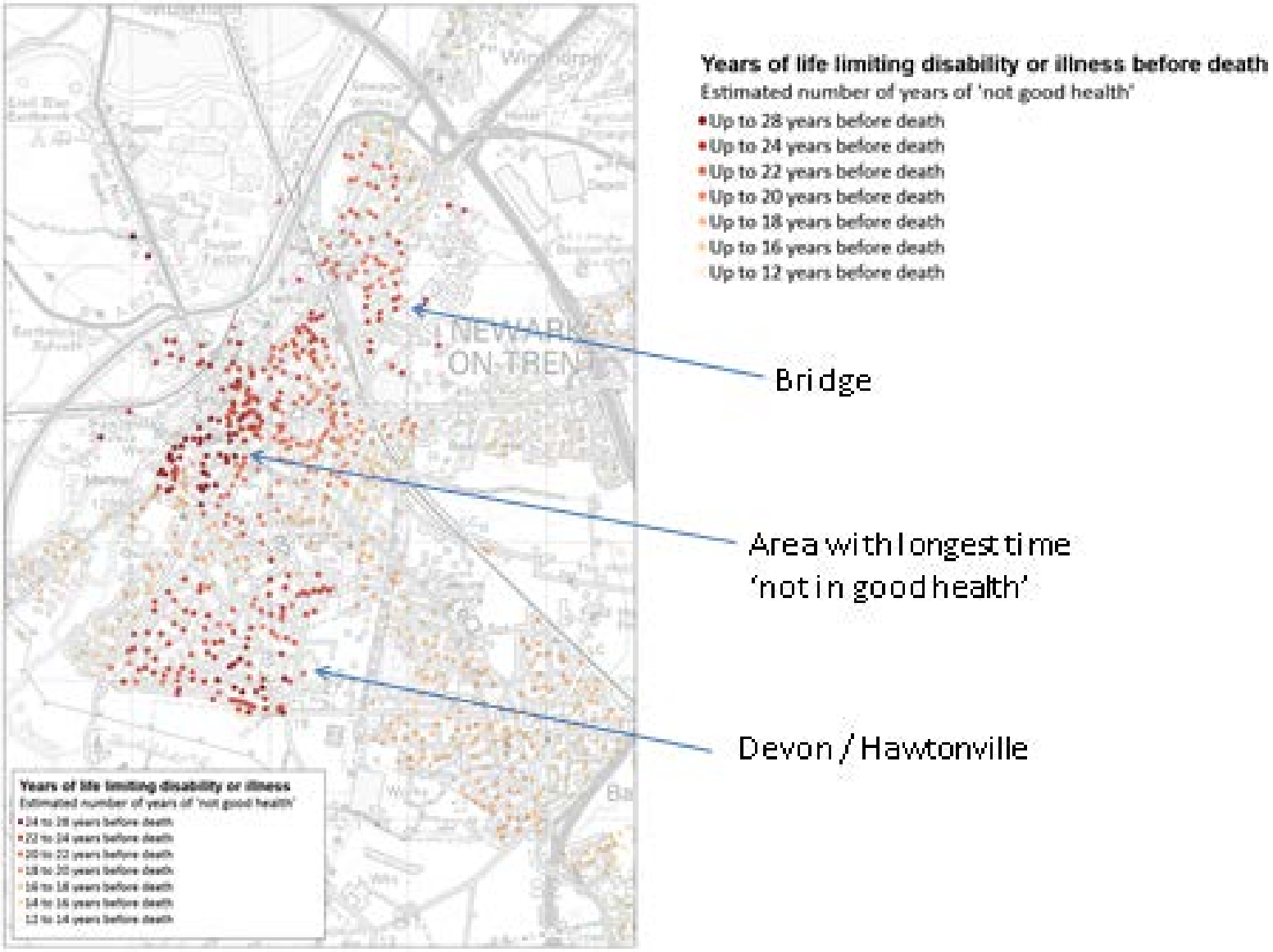
Years of life limiting disability or illness before death
Estimated number of years of 'not good health'
Up to 28 years before death
Up to 24 years before death
Up to 22 years before death
Up to 20 years before death
Up to 18 years before death
Up to 16 years before death
Up to 12 years before death
Bridge
Area with longest time 'not in good health'
Devon / Hawtonville
Years of life limiting disability or illness
Estimated number of years of 'not good health'

Appendix 2

NOTTINGHAMSHIRE FRAMEWORK FOR ACTION ON HEALTH INEQUALITIES

D.Jenkin, Specialty Registrar in Public Health, August 2015

INTRODUCTION

The locally developed health inequalities framework provides a brief, systematic and structured approach to identify focus areas for effective action on health inequalities.

In this context the framework uses a working definition of health inequalities from Public Health England: **"preventable and unjust differences in health status experienced by certain population groups"**

Therefore, whilst inequalities have frequently been expressed in terms of a relationship between health and deprivation, here we broaden our consideration to ensure that resources are aligned to those population groups and geographies in greatest need, with the greatest capacity to benefit from invested resource. This fits well with a consideration of population groups who experience the lowest life expectancy and healthy life expectancy.

The framework concentrates on 3 key areas for exploration:

Section 1: Knowledgebase – what do we know about the individuals and groups experiencing poorer health outcomes in our local area? Do we understand the key underlying causes of inequalities in health outcomes? And can we identify specific evidence based approaches that we could take to reduce these inequalities?

Section 2: Prioritising targeted actions to reduce the gap in health outcomes, to ensure resource is aligned with need.

Section 3: Prioritising systematic approaches to health inequalities which can be embedded within our commissioning and service delivery to ensure that systems and processes have a positive impact on health inequalities.

The framework is intended to provide a useful practical structure to our initial strategic thinking on local health inequalities. As such the framework can and should develop through stakeholder use, where feedback identifies ways to improve its usefulness. It has also been developed from a public health specialist perspective. Therefore its use will likely be most beneficial where it is delivered in a partnership setting, with facilitation by a public health specialist.

Its use will ideally result in the articulation of a short list of focus areas, agreed by stakeholders, for further exploration and development into a health inequalities action plan.

A further toolkit is in development, to accompany the framework, which will provide signposting to available evidence, guidance and best practice. This will support stakeholders to move from identified focus areas for action to credible and effective action plans.

FRAMEWORK SECTION 1: KNOWLEDGEBASE – UNDERSTANDING HEALTH INEQUALITIES IN THE LOCAL POPULATION

LOCAL HEALTH INEQUALITIES – BASE LINE INFORMATION	Have you identified vulnerable groups living in your area, and considered how to ensure they can both access and achieve good outcomes from your services? E.g. protected characteristics, homeless, older people, single parents, people living in isolation, those with English as a second language, travelling communities. Where are the most deprived communities in your area? How many children and older people are considered to be living in poverty in your area? Do you know where the inequality hotspots are in your local area? That is where local health outcomes are much poorer that the local or national averages? Do you have information from service users themselves (e.g. surveys) on their experience of care? Are vulnerable and deprived groups adequately represented in survey responses?
CHARACTERISING THE GAP	How does life expectancy and healthy life expectancy in your area compare with the national average? With other similar areas? How does life expectancy and healthy life expectancy vary within your area? E.g. Slope Index of Inequality. Have you identified the underlying conditions and risk factors are that contribute the most in your area to the gap in life expectancy and other outcomes?
INTERVENTIONS	Have you identified the ways in which your service/organisation can act on those underlying risk factors to improve health inequalities? i.e. specific evidence based interventions which will address the causes of local health inequalities?

DISCUSSION OUTCOME SECTION 1: Identify any critical information gaps which must be addressed in order to prioritise effective action on health inequalities locally.

FRAMEWORK SECTION 2: PRIORITISING TARGETTED ACTION – REDUCING THE GAP

Considering the interventions identified in framework section 1:

IDENTIFY OPPORTUNITIES FOR DEVELOPMENT	How do priorities for action on health inequalities overlap with existing wider priorities of the organisation? What interventions or initiatives are already underway that can be tailored to have a positive impact on health inequalities? Which initiatives provide the best opportunities to work with partners in the local health economy to improve outcomes?
UNDERSTAND THE IMPACT, COST AND SCALE	Which interventions will generate the greatest impact on health inequalities for a given resource investment? I.e. How do the proposed interventions compare in terms of relative cost and cost-effectiveness? How many individuals would you need to reach with these interventions in order to have an appreciable positive impact? Is this scale feasible? Are these interventions associated with a potential for cost savings, through more effective targeted prevention of ill health? Has this cost saving been quantified?
BALANCE INTERVENTIONS	Are these interventions appropriately balanced between: • Primary, secondary and tertiary prevention • Delivering short, medium and long term gains. • Achieving improvements across the life course?
TARGET INTERVENTIONS	How will you demonstrate proportionate universalism? i.e. how will you ensure that the interventions are delivered most effectively in areas of greatest need and taken up by those who are at greatest risk of poor outcomes? Should the intervention be delivered universally ie. Available to all with greater resource invested in those with greatest need? Or should the intervention be commissioned on the basis of need, and only available in areas of greatest need?

DISCUSSION OUTCOME SECTION 2: Identify specific high impact interventions to prioritise for further investigation and development, and accountable stakeholders to lead on each.

FRAMEWORK SECTION 3: SYSTEMATIC APPROACH – EMBEDDING ACTION ON HEALTH INEQUALITIES INTO ALL WORKSTREAMS – P1

(applying action on health inequalities systematically to pathways, processes, programmes, commissioned services)

SYSTEM AREA	DETAIL	This is a GAP
ACCESS AND OUTCOMES	Do you know how access and outcomes vary for your services? Do you routinely evaluate these variations, rather than considering only average performance? Do you routinely review those accessing your service to ensure that vulnerable, deprived and at risk groups are being reached? e.g. health equity audit Where are services located geographically? Do the most deprived communities have local, high quality and accessible services? Do you routinely review referral practices and thresholds for access to services e.g. to ensure that those in greatest need are appropriately engaged and supported? How do you ensure that the most vulnerable or deprived individuals are enabled to participate fully in surveys of service user experience? How do you prioritise improving outcomes for the sub-groups within the population most at risk of poor health (through multiple risk factors or vulnerabilities)? Are there particular care pathways and services that should be prioritised for review of impact on health inequalities?	
COMMISSIONING	Do you use contractual arrangements with providers to ensure that they provide you with evidence of monitoring health inequalities (access and outcomes) and acting to reduce health inequalities through their service provision? Have you set requirements for delivery of quality outcomes which are weighted towards those most in need?	

FRAMEWORK SECTION 3: SYSTEMATIC APPROACH – EMBEDDING ACTION ON HEALTH INEQUALITIES INTO ALL WORKSTREAMS – P2

SYSTEM AREA	DETAIL	This is a GAP
LEADERSHIP	Is there clearly defined system leadership, through designated accountable health inequality leads, inclusion of health inequalities within organisational strategic objectives and individual professional objectives. Is there an expectation of every staff member in the organisation to understand health inequalities and the role they can play to reduce these inequalities?	
POLICY, STRUCTURE & GOVERNANCE	Where a new policy or change to existing service is proposed, is the proposal routinely assessed to identify likely impacts on health inequalities? How is this documented? How are potential negative impacts on at risk groups within the population mitigated? Are there structures within the organisation through which assurance and accountability for action on inequalities is being achieved, including full visibility and priority at governing board?	
CORPORATE RESPONSIBILITY	Does the organisation make full use of its powers as employer and as commissioner to ensure that the way it conducts its business has a positive impact on reducing inequalities? Are all staff employed on at least the living wage? How do you promote vacancies in the organisation to local residents? How have you used procurement as an opportunity to strengthen local businesses and economy? Are corporate and community events routinely held in venues local to more deprived communities?	
PARTNERSHIP & INTEGRATION	Are your goals and initiatives aligned with activity by other organisations in the local health economy to reduce health inequalities? Have you identified opportunities to make use of overlapping priorities to increase effectiveness of the system in tackling health inequalities?	

DISCUSSION OUTCOME SECTION 3: Identify gaps in system and process to prioritise for further investigation and development, and identify accountable stakeholders to lead on each.

Nottinghamshire County Council

Report to The Health and Wellbeing Board

2 September 2015

Agenda Item: 8

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

IMPLEMENTATION OF THE HEALTH AND WELLBEING BOARD PEER CHALLENGE FINDINGS

Purpose of the Report

1. The report outlines progress on implementing the findings of the Health and Wellbeing peer challenge. It describes the consultation process undertaken to take forward specific actions and recommends the following changes to strengthen the work of the Health and Wellbeing Board:

    a. Approval of new working principles for the Health and Wellbeing Board to clearly describe the Board's role and support it in communicating its vision to public and partners.
    b. Review of the Health and Wellbeing Board's communication strategy to communicate a clear message on how the Board's vision will be delivered.
    c. Approval of revised strategic priorities for 2015/16, which will focus the Board's effort on targeted areas to maximise the Board's potential in delivering the Health and Wellbeing Strategy.
    d. Approval of the high level governance structure for the Board, including the establishment of a provider engagement forum and support for ongoing work to define locality health and wellbeing supporting structures.
    e. Support for ongoing actions described in the supporting action plan.

Information and Advice

2. The Council took part in the Local Government Association health and wellbeing peer challenge during the first week of February 2015. The purpose of the peer challenge was to support the Council, its Health and Wellbeing Board, health and other partners in implementing their new statutory responsibilities and maximising the potential to improve health and wellbeing for local people.

3. The on-site visit included one-to-one meetings with key individuals from the Council and partner agencies. There were also a number of group sessions which included wider stakeholders and Council officers. The peer challenge highlighted achievements and areas of good practice, and identified areas for further consideration.

4. There were three main themes to the feedback as follows:

- To improve the strategic leadership of the Board through a clear vision and refined strategy
- To streamline and strengthen governance and support arrangements to assist the Board and Chair in their leadership task and link the Board to complementary work streams and leadership structures.
- To build better communication and engagement with key partners, especially local acute providers and the Voluntary and Community Sector.

5. Following the visit from the peer challenge team, the Chair of the Nottinghamshire Health and Wellbeing Board convened a workshop (Lakeside II) to discuss the findings and recommendations made by the team. Members of the Board, the Health and Wellbeing Implementation Group and partner representatives were invited to attend the day.

6. The event provided a forum to reflect on the peer challenge findings from all perspectives, helping identify required actions. The event also showcased examples of good practice. The full report for the event is included in **Appendix One**.

7. The discussions at the workshop provided further support to the findings of the peer challenge, and identified where the Board and its partners saw the Board's role making most impact.

8. The Board asked the Health and Wellbeing Implementation Group to oversee the implementation of the findings. The Group has considered the feedback received through the peer challenge and engagement process and developed an action plan to implement the findings.

Purpose of the Health and Wellbeing Board

9. The Health and Wellbeing Implementation Group firstly defined the purpose of the Board. The Health and Wellbeing Board has the following statutory duties assigned to it through the Health and Social Care Act 2012. (These functions must be maintained alongside any discretionary roles and responsibilities given through local agreement):
   a. To prepare a Joint Strategic Needs Assessment to profile the health and wellbeing needs of the local population. This also includes the development of the Pharmaceutical Needs Assessment.
   b. To produce a joint health and wellbeing strategy to translate the priority areas identified in the JSNA into commissioning policy.
   c. To encourage integration and close working between health and social care partners.

<u>Feedback</u>

10. Conclusions from the Lakeside workshop found general support for the need for a clear vision for the Board and a common language to articulate this for all parties. It was felt to be particularly important to define what the Board meant by integration. The Board and partners felt the Board should maximise its unique selling point and use its membership and relationships to keep a system-wide approach to delivering health <u>and</u> wellbeing improvements.

11. The Health and Wellbeing Board is a unique partnership of health, social care and other agencies/public services working together to improve health and wellbeing in Nottinghamshire. Membership includes appointed officers, elected politicians, GPs and the

public through Healthwatch Nottinghamshire. As a consequence, it has an unprecedented mandate and ambition to bring everyone together to improve health and wellbeing.

12. Comment has been made throughout the process around whether the Board is a system enabler or system leader. However, this definition is fluid as it relies on investment of authority in the Board to lead, through the devolution of responsibilities.

13. The Health and Wellbeing Implementation Group considered the feedback, noting that with the national drive for devolution it is important that the Health and Wellbeing Board is in a strong position to take on new roles and responsibilities as the need arises. However, the group felt that a clear leadership role is not critical to enabling the system to work together in the meantime. Through the building of trust, confidence and momentum, the Board can develop its capacity and capability to extend its role in the future.

14. The group also considered the definition of integration and felt that this could not be defined in general terms as the principles of integration differed depending on the individual circumstances being considered.

New working principles for the Health and Wellbeing Board to clearly describe its role and support the Board in communicating its vision to public and partners

15. After taking the Board's responsibilities and feedback from the peer challenge and workshop into account, the Health and Wellbeing Implementation Group identified a clear set of principles to frame the work of the Health and Wellbeing Board. These focus on the need to work together to make the best use of the Board, ensure the Board keeps a system-wide view and holds itself and partners to account for delivering health and wellbeing improvements. In summary, the group agreed that the Board should hold the following system-wide roles:

    a. **Oversight -** An accountability role to ensure consistent quality and delivery of the Health and Wellbeing Strategy by individual partners
    b. **Leadership -** A lead role in taking forward defined actions where it can add value over work that is undertaken by individual organisations on a day to day basis
    c. **Enabling** - A role in identifying common issues, facilitating shared solutions and sharing good practice.

The draft principles are included in **Appendix Two.** The Health and Wellbeing Board is asked to approve these principles.

Review of the Health and Wellbeing Board's communication strategy to communicate a clear message on how the Board's vision will be delivered

16. The vision for the Health and Wellbeing Board is set out in the current Health and Wellbeing Strategy as follows:

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

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

17. The Board identified the following four key ambitions to achieve its vision:

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

18. The Health and Wellbeing Implementation Group reviewed the vision and ambitions and felt that these continued to reflect the Board’s purpose. Whilst the peer challenge found that there needed to be a clearer vision, the Board may wish to consider how best to articulate the current vision, so that the Board can better communicate what benefits it wishes to achieve for local people.

19. It is proposed that the Board endorses the current vision and agrees the review of the communication strategy to make best use of the vision and communicate a clear message on how the Board’s vision will be delivered. This will also allow the vision to be underpinned by complementary communication on how the Board wishes to keep a long term view, whilst taking forward actions in the more immediate future.

Revised strategic priorities for 2015/16, which will focus the Board’s effort on targeted areas to maximise the Board’s potential in delivering the Health and Wellbeing Strategy

20. At the strategic workshop, there was broad agreement with the current content of the Health and Wellbeing Strategy, but discussions identified a slightly smaller number of priorities. There was a consensus that the overall aim of the strategy should be to narrow the health inequalities gap, and that promoting prevention and maintaining independence were fundamental underlying principles. Furthermore, there was wide support for a range of public health priorities, including obesity, tobacco and mental health as well as a focus on wider determinants such as housing. A greater focus on children and young people was also suggested.

21. Following the workshop, discussions have been held with policy leads, CCG and Council representatives. These discussions have focussed on reviewing the strategic priorities to differentiate them into which are ‘business as usual’; being delivered outside the Board, and actions requiring the Board’s intervention.

22. It is proposed that all priorities included in the Health and Wellbeing Strategy will continue as they are important in delivering improvements in health and wellbeing. These will continue to

be monitored through the Health and Wellbeing Implementation Group. This will allow the Board to concentrate on what only it can deliver, utilising its unique position.

23. In accordance with the continued support for a wide range of priorities, the Health and Wellbeing Implementation Group recommends the following approach:

    a. Agree a core set of specific actions annually that require the Board's leadership and support utilising its unique selling point.

    b. Continue to report on all strategic priorities on an annual basis (or by exception) through the Health and Wellbeing Strategy delivery plan. This will allow the Board to retain system oversight to maximise improvements in health and wellbeing and reduce health inequalities through the full range of interventions.

    c. Explore performance to highlight areas of emerging need, and investigate potential solutions in year, so that these can form core priorities for subsequent years. (A report of the current position is presented alongside this report to highlight how this information is being used to identify annual actions.)

24. The report in **Appendix Three** provides information for the County and its districts and boroughs in relation to health and wellbeing. The indicators are taken from the Health Profiles produced through Public Health England. The report shows that priorities for Nottinghamshire include smoking status at time of delivery, breastfeeding initiation, excess weight in adults, and people killed and seriously injured on roads. The local profiles and trends showed differences across the districts and boroughs highlighting the inequalities that exist across the County. Many of these subjects have been discussed by the Health and Wellbeing Board. This information has also been used to inform the proposed priorities for 2015/16.

25. The focussed priorities will include short term and longer term actions that can be monitored to show progress, and the actions will be used to provide a compelling narrative for the Board's vision for improving health and wellbeing, tackling health inequalities and promoting integration.

26. The Health and Wellbeing Implementation Group will ensure performance is monitored and reported to the Board as required. The group will also take a lead role in highlighting system-wide problems and potential opportunities for integration on behalf of the Board. It will work with partners to harness the discretionary effort of individual organisations to support action. Discussion also highlighted the need to use the Better Care Fund as an enabler for change and focus on promoting primary / community care and a reduced reliance on secondary care.

Health and Wellbeing Strategic Actions for 2015/16

27. In order to progress this approach in the current year, the Health and Wellbeing Implementation Group has proposed the following action for 2015/16 subject to the Board's approval. These have been identified and prioritised for the following reasons. The proposed actions for 2015/16 are described in **Table One**:
    a. Feedback from policy leads' identified areas that required further action
    b. Review of performance information identified areas where Nottinghamshire did not perform as well as other parts of the country
    c. Assessment of the actions identified where the Board could add value above the contribution of individual organisations.

Table One: Proposed Actions for 2015/16

Objective	Rationale	Action
Improve uptake of breastfeeding, particularly in the Ashfield, Bassetlaw, Gedling, Mansfield and Newark and Sherwood districts.	This supports the '**Good Start'** Ambition. In Nottinghamshire, fewer mothers choose to breastfeed their babies compared to national figures. There is strong evidence that breast feeding improves health and wellbeing outcomes for children and mothers.	Implement the Breast Feeding Friendly places Initiative across all HWB partners.
Improve Children and Young People's Mental Health and Wellbeing across Nottinghamshire.	This supports the '**Living Well'** and '**Coping Well'** Ambitions. Enabling children of school age can improve health outcomes in later life.	Develop a partnership agreement to tackle child sexual exploitation in Nottinghamshire, in conjunction with the Nottinghamshire Safeguarding Children's Board. Implement the Nottinghamshire Children's Mental Health & Wellbeing Transformation Plan to develop a greater prevention and early intervention approach, such as the use of a single, unique brand identity for young people's health, improved access to better information and novel delivery mechanism for support.
Reduce the number of people that smoke in Nottinghamshire.	This supports the '**Living Well'** and '**Coping Well'** Ambitions. Smoking accounts for half the health inequalities present between local communities. It is linked to long term illness and premature death. Reduced smoking and tobacco use can only be achieved through multifaceted partnership working.	Health and wellbeing partners to implement their agreed actions for the Nottinghamshire County and Nottingham City Declaration on Tobacco Control.
Develop healthier environments to live and work in Nottinghamshire.	This support all Ambitions. Environments that are planned to maximise health and wellbeing resources can have benefits for communities in the longer term, through encouraging physical activity, healthy eating or access to support /services.	Facilitate a joint approach across Health and Wellbeing partners to planning to maximise benefits, leading to the use of Health Impact Assessments.
Ensure crisis support (inc. housing) is available for people with mental health problems living in the community.	This supports the '**Coping Well'** and **'Working Together'** Ambitions. A joint approach will provide support to individuals in a streamlined way, and help people maintain independence.	Facilitate a joint approach to crisis support (including work around the crisis care condcorat) to maximise resources to support individuals in the community.
Ensure vulnerable people living in the community can access the housing support they need.	This supports the '**Coping Well'** and **'Working Together'** Ambitions. A joint approach will provide support to individuals in a streamlined way, and help people maintain independence	Extend integrated working to include Housing so that support for vulnerable people is assessed collectively and delivered by the most appropriate agency.

28. Through delivery of these actions, there will be a focus on health inequalities to ensure the potential impact is maximised for local communities.

29. In addition to the actions identified, the Board retains responsibility for the implementation of the Better Care Fund which supports the Board's duty to promote integration. The Board will retain oversight of the fund and the plans agreed to deliver Health and Wellbeing improvements. These actions will support and complement the annual actions identified in this report where possible. The Board will receive regular reports on progress and respond to further announcements regarding the future of the fund.

30. The Health and Wellbeing Board is asked to agree the proposed approach described in paragraph 23 and the health and wellbeing strategic actions for 2015/16. It is proposed that the Board receives further detail for each action and individual responsibilities, once agreed through the Health and Wellbeing Implementation Group.

Review of high level governance structure for the Board and establishment of a provider engagement forum

31. There was general support for the Board and its structure to ensure that the priorities in the Strategy are delivered and there remains oversight on delivery using defined and specific outcomes. It was also felt that the Board should have a role in showcasing and sharing good practice and be prepared to make decisions around disinvestment.

32. The current governance structure for the Health and Wellbeing Board uses thematic policy-based integrated commissioning groups to deliver the Health and Wellbeing Strategy. Comments reinforced the need for a place–based governance structure to support the work of the Board, which would fit with the NHS planning unit. Feedback also highlighted the current disconnect between the Health and Wellbeing Board and the Better Care Fund and transformation agendas. The need to interface with wider bodies like the Safer Nottinghamshire Board and Nottingham City Health and Wellbeing Board was also noted.

33. Taking feedback into account, the Health and Wellbeing Implementation Group reviewed current support structures to simplify them, clarify accountability and encourage more cohesion. **Appendix Four** describes a simplified high level structure using NHS planning units as the channel of engagement and delivery at local levels.

34. It is proposed that the Health and Wellbeing Implementation Group maintains a pivotal role in overseeing the work of the Health and Wellbeing Board. As the Board cannot keep a detailed overview on all areas of the strategy, it is suggested that the role of the Health and Wellbeing Implementation Group should be strengthened to support the work of the Board by holding groups to account for delivery.

35. There is more work to be undertaken at a local level to determine the most appropriate locality structures to deliver the work of the Board and ensure connection with associated transformation and integration work-streams. There is also further work needed to address elements, such as the links with the South Nottinghamshire Transformation Board, Safer Nottinghamshire Board and Nottingham City Health and Wellbeing Board. It is therefore suggested that the structure be consulted upon more widely to identify any gaps and weaknesses for further consideration by the Health and Wellbeing Implementation Group.

36. It is proposed that the local health and wellbeing forum are managed and chaired through CCGs to support shared leadership of the system. Membership will include district council and provider representation. Integrated commissioning groups, including the Children's Trust, will act as advisory groups to establish a local focus for commissioning strategy, but will continue to be accountable to the Health and Wellbeing Implementation Group.

37. There was a strong theme in the feedback about improved provider engagement within the work of the Health and Wellbeing Board. It was acknowledged that steps had been taken to engage these important partners, but that more needed to be done, especially around engaging them at an early stage of strategy development.

38. NHS providers highlighted the potential for them to be exemplary employers promoting health and wellbeing with employees as well as patients. The voluntary and community sector organisations also highlighted opportunities to work more closely with the sector to deliver the strategy and ambitions of the Board.

39. In response to the feedback, the Health and Wellbeing Implementation Group proposes that a provider forum be established to engage providers in the work of the Board. This will be led by a self-selected provider organisation. It is proposed that the chair and vice chair of this forum become members of the Implementation Group to ensure direct links to the Board. It is suggested that further provider engagement will take place at locality level through the Health and Wellbeing forum and integrated commissioning groups.

40. The Board is asked to support the proposed high level structure and ongoing work which aims to bring coherence to our local health and wellbeing system.

Future actions included in the supporting Health and Wellbeing Peer Challenge Action Plan

41. Alongside the work described in this report, there are a number of additional ongoing actions designed to fully implement the findings of the peer challenge. These are detailed in the action plan in **Appendix Five**. The Board is asked to support this work and agree the direction of travel.

42. A particular area of work is around improving communications, as there are a number of examples where improved communications would facilitate more joined up working. The Health and Wellbeing Implementation Group recommends that the communications strategy for the Health and Wellbeing Board be revised to take the findings from the peer challenge into account.

Statutory and Policy Implications

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

RECOMMENDATION/S

The Health and Wellbeing Board is asked to:

1) Approve new working principles for the Health and Wellbeing Board to clearly describe its role and support the Board in communicating its vision to public and partners.
2) Support the need to review the Health and Wellbeing Board's communication strategy to communicate a clear message on how the Board's vision will be delivered.
3) Approve revised strategic priorities for 2015/16, which will focus the Board's effort on targeted areas to maximise the Board's potential in delivering the Health and Wellbeing Strategy.
4) Approve the high level governance structure for the Board, including the establishment of a provider engagement forum and support ongoing work to define locality health and wellbeing supporting structures.
5) Support the ongoing actions described in the supporting action plan.

David Pearson
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Constitutional Comments (LMC 24/07/2015)

44. The recommendations in the report fall within the terms of reference of the Health and Wellbeing Board.

Financial Comments (KAS 24/07/2015)

45. 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.

- Paper to the Health and Wellbeing Board 1 April 2015 - 'Key findings from the Health and Wellbeing peer challenge.'

Electoral Divisions and Members Affected

- All

Appendices

Appendix One: **Health and Wellbeing Board Strategic Workshop – Summary of Discussions**
Appendix Two: **Draft Principles for the Health and Wellbeing Board**
Appendix Three: **Nottinghamshire Health Profile report 2015**
Appendix Four: **Proposed High Level Governance Structure**
Appendix Five: **Action Plan**

Health & Wellbeing Board Strategic Workshop

29 April 2015

Summary of discussions

Introduction

Following the visit from the Local Government Association Peer Challenge team in February 2015, the Chair of the Nottinghamshire Health and Wellbeing Board convened a workshop to discuss the findings and recommendations made by the team. Members of the Board, the Health and Wellbeing Implementation Group and partner representatives were invited to attend the day. The morning session was a closed workshop for the Board and Implementation Group members. The afternoon session was extended out to include representatives from the local providers, including NHS acute trusts and representatives from the voluntary sector.

Presentations was given on the national context and changing landscape in which Health & Wellbeing Boards operate; key findings of the Peer Challenge and showcasing achievements and areas of good practice.

The feedback from the Peer Challenge *included in Appendix A* highlights the three broad themes from the review. These are strategic leadership, communications & engagement & governance & support.

Participants were given the opportunity to explore current experiences of the Health & Wellbeing Board, future ambition and how this will be achieved.

The following summary details the key comments collated from the workshop which were based around key questions posed to participants. The feedback is taken from both the morning and afternoon sessions.

The Health & Wellbeing Board - What is working well?

There was a general feeling that the wider Board membership was positive and that including Councillors in the Board, both county and district representatives has raised awareness of health related issues and improved engagement with the district and borough councils.

Delegates agreed that relationships within the Board were positive and had provided an opportunity to build trust within a complex system. It was felt that the Board were having better conversations and that there were examples of success and consensus but visible delivery was less apparent. Generally agreement was reached through a consensus rather than through voting rights.

The JSNA and Health and Wellbeing Strategy were felt to be evidence based and the profile of the JSNA had been raised and its value as a useful tool was recognised. Within the discussions it was suggested that the Board should invest in evaluation to build a bank of evidence for interventions.

The Board had also raised the profile of the wider determinants of health – particularly housing, which has resulted in the development of shared objectives.

The development sessions were recognised as good practice and an opportunity to link providers into networks and support delivery.

The Health & Wellbeing Board – What could be improved?

There was a general feeling that the Board lacked clarity of purpose and needed a common language, in particular to define what it wants it means by integration and prevention. The Board should also concentrate on its unique selling point and do what only it could deliver. Comment was made that 'The Board should set the ambition for the system'.

There was a common view that the Health and Wellbeing Strategy needed refinement. It was felt that there were too many priorities and the value that the Board can add is not clear. There were numerous suggestions that the number of priorities should be reduced and suggestion that a smaller number of projects considered. It was suggested that any priorities identified should have clear quantifiable outcomes with clarity about the accountability of the Health and Wellbeing Board and common ownership across partners. Early actions were suggested that could be achieved in the short term, linking with the idea that success breeds success.

Comments also suggested that reassurance would be required that those areas which were not identified as priorities would not 'fall through the gaps'.

There was a feeling that the profile of the Board could be improved with partners as well as the public and that there was a general lack of understanding about its role. The role of Board members was also raised – who they represent & their role on the Board. Comments were also made about a potential lack of understanding about what the public want. A suggestion was also made that funding pressures may impact on trust between partners.

Comments were made about the complexities of working with the planning units within health and a potential struggle/challenge between other countywide boards where leadership responsibility sits. A disconnection between the Health & Wellbeing Strategy & the transformation agenda was also raised, as was potential duplication between different work-streams as well as the need to make sense of a complex funding and governance system.

Concerns were raised that there was a variable degree of ownership between Board members, discussions could be 'polite' and that the size of the Board could result in a 'talking shop'.

The interface of the Board with the City was raised, particularly with the overlap of providers. It was also suggested that the focus had been on older people and that children and young people had not been prominent enough.

The Better Care Fund was highlighted and during the feedback there was a question about the role of the Board and whether members were sufficiently well informed about the plans and whether they have added value to them.

What are the priority health outcomes we want to achieve?

During the course of the workshop the following areas were raised as priorities for the Board:

Public Health priorities

Alcohol (& drug) misuse
Tobacco
Obesity
Children & young people
Mental Health

Tackling Health Inequalities

Targeted populations
Areas of Poverty

Wider determinants of health

Housing
Employment

Independence, integration & managing system pressures

Better Care Fund
Independence for older people / people with learning disabilities
Self-care for long term conditions
Home care
Care homes

Other priorities

End of life care

Feedback suggested that the language of the Board should change from 'the Board' to 'we and us'. There was also an ambition to support wellbeing and independence with a focus on individuals and prevention to improve wellbeing and not just health.

What do we want to achieve in the next five years?

As with the other questions there were a range of views expressed during the workshop about the ambitions of the Board. These included:

- Mental health – a cross cutting theme which could potentially have a bigger impact.
- Financial sustainability and redirecting services to where they are most needed.
- Reducing health inequalities and being nationally recognised for achievements in Nottinghamshire.
- For the Better Care Fund to deliver outcomes.
- To develop and focus on community resilience.
- To tackle access to services – timeliness & access to GP & dentistry
- Focus on the individual, prevention

Prevention, recovery and wellbeing were all highlighted as principles for the Board.

What does the HWB have to do/be – to make this happen?

Comments mostly related to the Boards leadership and included:

- The need to identify a goal and stick to it
- Agree long-term goals for prevention and recognise the difficulties this may cause.
- Be responsible for the health and wellbeing system and whether it's working. 'Provide robust challenge to partners, which is taken seriously and facilitates a shift to invest in interventions which have a longer term impact on reducing demand'.
- Measure spend across the system and make sure it's allocated most effectively.
- Identify core standards demonstrating a minimum service offer.
- Refine the priorities & give explicit outcomes for those which remain including partner roles in delivery. Identify risks against each priority & mitigation in place.

Provider engagement

There were a number of comments made throughout the workshop about engagement with providers and that the Board could be more inclusive. This included recognition that the acute trusts were major employers in the area and could potentially influence the health and wellbeing of their employees and their families representing a large proportion of the population.

There were also requests to utilise smaller providers within the voluntary sector to trial methods and innovation on a small scale to build an evidence base in order to demonstrate return on investment.

Suggestions were made about more flexible contracting arrangements as generic contracts may not deliver the responsiveness required.

There were general comments about needing a better sense of connection between the Board and providers and more direct engagement at an early stage when issues were raised to give an understanding of what's happening on the ground.

General comments

There were some general comments made during the discussions and feedback. In terms of the Boards agenda, there were suggestions that Board members should be feeding more issues in to the Board and that there should be a clearer feedback mechanism.

The need for clarity about the role of the Health and Wellbeing Implementation Group was raised.

There was also a comment made about the risk that issues could become too disease or problem specific leading to services fragmented. An example was given of the impact of housing on obesity.

The Board's role in workforce and recruitment was mentioned during the discussions, in establishing career pathways within social care providers for example. The Board has the potential to have an overview on shared problems such as recruitment and lead a mutli-agency workforce plan.

It was suggested that the Board could also have a role in ensuring consistent quality across the county to improve services and reduce complexity. There was also suggestion that the Board should lead a move to 'One Nottinghamshire' ensuring evidence based services for the whole population.

Nottinghamshire County Council

Draft Principles for the Health & Wellbeing Board

The Board' vision for the people of Nottinghamshire is:

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

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

The Board have identified four key ambitions to achieve its vision:

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

In order to deliver its vison and ambitions, the Health & Wellbeing Board needs to prioritise its work to achieve the most from the available resources.

The following principles aim to assist in managing the Boards delivery of its strategic priorities:

- The Board will not duplicate the good work that is already happening in each locality and by each health and wellbeing partner organisation.
- The Board will hold people to account for delivering on their contribution to the Health & Wellbeing Strategy.
- The Board will concentrate its efforts on issues that cannot be achieved independently and require a shared solution.
- The Board will only prioritise actions that require a multi-agency approach.
- The Board will maintain an overview to promote consistency of quality across the County.
- The Board will keep a system-wide perspective to encourage integration.
- The Board will focus on Health and Wellbeing.
- The Board will prioritise preventative, recovery and independence strategies.
- The Board will concentrate on delivery of outcomes.
- The Board will promote shared learning and spread good practice.

Health summary for Nottinghamshire

Indicators | **Spine Chart** | **Variation between Counties nationally**

Source: Public Health England (PHE) fingertips Health Profiles 2015

URL: http://fingertips.phe.org.uk/profile/health-profiles

East Midlands region
Nottinghamshire districts
Nottinghamshire Better
Nottinghamshire Similar
Nottinghamshire Worse

Domain		Indicator	Period	Local No. per year	Local value	Eng. Value	Eng. Worst	England range	Eng. Best
Our communities	1	Deprivation	2013	129,284	**16.2**	20.4	83.8		0.0
	2	Children in poverty (under 16s)	2012	23,500	**16.9**	19.2	37.9		6.6
	3	Statutory homelessness	2013/14	480	**1.4**	2.3	12.5		0.1
	4	GCSE achieved (5A*-C inc. Eng & Maths)	2013/14	5,008	**57.6**	56.8	35.4		74.4
	5	Violent crime (violence offences)	2013/14	7,390	**9.4**	11.1	27.8		4.6
	6	Long term unemployment	2014	3,224	**6.5**	7.1	23.5		1.3
Children's and young people's health	7	Smoking status at time of delivery	2013/14	1,331	**16.7**	12.0	27.5		1.9
	8	Breastfeeding initiation	2013/14	5,711	**70.6**	73.9	36.6		93.0
	9	Obese children (Year 6)	2013/14	1,273	**17.5**	19.1	26.7		11.1
	10	Alcohol-specific hospital stays (under 18)	2011/12 - 13/14	57	**34.9**	40.1	100.0		13.7
	11	Under 18 conceptions	2013	340	**24.2**	24.3	43.9		9.2
Adults' health and lifestyle	12	Smoking prevalence	2013	N/A	**18.4**	18.4	29.4		10.5
	13	Percentage of physically active adults	2013	1,888	**58.1**	56.0	43.5		67.0
	14	Obese adults	2012	N/A	**24.0**	23.0	35.2		11.2
	15	Excess weight in adults	2012	1,357	**66.4**	63.8	74.4		45.9
Disease and poor health	16	Incidence of malignant melanoma	2010 - 12	130	**18.2**	18.4	37.3		4.8
	17	Hospital stays for self-harm	2013/14	1,632	**207.9**	203.2	682.7		60.9
	18	Hospital stays for alcohol related harm	2013/14	5,351	**674.7**	645.1	1,230.5		366.3
	19	Prevalence of opiate and/or crack use	2011/12	4,436	**8.7**	8.4	20.8		1.9
	20	Recorded diabetes	2013/14	40,222	**6.4**	6.2	8.7		3.7
	21	Incidence of TB	2011 - 13	32	**4.0**	14.8	113.7		0.5
	22	New STI (exc Chlamydia aged under 25)	2013	3,558	**700.3**	818.3	2,891.4		365.4
	23	Hip fractures in people aged 65 and over	2013/14	884	**556.8**	580.0	838.5		381.6
Life expectancy and causes of death	24	Excess winter deaths (three year)	Aug 2010 - Jul 2013	418	**17.4**	17.4	27.0		4.3
	25	Life expectancy at birth (Male)	2011 - 13	N/A	**79.6**	79.4	74.3		82.6
	26	Life expectancy at birth (Female)	2011 - 13	N/A	**83.0**	83.1	80.0		86.2
	27	Infant mortality	2011 - 13	33	**3.7**	4.0	7.1		1.3
	28	Smoking related deaths	2011 - 13	1,282	**279.5**	288.7	471.6		186.6
	29	Suicide rate	2011 - 13	67	**8.5**	8.8	13.6		4.5
	30	Under 75 mortality rate: cardiovascular	2011 - 13	526	**74.2**	78.2	137.0		52.1
	31	Under 75 mortality rate: cancer	2011 - 13	1,041	**145.7**	144.4	198.9		104.0
	32	Killed and seriously injured on roads	2011 - 13	414	**52.4**	39.7	78.9		16.6

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Health summary for Nottinghamshire

Indicators

Source: Public Health England (PHE) fingertips Health Profiles 2015

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Statistical significance relative to England

England **Region** **County** **County Districts**

Better than England	Similar to England	Worse then England

Domain		Indicator	Period	England	East Midlands region	Nottinghamshire	Bassetlaw	Ashfield	Mansfield	Newark and Sherwood	Gedling	Broxtowe	Rushcliffe
Our communities	1	Deprivation	2013	20.4 n=10,987,926	17.0 n=780,832	16.2 n=129,284	27.9 n=31,739	24.1 n=29,319	39.6 n=41,660	14.3 n=16,661	3.3 n=3,751	5.5 n=6,154	0.0 n=0
	2	Children in poverty (under 16s)	2012	19.2 n=1,912,310	18.2 n=151,375	16.9 n=23,500	17.5 n=3,470	23.2 n=5,195	22.7 n=4,345	16.0 n=3,300	15.7 n=3,070	15.2 n=2,710	7.3 n=1,410
	3	Statutory homelessness	2013/14	2.3 n=52,270	1.9 n=3,600	1.4 n=480	0.8 n=41	1.6 n=85	3.3 n=150	2.6 n=127	1.0 n=51	0.2 n=10	0.2 n=11
	4	GCSE achieved (5A*-C inc. Eng & Maths)	2013/14	56.8 n=315,873	54.0 n=26,608	57.6 n=5,008	63.7 n=780	51.6 n=695	53.8 n=666	48.4 n=473	54.6 n=763	57.1 n=592	70.6 n=1,039
	5	Violent crime (violence offences)	2013/14	11.1 n=593,830	10.2 n=46,512	9.4 n=7,390	10.6 n=1,198	10.6 n=1,275	15.1 n=1,581	9.2 n=1,066	6.7 n=N/A	6.7 n=N/A	6.7 n=N/A
	6	Long term unemployment	2014	7.1 n=245,327	6.9 n=19,993	6.5 n=3,224	7.2 n=510	8.6 n=658	10.0 n=671	5.1 n=371	6.2 n=444	5.0 n=349	3.2 n=221
Children's and young people's health	7	Smoking status at time of delivery	2013/14	12.0 n=75,913	15.1 n=7,616	16.7 n=1,331	20.3 n=218	20.9 n=295	23.5 n=287	19.5 n=203	15.0 n=172	11.1 n=106	4.6 n=51
	8	Breastfeeding initiation	2013/14	73.9 n=449,063	71.9 n=36,810	70.6 n=5,711	69.0 n=752	63.6 n=902	N/A	68.1 n=843	N/A	N/A	85.7 n=936
	9	Obese children (Year 6)	2013/14	19.1 n=98,190	18.1 n=7,993	17.5 n=1,273	19.1 n=191	20.1 n=225	20.6 n=191	18.5 n=198	17.4 n=193	18.1 n=170	9.7 n=105
	10	Alcohol-specific hospital stays (under 18)	2011/12 - 13/14	40.1 n=4,575	33.8 n=323	34.9 n=57	40.5 n=10	42.6 n=12	47.7 n=10	30.8 n=7	28.7 n=7	34.3 n=7	20.0 n=5
	11	Under 18 conceptions	2013	24.3 n=22,830	24.6 n=1,982	24.2 n=340	26.0 n=56	28.1 n=61	36.0 n=68	27.9 n=55	23.5 n=48	15.0 n=28	12.4 n=24
Adults' health and lifestyle	12	Smoking prevalence	2013	18.4 n=N/A	19.1 n=N/A	18.4 n=N/A	22.5 n=N/A	21.6 n=N/A	25.8 n=N/A	17.6 n=N/A	14.9 n=N/A	15.5 n=N/A	11.3 n=N/A
	13	Percentage of physically active adults	2013	56.0 n=86,509	55.9 n=10,675	58.1 n=1,888	59.5 n=269	56.8 n=254	50.2 n=250	54.3 n=268	64.4 n=285	60.8 n=269	60.1 n=293
	14	Obese adults	2012	23.0 n=N/A	24.1 n=N/A	24.0 n=N/A	24.7 n=N/A	28.2 n=N/A	32.4 n=N/A	19.2 n=N/A	23.7 n=N/A	20.9 n=N/A	19.1 n=N/A
	15	Excess weight in adults	2012	63.8 n=85,221	65.6 n=7,630	66.4 n=1,357	69.2 n=206	69.6 n=220	70.5 n=193	64.8 n=189	67.9 n=202	64.4 n=183	58.3 n=164
Disease and poor health	16	Incidence of malignant melanoma	2010 - 12	18.4 n=8,261	17.7 n=699	18.2 n=130	18.0 n=19	15.9 n=17	14.5 n=13	22.2 n=24	16.3 n=17	15.9 n=16	23.9 n=24
	17	Hospital stays for self-harm	2013/14	203.2 n=111,997	209.2 n=9,781	207.9 n=1,632	262.6 n=285	250.5 n=305	205.3 n=218	215.9 n=242	198.9 n=227	180.8 n=199	141.9 n=156
	18	Hospital stays for alcohol related harm	2013/14	645.1 n=333,014	673.9 n=30,137	674.7 n=5,351	708.6 n=806	754.8 n=893	712.5 n=738	627.8 n=740	666.2 n=767	669.7 n=750	584.4 n=658
	19	Prevalence of opiate and/or crack use	2011/12	8.4 n=293,879	8.1 n=24,085	8.7 n=4,436	13.5 n=984	9.9 n=772	16.5 n=1,136	7.2 n=527	4.3 n=314	6.5 n=472	3.2 n=231
	20	Recorded diabetes	2013/14	6.2 n=2,814,004	6.6 n=256,581	6.4 n=40,222	7.3 n=6,563	6.6 n=6,492	6.7 n=5,187	6.3 n=6,791	6.1 n=4,941	6.3 n=5,371	5.3 n=4,877
	21	Incidence of TB	2011 - 13	14.8 n=7,891	10.3 n=469	4.0 n=32	2.9 n=3	3.9 n=5	3.8 n=4	2.0 n=2	5.5 n=6	6.0 n=7	4.2 n=5
	22	New STI (exc Chlamydia aged under 25)	2013	818.3 n=286,245	671.7 n=19,934	700.3 n=3,558	641.9 n=464	824.2 n=643	953.9 n=652	582.9 n=428	747.8 n=547	630.4 n=452	523.1 n=372
	23	Hip fractures in people aged 65 and over	2013/14	580.0 n=57,377	553.1 n=4,786	556.8 n=884	639.0 n=148	553.2 n=120	671.6 n=129	629.5 n=151	464.2 n=110	571.0 n=130	383.8 n=96
Life expectancy and causes of death	24	Excess winter deaths (three year)	Aug 2010 - Jul 2013	17.4 n=25,545	18.2 n=2,383	17.4 n=418	21.0 n=76	10.6 n=40	15.3 n=50	17.2 n=63	18.0 n=62	14.6 n=49	26.5 n=79
	25	Life expectancy at birth (Male)	2011 - 13	79.4 n=N/A	79.3 n=N/A	79.6 n=N/A	78.8 n=N/A	78.2 n=N/A	78.5 n=N/A	79.5 n=N/A	80.6 n=N/A	80.7 n=N/A	81.4 n=N/A
	26	Life expectancy at birth (Female)	2011 - 13	83.1 n=N/A	83.0 n=N/A	83.0 n=N/A	82.4 n=N/A	82.1 n=N/A	81.9 n=N/A	82.9 n=N/A	83.4 n=N/A	83.6 n=N/A	84.6 n=N/A
	27	Infant mortality	2011 - 13	4.0 n=2,715	4.2 n=230	3.7 n=33	3.5 n=4	4.3 n=7	2.7 n=4	4.0 n=5	2.9 n=4	3.7 n=5	4.8 n=5
	28	Smoking related deaths	2011 - 13	288.7 n=81,902	282.4 n=7,093	279.5 n=1,282	303.4 n=203	340.3 n=218	332.4 n=190	277.6 n=194	255.9 n=172	261.2 n=170	196.9 n=134
	29	Suicide rate	2011 - 13	8.8 n=4,586	8.4 n=375	8.5 n=67	10.8 n=12	7.6 n=9	12.0 n=12	7.8 n=9	N/A	7.6 n=8	7.8 n=9
	30	Under 75 mortality rate: cardiovascular	2011 - 13	78.2 n=33,483	80.0 n=3,091	74.2 n=526	78.8 n=83	86.0 n=91	90.1 n=80	76.9 n=84	62.5 n=64	73.6 n=72	52.7 n=52
	31	Under 75 mortality rate: cancer	2011 - 13	144.4 n=62,215	143.8 n=5,597	145.7 n=1,041	144.6 n=154	170.9 n=181	159.9 n=143	131.2 n=145	153.7 n=158	134.1 n=133	126.8 n=126
	32	Killed and seriously injured on roads	2011 - 13	39.7 n=21,245	44.7 n=2,041	52.4 n=414	62.4 n=71	48.6 n=58	44.6 n=47	68.0 n=79	44.7 n=51	40.3 n=45	57.1 n=64

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Health summary for Nottinghamshire

Indicators

Indicator metadata

Source: Public Health England (PHE) fingertips Health Profiles 2015

URL: http://fingertips.phe.org.uk/profile/health-profiles

Domain		Indicator	Period	Definition	Value type	Unit
Our communities	1	Deprivation	2013	% of the relevant population in this area living in the 20% most deprived Lower Super Output Areas in England.	Proportion	%
	2	Children in poverty (under 16s)	2012	Percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16s only	Proportion	%
	3	Statutory homelessness	2013/14	Statutory homeless households, crude rate per 1,000 estimated total households, all ages	Crude rate	per 1,000
	4	GCSE achieved (5A*-C inc. Eng & Maths)	2013/14	Percentage of pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent at end of Key Stage 4 in schools maintained by the Local Authority, at the end of the academic year	Proportion	%
	5	Violent crime (violence offences)	2013/14	Violence against the person offences, based on police recorded crime data, crude rate per 1,000 population	Crude rate	per 1,000
	6	Long term unemployment	2014	Claimant count for jobseekers allowance, 16-64 year olds claiming for more than 12 months, crude rate per 1000 resident population, 16-64 year olds.	Crude rate	per 1,000
Children's and young people's health	7	Smoking status at time of delivery	2013/14	Number of women who currently smoke at time of delivery per 100 maternities.	Proportion	%
	8	Breastfeeding initiation	2013/14	The percentage of mothers who give their babies breast milk in the first 48 hours after delivery. The numerator is the number of mothers initiating breast feeding and the denominator is the total number of maternities.	Proportion	%
	9	Obese children (Year 6)	2013/14	Prevalence of obesity (BMI greater than 95th centile of the UK90 growth reference) among children in Year 6 (age 10-11 years)	Proportion	%
	10	Alcohol-specific hospital stays (under 18)	2011/12 - 13/14	Persons admitted to hospital due to alcohol-specific conditions - under 18 year olds. See LAPE user guide for further details - http://www.lape.org.uk/downloads/Lape_guidance_and_methods.pdf	Crude rate	per 100,000
	11	Under 18 conceptions	2013	Conceptions in women aged under 18 per 1,000 females aged 15-17	Crude rate	per 1,000
Adults' health and lifestyle	12	Smoking prevalence	2013	Prevalence of smoking among persons aged 18 years and over.	Proportion	%
	13	Percentage of physically active adults	2013	Respondents aged 16 and over, with valid responses to questions on physical activity, doing at least 150 'equivalent' minutes of at least moderate intensity physical activity per week in bouts of 10 mins or more in the previous 28 days	Proportion	%
	14	Obese adults	2012	Adults with a BMI greater than or equal to 30kg/m2	Proportion	%
	15	Excess weight in adults	2012	Percentage of adults classified as overweight or obese	Proportion	%
Disease and poor health	16	Incidence of malignant melanoma	2010 - 12	Registrations for malignant melanoma of the skin (ICD-10 C43), directly age-standardised rate, persons, under 75, (3-year average of annual rates), per 100,000 2013 European Standard population.	Directly standardised rate	per 100,000
	17	Hospital stays for self-harm	2013/14	Emergency Hospital Admissions for Intentional Self-Harm, directly age-sex standardised rate, all ages, Persons.	Directly standardised rate	per 100,000
	18	Hospital stays for alcohol related harm	2013/14	Admissions to hospital where the primary diagnosis is an alcohol-attributable code or a secondary diagnosis is an alcohol-attributable external cause code. See LAPE user guide for further details	Directly standardised rate	per 100,000
	19	Prevalence of opiate and/or crack use	2011/12	Estimated prevalence of opiate and/or crack cocaine users (previously defined as 'problem drug users'), crude rate per 1,000 population, ages 15-64, persons.	Crude rate	per 1,000
	20	Recorded diabetes	2013/14	The prevalence of Quality and Outcomes Framework (QOF) recorded diabetes in the population registered with GP practices aged 17 and over.	Proportion	%
	21	Incidence of TB	2011 - 13	The three-year average number of reported new cases per year (based on case notification) per 100,000 population	Crude rate	per 100,000
	22	New STI (exc Chlamydia aged under 25)	2013	All new STI diagnoses (excluding Chlamydia in under 25 year olds) in GUM clinic attendees who are resident in England (excludes non-residents accessing English clinics)	Crude rate	per 100,000
	23	Hip fractures in people aged 65 and over	2013/14	Emergency Hospital Admission for fractured neck of femur in persons aged 65 and over, directly age-sex standardised rate per 100,000.	Directly standardised rate	per 100,000
Life expectancy and causes of death	24	Excess winter deaths (three year)	Aug 2010 - Jul 2013	Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months compared with the average of the number of non-winter deaths.	Ratio	
	25	Life expectancy at birth (Male)	2011 - 13	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive.	Life expectancy	Years
	26	Life expectancy at birth (Female)	2011 - 13	The average number of years a person would expect to live based on contemporary mortality rates. For a particular area and time period, it is an estimate of the average number of years a newborn baby would survive.	Life expectancy	Years
	27	Infant mortality	2011 - 13	Infant deaths under 1 year of age per 1000 live births	Crude rate	per 1,000
	28	Smoking related deaths	2011 - 13	Deaths attributable to smoking, directly age-sex standardised rate for persons aged 35 years +. Relative risks by ICD10 code from The Information Centre for Health and Social Care, Statistics on Smoking: England 2010.	Directly standardised rate	per 100,000
	29	Suicide rate	2011 - 13	Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	Directly standardised rate	per 100,000
	30	Under 75 mortality rate: cardiovascular	2011 - 13	Age-standardised rate of mortality from all cardiovascular diseases (including heart disease and stroke) in persons less than 75 years per 100,000 population.	Directly standardised rate	per 100,000
	31	Under 75 mortality rate: cancer	2011 - 13	Age-standardised rate of mortality from all cancers in persons less than 75 years per 100,000 population	Directly standardised rate	per 100,000
	32	Killed and seriously injured on roads	2011 - 13	Number of people reported killed or seriously injured (KSI) on the roads, all ages, per 100,000 resident population.	Crude rate	per 100,000

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Nottinghamshire Health and Wellbeing Board

Proposed High Level Place – Based Supporting Structures

Links to Wider Partnership Boards

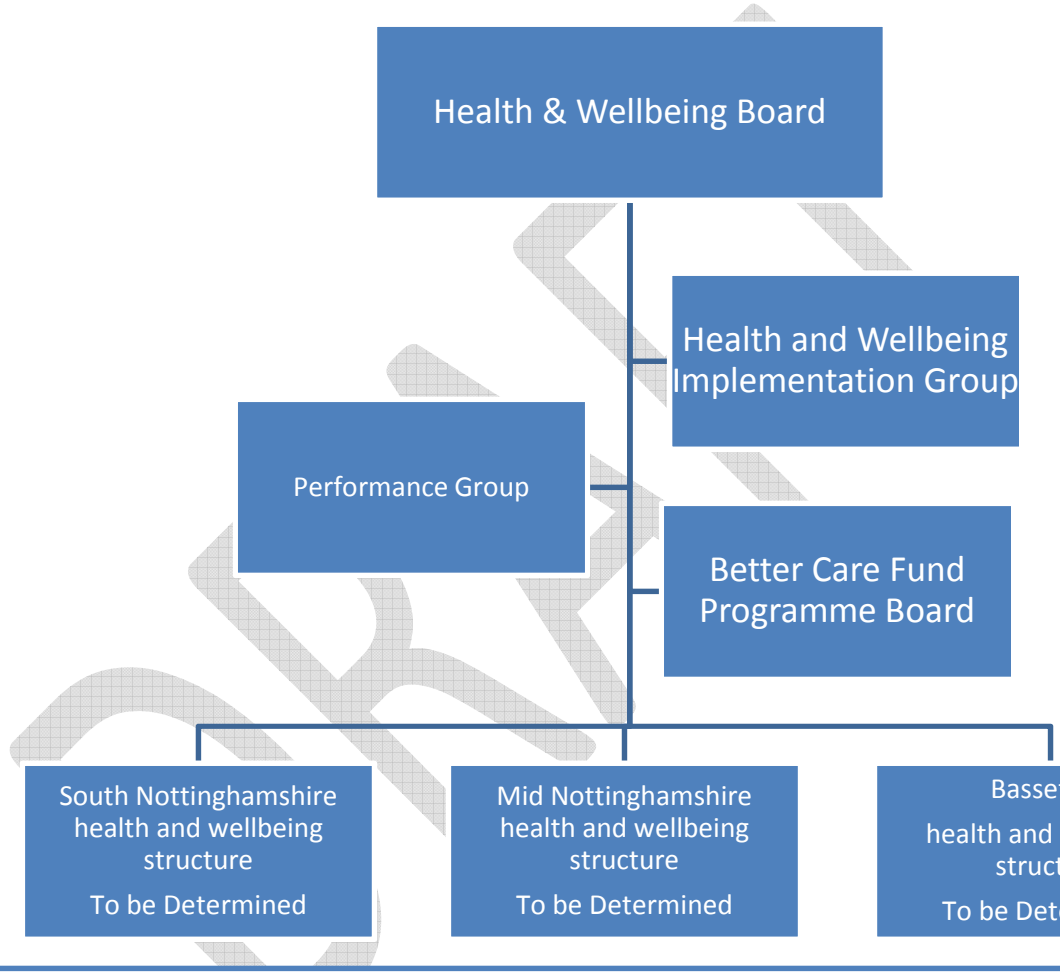
Safer Notts Board

Safeguarding Board

Nottingham City HWB

Day-to-Day Business to be considered by relevant Board/Committee according to commissioning responsibility (Escalation to HWB as required)

- Scrutiny
- ASCH Committee
- Children & Young People's Committee / Children's Trust Board
- Public Health Committee
- CCG Governing Bodies
- CCG Transformation Boards



Provider Forum, JSNA and Integrated commissioning Groups to be accountable to HWIG

Provider/VCS Participation and Engagement at locality level and policy level.

Locality groups have multiple governance arrangements to reflect accountability with partners at local level and range of responsibilities.

Links to Locality and Countywide operational groups

H&W Locality groups

Policy based groups – provide strategic advice into Health & Wellbeing Forum

Health & Wellbeing Board Peer Challenge

Action Plan to Implement Findings

Strategic leadership

Ref.	Objective	Action	Timescale / responsibility	Notes / Supporting Actions
1.1	**Discuss findings of HWB peer challenge**	Hold Board workshop with key partners	April 2015 **Complete**	Write up report from workshop and circulate to partners.
1.2	**Review the core ambition of the HWB**	Hold Board workshop with key partners to collate views	29 April 2015 **Complete**	Collaborate with partners to input views into action plan
1.3		Health & Wellbeing Implementation Group (HWIG) to review current HWB ambition using findings from workshop	HWIG. July 2015 **Complete**	Paper to Health & Wellbeing Board September 2015.
1.4		HWB to agree ambition	HWB. Sep 2015	Paper to Health & Wellbeing Board September 2015.
1.5		Develop supporting narrative to communicate ambition	HWIG. Nov 2015	See communications **15.1** below
2.1	**Review the role & purpose of the HWB**	Develop Principles for HWB	HWB. Sep 2015	Paper to Health & Wellbeing Board September 2015 with proposed principles for approval.
2.2		Review TORs and membership for HWB	HWIG. Dec 2015	Paper to Health & Wellbeing Board Dec 2015 with reccomendations for approval.
2.3		Review champion roles to reflect policy/locality/function	HWIG. Mar 16	For discussion by HWIG
2.4		Develop role descriptions for HWB members & champions	HWIG. Mar 16	For discussion by HWIG
3.1	**Support HWB members to undertake role**	Review and extend development programme for the HWB - inc. Closed workshops pre-Board & Workshop programme (full afternoons)	HWIG/Associate Director of Public Health (ADPH.)	Ongoing

Ref.	Objective	Action	Timescale / responsibility	Notes / Supporting Actions
4.1	**Review the Health & Wellbeing Strategic priorities to focus on what can only be achieved through the HWB. - inc. Short-term and longer term priorities**	Meetings with policy leads to review actions and ID added value/multiagency approach.	ADPH. Jun - Aug 15 **Complete**	Review with HWIG/HWB CCG Clinical leads/ Partners to validate actions
4.2		HWIG to endorse proposed annual actions using findings from workshop	ADPH/HWIG. Aug 15 **Complete**	Paper to Health & Wellbeing Board September 2015.
4.3		Review local performance against outcomes to support work - Health Profiles, PHOF,ASCOF, NHSOF	ADPH/HWIG. Aug 15 **Complete**	Performance framework to be developed.
4.4		Develop proposal for HWB approval	HWIG. Sep 15	Paper to Health & Wellbeing Board September 2015. Follow up reports on individual annual actions
4.5		Define clear measurable outcomes for each priority within the strategy	HWIG. Nov 15	To be discussed at HWIG meeting Sep 15
4.6		Assign HWB champions to priority areas as required	HWB. Oct 15	
4.7		Define roles and responsibilities for each partner in delivery	HWIG. Nov 15	
4.8		Refresh delivery plan to reflect revised priorities	ADPH. Nov 15	
4.9		Develop performance framework, inc monitoring system/schedule	ADPH. Nov 15	To be discussed at HWIG meeting Nov15
5.1	**Develop equal HWB leadership across Health and Local Government**	Establish regular meeting with CCG clinical leads re: HWB business	ADPH. Jul 15 **Achieved**	Regular meetings after each HWB meeting
5.2		Build links to local Transformation Boards and H&W groups to strengthen involvement	ADPH. Nov 15	NB: consider role of HWIG in agenda setting/feedback
6.1	**Define roles across HWB, scrutiny, CCG governing bodies, Council committees**	Develop protocol to define roles across scrutiny, HWB and Healthwatch	1 April 2015 **Complete**	
6.2		Create clear definition of responsibilities across responsible committees/Boards	ADPH. Dec 15	
6.3		Define link across strategies - BCF, Care Act & Health & Wellebing Strategy.	ADPH/HWIG. Dec 15	

	Governance & Support			
Ref.	**Objective**	**Action**	**Timescale / responsibility**	**Supporting Actions**
7.1	**Review governance structure for HWB**	Propose HWB governance structure that reflect NHS planning units, wider interface with other structures e.g. SNB, city HWB	HWIG. Sep 15	Review with HWB CCGs/Partners to clarify barriers/feasibility. Paper to HWB Sept 15
7.2		Review role & responsibilities of HWIG and key groups within structure	HWIG. Dec 15	To discuss at meeting Sept 15
7.3		Review accountability arrangements within governance system	HWIG. Dec 15	
7.4		Develop approach for provider engagement in structure	HWIG Dec 15	HWB paper Sep 15
8.1	**Establish Reporting mechanism for HWB**	Create process to ensure HWB has full oversight and leadership of BCF	HWIG/BCF Programme Board. Dec 15	
8.2		Agree reporting mechanism to minimise workload/duplication	HWIG	
8.3		Establish feedback mechanism for HWB discussions * circulate and agree actions * ID responsibilities by organisation * report progress via Chairs report to next meeting * include progress in HWB newsletter	HWIG. Oct 15	Initial reports included in Chair's Report. To continue development.
9.1	**Establish meeting schedule to cover core roles of HWB**	Develop approach to include core roles of HWB: * Assurance * Immediate priorities for HWB * Sharing lessons / good practice * Oversight of system inc. horizon scanning/ addressing new pressures/issues	HWIG. Oct 15	Initial discussion Jul 15. Further development required subject to HWB paper Sep 15.
10.1	**Review HWB work programme**	Establish template and process to manage agenda for HWB	ADPH/HWB support team	
10.2		Engage CCG clinical leads to review HWB work programme	ADPH. Jul 15 **Achieved**	include as part of regular meeting.
Ref.	**Objective**	**Action**	**Timescale / responsibility**	**Supporting Actions**

11.1	**Create opportunity to review financial pressures across system**	Hold a follow up workshop on H&SC finances to build knowledge and highlight opportunities for integration	ADPH/HWB support team	Workshop to focus on workforce to take place Nov 15.
12.1	**Develop risk management process**	Implement risk register for HWB	ADPH. Oct 15	
13.1	**Establish HWB support team**	Recruit to HWB Executive Officer to support HWB	ADPH. Sep 15	Identify dedicated admin support for HWB. Advert placed to recruit. Closing date 9.9.15
13.2		Extend role of ADPH in leadership of HWB	DPH. Sep 15	
	Communications & engagement			
Ref.	**Objective**	**Action**	**Timescale / responsibility**	**Supporting Actions**
14.1	**Review provider engagement for HWB**	Establish provider forum to support work of HWB	HWIG. Dec 15	See action 7.4
15.1	**Communicate revised ambition, priorities and narrative.**	Develop Communication strategy and plan	Comm lead / HWIG. Nov 15	
16.1	**HWB identity is recognised by partners and the public**	Use HWB identity for all events / meeting sin HWB supporting structure	All HWB	Ongoing
17.1	**HWB has a recognised communication network with partners & the public**	Expand HWB summaries into newsletters for partners to include good practice	ADPH/ HWB Team	Ongoing development of newsletter.
17.2		Rotate meetings around County	Democratic Services	
17.3		Agree annual plan for stakeholder network and workshops	ADPH/ HWB Team	Plan available until Feb 16
17.4		Coordinate communication messages across health & social care to ensure consistent & timely sharing of information.	HWIG	To discuss at meeting Sept 15
18.1	**Share learning and good practice through HWB**	Create mechanism to share problems and learning	HWIG. Dec 15	Stakeholder Network event Sep 15.
18.2		Consider role of Board to initiate research & innovation	HWIG. Dec 15	

Nottinghamshire County Council

Report to the Health and Wellbeing Board

2 September 2015

Agenda Item: 9

REPORT OF THE CHAIR OF THE HEALTH AND WELLBEING BOARD

CHAIR'S REPORT

Purpose of the Report

1. To provide members with information on issues relevant to the Health and Wellbeing Board.

Information and Advice

2. **Sustainable care homes**
   A bid for European funding is being put together for a Sustainable Care Homes project. The aim of the project is to support 50 private and third sector residential and nursing care homes across Nottingham and Nottinghamshire to improve their business effectiveness and reduce their greenhouse gas emissions in order to improve the lives of residents and carers including staff, relatives and friends of residents. It will do this by supporting the implementation of energy efficiency and renewable energy measures, reducing waste and increasing sustainable outdoor activities for residents.

   A steering group is being set up to develop the project. Councillor Weisz has kindly agreed to participate and a meeting is being planned for September to further develop the draft bid.

   The total value of the project is £1,300,000 of which just under half is sought from European funds. The balance will be provided by participating care homes and resources from partner agencies such as time, meeting room space and so on.

   For further information, please contact Helen Ross – Insight Specialist Public Health (Sustainable Development) Nottingham City and Nottinghamshire County helen.ross@nottinghamcity.gov.uk

3. **Avoidable Injuries in Children & Young People**
   The joint strategy, 'Reducing Avoidable Injuries in Children and Young People: A Strategy for Nottingham and Nottinghamshire,' describes how this agenda will be addressed across key local partnerships for the period 2014-2020, with the aim the strategy should be reviewed annually and revised in line with the latest evidence, evaluation and progress.

   There has been some good partnership working both at a strategic and operational level between the City and County. With the launch of the 2014 Public Health England National Guidance on Home Safety and Road Safety; the joint strategic group are

pleased the actions and outcomes from current work streams are currently being met as stated and outlined in the document.

Also in progress are the Joint Strategic Needs Assessment chapters for City and County on Avoidable Injuries for Children and Young People which are due to be completed by July/August 2015. These will form a key part in determining future commissioning decisions.

There are two Consultants in Public health leads for the avoidable injuries agenda; Lynne McNiven in the City and Kate Allen in the County and it is proposed that a rotational chair will take place for the Strategic group.

For further information, please contact Dr Kate Allen, Consultant in Public Health Kate.allen@nottscc.gov.uk

4. **Mental Health Crisis Care Concordat update**

A report was presented to the December 2014 Health and Wellbeing Board which provided an overview of the expectations and requirements of the mental health crisis concordat.Since the meeting, The Nottingham City and Nottinghamshire action plan for the Crisis Care Concordat has been developed by a cross agency group and approved by the Department of Health. It is uploaded to the map on national crisis concordat website: http://www.crisiscareconcordat.org.uk/explore-the-map/. It is a live document and will be continually updated and revised. Progress has been acknowledged by the Department of Health; via a letter from Alistair Burt MP, Minister of State for Community and Social Care, who noted the significant progress made across Nottinghamshire in reducing MHA 136 detentions in police cells by 50%. This has been achieved by the success of the Street Triage partnership project which pairs CPNs with police officers in a dedicated police car.This is just the beginning of a long process to ensure compliance with the Concordat standards. A county wide Crisis Concordat Board has been established. There are a significant range of actions that will require **additional investment** by CCGs and Nottinghamshire County Council.
Expectations include:

- Access to a 24/7 mental health helpline
- Improved access to a 24/7 crisis care for all ages
- Improved access to early intervention services
- Eradication of the use of police cells for Section 136 detentions
- Increase awareness and understanding of mental health across the community
- Improved response by agencies when in a mental health crisis

The action plan is attached as Annex 1.

For further information, please contact Karon Glynn, Assistant Director Mental Health and Learning Disabilities, Newark and Sherwood CCG.
Karon.glynn@newarkandsherwoodccg.nhs.uk

5. **Nottinghamshire Warm Homes on Prescription**
This is a project across Nottinghamshire & Derbyshire where GP practices and integrated care teams will identify and contact high risk patients with long term conditions which are made worse by living in cold living conditions. Patients will then be visited and assessed by someone from the project team and actions taken to achieve affordable warmth on behalf of the householder.

   For more information please contact Dr Rina Jones Partnership Manager Nottinghamshire and Derbyshire Local Authorities' Energy Partnership (LAEP) Tel 01629 536130.

6. **ASSIST Hospital Discharge Scheme**
Mansfield District Council's ASSIST Hospital Discharge Scheme commenced in October 2014 providing holistic 'whole system' interventions that support the early discharge from hospital. During the pilot MDC has prioritised its resources to respond to hospital/residential care discharges which required the commitment of staff across the Housing Department to meet individual patient/customer need. Staff based at Kings Mill Hospital on a daily basis assessed individual need, completed relevant forms including Homefinder and benefit applications, facilitated the discharge process by co-ordinating actions required to expedite a safe discharge. The staff have access to a wide range of in house resources to meet individual need and during the pilot working with health and social care colleagues, have built up a much stronger co-ordination between hospitals, social care and the community.

   The scheme has been commissioned by Mid Nottinghamshire Commissioning Group to continue until end of March 2016.

   For further information please contact Michelle Turton, Housing Needs Manager Tel: 01623 463177 or email: mturton@mansfield.gov.uk

7. **Countywide Multi Agency Hoarding Framework**
In response to an increase in reported cases of hoarding, Nottinghamshire Fire and Rescue Service has developed a multi-agency framework which uses a person-centred approach to deal with people who hoard. The framework has been developed in partnership with other organisations across the county and city and gives practical support to agencies dealing with people who hoard as well as an overview of the relevant legislation and useful links and contacts.

   For further information please contact Emma Darby, Partnerships Manager Nottinghamshire Fire and Rescue Service tel: 07967 690 750 or email: emma.darby@notts-fire.gov.uk

8. **Transforming care for people with learning disabilities (Winterbourne) update**
Following the well-publicised abuse cases from Winterbourne View, a long term hospital for people with learning disabilities, there has been a high profile government agenda to reduce the number of people in hospital. This is called the Transforming Care Agenda. This programme is led jointly by NHS England, the Association of Adult Social Services (ADASS), the Care Quality Commission (CQC), Local Government Association (LGA), Health Education England (HEE) and the Department of Health (DH).

Nottinghamshire has moved 32 people with complex needs out of hospital since April 2013 but still have a way to go with approximately 40 people with learning disabilities and/or autism from Nottinghamshire still in hospital. (This includes people in ATU). Nationally the government is concerned that new admissions are just replacing the hospital population.

Nottinghamshire (including Nottingham City) has been chosen as one of five 'fast track authorities' mainly because there are 180 hospital beds within the Nottinghamshire area and the current NHS England agenda is to close some hospitals. However, Nottingham and Nottinghamshire only use about 45 of these beds currently, with a further 25 out of area (mainly in neighbouring authorities). It is not yet clear exactly what work is expected to be undertaken with other authorities to address the reduction of hospital beds in Nottinghamshire or how this will be funded.

This programme has had intense scrutiny from NHS England to date with individuals being tracked and weekly phone calls being held about the progress of individuals. The 'FAST TRACK' will be scrutinised just as hard.

The aim of the fast track is to make rapid local changes to significantly reduce the numbers of people in hospital. This will be achieved through reducing the number of admissions to hospital and, where an admission has been necessary, ensuring the length of stay is kept to a minimum. The vision is that only people with acute mental health problems which need treating in hospital and those diverted from the criminal justice system will ever go into secure hospital/ATU. Currently, people do get admitted to hospital when behaviours cause placement breakdown and this will no longer be acceptable.

Nottingham and Nottinghamshire CCGs and local authorities will be working together to put in place alternatives to hospital, both in terms of extra clinical support available in the community and alternative placements. A Transformation Board has already been established across city and county CCGs and local authorities and NHS England Specialised Commissioning to progress plans.

A bid will be submitted to the Department of Health for a share of £10m across the five fast track areas in order to 'kick start' service transformation. It has been suggested that match funding may be required from CCGs but this is not yet clear.
The bid and a plan to accompany it must be submitted by the Board by 7th September 2015.

9. **We're in it together - Stakeholder Network Event**

The next Stakeholder Network event will take place on 22 September 2015 at the John Fretwell Centre. It will build on the discussions from the event last year which looked at the relationship between the Board and the voluntary sector.

More information is available from the HWB stakeholder network website and places can be booked through Eventbrite

For more information please contact Nicola Lane nicola.lane@nottscc.gov.uk or 0115 977 2130.

Progress from previous meetings

10. **Breastfeeding**

During the discussion at the June Board meeting Mansfield and Ashfield District Council both committed to implementing the breast feeding friendly initiative locally.

Mansfield DC are working with Mansfield Town Centre BID (Business Improvement District who represent a large number of businesses and retailer) and the manager of the Four Seasons shopping centre with a number of retail premises within the town and district to identify venues which will be promoted as breast feeding friendly places. The Council have a training programme for front line staff and will be working with public health develop a marketing campaign to promote Mansfield over the coming months.

Ashfield DC are working to develop an action plan to actively support being both a breastfeeding organisation and also promoting breastfeeding across the district.

They are keen to have a greater awareness and discuss and implement innovative ways of targeting promotion of sustained breast feeding in partnership to understand why initial breastfeeding rates locally are low and drop further by 6-8 weeks. They are working with a range of health partners to do this.

The Council are also auditing the various health 'friendly' initiatives that are currently available to determine priority areas based on the district's priority health needs.

Since the meeting the representative from Broxtowe has also expressed an interest in implementing the scheme in Broxtowe.

11. **Pharmaceutical Needs Assessment**

At the Board meeting in April 2015 members asked for a public summary of the Pharmaceutical Needs Assessment. This has now been prepared and is available on the Nottinghamshire County Council website.

12. **HWB Workshop – workforce**

Following the discussions at the finance workshop and subsequent Board meetings a dedicated workshop has been arranged to focus on creating a sustainable health and wellbeing workforce in Nottinghamshire.

This will be a closed workshop in place of the Board meeting on 4 November 2015.

The session will include invited partners and will give an opportunity to share experiences and discuss workforce issues locally with a view to identifying how the Board and partners can work together to ensure that there is a sustainable workforce in Nottinghamshire.

More information and a draft agenda will be circulated shortly.

13. **Health and Wellbeing Board Support team**
Following approval of recommendations made to the Public Health Committee recruitment is underway for an Executive Officer to support the Health and Wellbeing Board. The Executive Officer will work alongside existing staff to support the Board and should be in post in the autumn.

14. **Planning healthier environments in Nottinghamshire**

Board members are invited to a workshop to consider planning healthier environments in Nottinghamshire with an initial focus on healthy weight. The workshop will be held between 12.30 and 4.30pm on Thursday 1st October in the Rufford Suite at County Hall.

The event will focus on planning environments to support health and how the planning system can promote healthy communities, ensure adequate healthcare infrastructure and reduce health inequalities. Colleagues from planning, public health and health service commissioning have been invited to attend.

Places for the event can be booked through EventBrite.

Papers to other local committees

15. Integrating health and social care two schemes to reduce the length of stay in hospital
Paper to Adult Social Care & Health Committee meeting 29 June 2015.

16. The Impact of early help in Nottinghamshire
Paper for Children and Young People's Committee meeting 15 June 2015.

17. Proposed transition changes within adult mental health services
Paper to Joint City & County Health Scrutiny Committee meeting 16 June 2015

18. Development of early support services to children and young people with disabilities and their families
Paper to Children and Young People's Committee

19. General practitioner Commissioning
Sherwood Forest Hospitals Trust – Winter pressures
Mental Health Issues in Nottinghamshire
Papers to Health Scrutiny Committee 20 July 2015

Update on policy and guidance

There have been a number of policies and guidance documents issued which are aimed at health and wellbeing boards. The following is a summary of those which may be of interest to Board members:

Starting well

20. **Generation Inactive: An analysis of the UK's childhood inactivity epidemic and tangible solutions to get children moving**
    UK Active
    This report explores the current understanding of children's physical activity in primary schools and investigates the measures that are used to track the activity and fitness levels of pupils. It found that more could be done to support both primary schools/academies in this agenda and makes a number of recommendations.
    Additional link: Royal College of Paediatrics and Childhealth press release

Living well

21. **Local Alcohol Profiles for England 2015**
    Public Health England
    This interactive tool presents data for 19 alcohol-related indicators and allows users to view and analyse data in a user-friendly format. The website also provides links to further supporting and relevant information.
    Additional link: PHE press release

22. **Smoking still kills: protecting children reducing inequalities**
    ASH
    The five-year strategy set out in the Government's Tobacco Control Plan for England comes to an end in 2015, this report proposes new targets for a renewed national strategy to accelerate the decline in smoking prevalence over the next decade.
    Additional links: RCM press release Royal College of Physicians press release

23. **Designed to move: Active cities**
    Designed to move
    This report lays out the economic case for designing cities to encourage greater physical activity such as walking and cycling. It argues that active cities not only confer benefits to health but also to the economy, society, the environment and personal safety

24. **Healthy New Towns programme**
    NHS England and Public Health England have launched this programme to put health at the heart of new neighbourhoods and towns across the country. Local authorities, housing associations and the construction sector are invited to identify development projects where they would like NHS support in creating health-promoting new towns and neighbourhoods in England. Up to five long-term partnerships will initially be selected from across the country, covering housing developments of different sizes. Each site will benefit from a programme of support including global expertise in spatial and urban design, national sponsorship and increased local flexibilities.

Coping well

25. **Right here, right now: People's experiences of help, care and support during a mental health crisis**
    Care Quality Commission
    This report reviews the quality, safety and effectiveness of care provided to those experiencing a mental health crisis. The findings show that there are clear variations in the help, care and support available to people in crisis and that a person's experience depends not only on where they live, but what part of the system they come into contact with.
    There is also a related press release, summary report and a BBC News report.

26. **Mental health crisis review – experiences of black and minority ethnic communities.**
    The Race Equality Foundation
    This follows a series of interviews and focus groups with black and minority ethnic people who had experience of crisis care and provides an insight into patient experience of mental health care from a black and minority ethnic perspective.

27. **Dementia: a public health priority**
    World Health Authority & Alzheimer's Disease International
    This report aims to raise awareness of dementia as a public health priority, to articulate a public health approach and to advocate for action at international and national levels. It is expected to facilitate governments, policy-makers, and other stakeholders to address the impact of dementia as an increasing threat to global health& promote dementia as a public health and social care priority worldwide.
    Additional link: WHO press release

28. **Dementia from the inside**
    The Social Care Institute for Excellence
    This film highlights what it might feel like to live with dementia based on true experiences of people living with dementia. Viewers will experience a little of what it is like to find yourself in a world that seems familiar and yet doesn't always make sense. It is aimed at professionals and the public.

29. **Ageing: the silver lining: The opportunities and challenges of an ageing society for local government.**
    The Local Government Association
    This report sets out the increasing contribution to society and the economy that older people can make through empowered local government, and challenges the commonly-held belief that an ageing population is a burden. The report includes a chapter on health and wellbeing and details case studies from areas across country of schemes targeted at promoting and improving the health and wellbeing of older people.

30. **Dementia 2015: aiming higher to transform lives**
    The Alzheimer's Society
    This is the Society's fourth annual report which looks at the quality of life for people with dementia in England. It contains the results of the Society's annual survey of people with dementia and their carers and an assessment of what is currently in place and needs to be done to improve dementia care and support in England over the next five

years. It makes practical recommendations to the government on the steps that need to be taken to make quality of life better for people with dementia.

31. **Transforming services for people with learning disability**
NHS England has established five fast-track sites that will test new approaches to re-shaping services for people with learning disabilities and / or autism, to ensure more services are provided in the community and closer to home. The five sites will bring together organisations across health and care that will benefit from extra technical support from NHS England. The sites will be able to access a £10 million transformation fund to kick-start implementation from Autumn 2015.
N.B. Nottinghamshire is one of the fast-track sites – see Item 8.

32. **Housing for Health: commissioning resource**
NHS Alliance has collaborated with the housing sector to develop an online resource to better understand the correlation between housing and health. Intended for strategic leads in general practice, primary care and clinical commissioning Housing for Health provides: information about the housing system and how it is organised; insights into roles housing organisations are adopting within local health economies to improve patient care, reduce demand on the NHS and prevent people from needing expensive healthcare; specific examples of health-housing partnerships that are emerging; and advice on how to build relationships with local housing partners.

Working together

33. **Options for integrated commissioning: beyond Barker**
The Kings Fund
This report explores the options for implementing the recommendation from the Independent Commission on the Future of Health and Social Care in England regarding a single ring-fenced budget and a single local commissioner. It assesses evidence of past joint commissioning attempts, studies the current policy framework and local innovations in integrated budgets and commissioning, and considers which organisation is best place to take on the role of single local commissioner.

34. **English Devolution: local solutions for a healthy nation**
The Local Government Association (LGA)
The LGA is calling for more devolution to local areas, which can bring economic, political and social benefits to communities across the country. This publication was commissioned by the LGA to capture the thoughts of councillors, directors of public health, providers, commissioners, academics and other key opinion formers on the challenges and opportunities devolution could bring in terms of improving the public's health.

35. **Devolution: a Road Map**
The Local Government Information Unit (LGiU)
This Road Map outlines proposals to invert the current relationship between central and local government by creating a locally led process of devolution in England, which would strengthen local economies and improve public services. It sets out the practical ways in which devolution can happen at scale and at speed to avoid a bureaucratic log jam in Whitehall. There is also an LGiU press release and blog.

36. **Creating a better care system: setting out key considerations for a reformed, sustainable health, wellbeing and care system of the future.**
Ernst and Young Commissioned by the Local Government Association
This report proposes the establishment of a £1.3 billion a year transformation fund until 2019/20 to develop a new health and social care system. This would be supported by a pooled health and social care budget, devolved powers for health, and reform incentives. The fund would focus on keeping people independent and preventing complex and long-term conditions. The report is designed to prompt debate at both a national and local level.

37. **Making it better together: a call to action on the future of health and wellbeing boards**
The Local Government Association (LGA) and NHS Commissioners
This document sets out proposals to local system leaders and the Government to strengthen the impact and leadership of health and wellbeing boards across the country. The document also outlines the LGA and NHS Clinical Commissioners shared commitment to support boards to reach their full potential as system leaders driving forward changes that will improve the health of their communities.
Additional link: NHS Clinical Commissioners press release

General

38. **Care Act first-phase reforms**
The National Audit Office
This report indicates the Department of Health has implemented the first phase of the 2014 Care Act well. Ninety-nine per cent of local authorities were confident that they would able to carry out the Act reforms from April 2015. However, it warns that the Department's cost estimates and chosen funding mechanisms have put local authorities under increased financial risk given the uncertain level of demand for adult social care.

39. **Five year forward view: time to deliver**
PHE, NHSE, CQC, Monitor & others
This document looks at the progress made towards the 'Five Year Forward View', and sets out the next steps needed to take to achieve the shared ambitions.

The paper starts a period of engagement with the NHS, patients and other partners on how we can respond to the long-term challenges and close the health and wellbeing gap; the care and quality gap; and the funding and efficiency gap.

Consultations

40. **Health & Wellbeing consultations**
Nottinghamshire County Council have the following open consultation relating to health and wellbeing:

a. Nottinghamshire Wellbeing@Work - Workplace Award Scheme
b. 20mph speed limits outside schools

All consultations can be found at:
http://www.nottinghamshire.gov.uk/thecouncil/democracy/have-your-say/consultations/

Other options considered

41. Report to be noted only.

Reason for recommendation

42. Report to be noted only.

Statutory and Policy Implications

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

RECOMMENDATION/S

1) That the report be noted.

Councillor Joyce Bosnjak
Chairman of Health and Wellbeing Board

For any enquiries about this report please contact:

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

Constitutional Comments

14. This report is for noting only.

Financial Comments

15. 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.

- None

Electoral Divisions and Members Affected

- All

Nottingham City and Nottinghamshire Crisis Care Concordat Action Plan – version 1

This action plan covers Nottingham City and Nottinghamshire. It has been developed following a multi-agency event in September 2014 and has been reviewed by a Concordat task and finish group. The action plan is a 'live' document and will be reviewed and amended at regular intervals. Progress against the actions will be presented to the Health and Wellbeing Boards for Nottingham City and Nottinghamshire County.

We welcome feedback on the action plan from all stakeholders. Please send any feedback to:

Ciara Stuart
Head of Contracts and Service Redesign – Mental Health, Nottingham City CCG
ciara.stuart@nottinghamcity.nhs.uk

1. Commissioning to allow earlier intervention and responsive crisis services for all ages				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
Matching local need with a suitable range of services				
1	**Public Health and Clinical Commissioning Groups (CCGs) to commission mental health awareness and suicide prevention training**	15-16	Nottingham City Council Working with: Nottingham City CCG Nottinghamshire County Council Working with: All Nottinghamshire CCGs and Mind	- To ensure improved identification and access to early intervention - To reduce stigmatisation and discrimination

2	**To consolidate existing meetings/ task and finish groups and establish a Partnership Board to steer and inform progress on work streams to deliver the Concordat requirements** Terms of reference and membership to be finalised during Q1 15-16.	15-16	Nottingham City CCG Working with: all main signatories to the declaration	- To ensure the contribution of primary, community and hospital care in addition to other partners - To establish better links between partners and promote improved partnership working
3	**To develop and implement an all ages engagement strategy to inform Crisis Concordat work** A specific focus will be on the involvement of carers and service users with specific needs. This will include a service user and carer engagement on the action plan itself.	Q1 15-16	Partnership Board	- Commissioning to reflect the needs, ages and ethnic background of local communities - Commission a range of care options to meet the diverse range of needs
4	**To review commissioned services to ensure the inclusion of people who have specific needs** This will include promotion of mental health issues and services, as well as monitoring uptake, for those groups with a history of poor access. These groups may include veterans, Black, Asian and Minority Ethnic communities and students, as well as working with housing providers and other services which come into contact with those experiencing debt. The review will include an assessment of commissioning gaps and consideration of how this are addressed by partner organisations.	15-16	All CCGs, Nottingham City Council, Nottingham County Council and district councils, Police and Crime Commissioner (PCC), Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire CityCare Partnership	- To provide early intervention and prevention for individuals with specific needs - To provide better access to services for individuals who do not regularly access mental health services

5	**Update the Joint Strategic Needs Assessment to include information to help plan and monitor against the Concordat actions**	15-16	Nottinghamshire County Council and Nottingham City Council Public Health Departments, all CCGs	- Commissioners have robust data through which to monitor services
2. Access to support before crisis point				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
1	**To monitor the development of a Mental Health Crisis response by the 111 Service** 111 Service will be linked with the Crisis Team to ensure a detailed assessment of service users and to enable referral to alternative community services as appropriate.	15-16	All CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust and 111 providers	- To provide service users with appropriate advice and reduce attendance at Emergency Departments
2	**Monitor and review the range of telephone advice services to ensure that there is appropriate advice available**	15-16	All CCGs Working with: Nottinghamshire County Council and Nottingham City Council	- Ensure people have access to advice and support - Ensure the best use of resources
3	**To monitor and evaluate the outcomes of the 24/7 Enhanced Crisis Resolution and Home Treatment Team in the City and County South area on a quarterly basis** The review will include how well service users are being supported in the community	15-16	Nottingham City and South County CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust	- Service users should be treated in the least restrictive setting possible - People in crisis should expect that their needs can be met appropriately at all times

	and ensure there are an adequate number of beds available to those assessed as needing them. Ensure the 4 hour response time is consistently met.			
4	**To explore the development of a 24/7 Crisis Service across Mid-Nottinghamshire and Bassetlaw CCGs**	15-16	Mid-Nottinghamshire and Bassetlaw CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust	- Service users should be treated in the least restrictive setting possible - Individuals in crisis should expect that their needs can be met appropriately at all times - Responses should be on a par with responses to physical health
5	**To monitor and evaluate the outcomes from the Crisis House for Nottingham City and South County CCGs that was commissioned in 2014 and became operational in January 2015**	15-16	Nottingham City and South County CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust and Framework Housing Association	- To promote peer support and an alternative to admission - Service users should be treated in the least restrictive setting possible
6	**Mid-Nottinghamshire and Bassetlaw CCGs to explore establishment of a Crisis House**	15-16	Mid-Nottinghamshire and Bassetlaw CCGs	- To promote peer support and an alternative to admission - Service users should be treated in the least restrictive setting possible
7	**To review the current single point of access arrangements for secondary mental health services for both Adult**	15-16	All CCGs Working with: Nottinghamshire	- To identify gaps in access - To support earlier intervention for those requiring support

	Mental Health and Child and Adolescent Mental Health Services Commissioners to work with Nottinghamshire Healthcare NHS Foundation Trust and referrers to establish whether the current pathway can be streamlined in order to ensure that those that need access can be referred quickly and efficiently.		Healthcare NHS Foundation Trust and referring organisations	- To ensure compliance with the National Institute for Health and Care Excellence Quality Standard 14 Statement 6
8	**To monitor the implementation and effectiveness of the national Liaison and Diversion pilot across Nottingham and Nottinghamshire custody suites**	15-16	NHS England Health and Justice – North Midlands	- To promote early intervention for those groups coming to the custody suites who may not be known to mental health services
9	**To review the implementation and effectiveness of the recently launched suicide prevention strategies for both Nottingham and Nottinghamshire**	15-16	Nottinghamshire County Council / Nottingham City Council	- To provide appropriate early intervention for those at risk of suicide
3. Urgent and emergency access to crisis care				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
1	**The cross-agency Partnership Board will oversee all joint policies, procedures, protocols and guidelines to ensure clear signed protocols, to demonstrate effective partnership working** This will include: - s136 pathway - Agreed response times for conveyance and Approved Mental Health Professional assessment - Information sharing protocols	15-16	All	- To ensure robust partnership working and locally agreed messages, roles and responsibilities, to protect and safeguard service users and staff

	- Escalation policies - Security protocols - Review of the use of restraints by police in health-based settings - Explore opportunity of having a mental health practitioner within the police control room - Monitor compliance with missing persons/ Absent Without Leave from care protocols			
2	**To monitor and evaluate the performance and outcomes of the Street Triage Team pilot and make recommendations for future commissioning**	15-16	All CCGs, Nottinghamshire Police	- To reduce s136 detentions - Service users experience more joined up care - To inform commissioning decisions from 16-17 onwards
3	**To analyse current Rapid Response Liaison Psychiatry (RRLP) activity** Ensure there are adequate and effective levels of liaison psychiatry services across acute settings.	15-16	All CCGs Working with: Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham Crime	- To ensure an adequate level of support is provided to acute trusts based on the size and acuity of hospital as per national waiting time and access standards

			and Drugs Partnership	
4	**To ensure consistent application of the new Codes of Practice across all providers to protect the rights of individuals detained under the Mental Health Act**	15-16	All	- Professionals carry out their responsibilities under the Mental Health Act 1983 and provide high quality and safe care
Services for children and young people				
1	**CCGs to commission a pilot Child and Adolescent Mental Health Services Crisis Service for children and young people during 15/16 and 16/17** Outcomes of service to be measured throughout year to determine future commissioning plans. To explore pathways between adult crisis services and under 18 crisis service to ensure parity of response outside of operating hours.	15-16	All CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire Police, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Nottingham City & Nottinghamshire County Councils (Children's Social Care/ Children's Services)	- To provide emergency mental health care for children and young people - Individuals in crisis should expect that their needs can be met appropriately at all times - Responses should be on a par with responses to physical health

2	**To continue to review and monitor the number of tier 4 beds for children and young people**	15-16	NHS England Midlands and East	- To ensure suitable accommodation for the age group
3	**To review services for children and young people to ensure adoption of a new transition protocol**	15-16	Nottingham City and County CCGs	- To ensure careful management of transition arrangements between child and adult services for the relevant service user group
4	**To monitor and evaluate the outcomes of the Pathway for Children and Young People with Behavioural, Emotional or Mental Health Needs**	15-16	Nottingham City CCG	- To establish the interface between Child and Adolescent Mental Health Services and primary care at the heart of service provision - To inform ongoing commissioning decisions following end of pilot
5	**To monitor and evaluate the implementation of the Nottinghamshire Child and Adolescent Mental Health Services Review**	15-16	Nottinghamshire CCGs	- To improve access to mental health and wellbeing services for children and young people - To establish an integrated pathway from universal to specialist services - To inform long-term commissioning intentions and plans
Improved quality of response when people are detained under Section 135 and 136 of the Mental Health Act 1983				
1	**To monitor and analyse the response times for Approved Mental Health Professionals in coordinating and attending Mental Health Act assessments, to understand and address any challenges in the current pathways**	15-16	Nottinghamshire County and Nottingham City Councils Working with: Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire Police	- To explore whether the current levels of resource are adequate to meet current response targets - To understand the other factors impacting on assessment times, e.g. availability and location of beds
2	**To review the use of s136 suites, to ensure that individuals detained**	15-16	Nottinghamshire Healthcare NHS	- To ensure that no under 18s are detained in custody suites from April 2015 and no adults

	under the Mental Health Act are not being held in police cells A s136 action plan will be developed to focus on under 18 provision		Foundation Trust, all CCGs, Nottinghamshire Police	from October 2015 - To confirm appropriate and robust pathways are in place
3	**To monitor s136 conveyance response times through the East Midlands Ambulance Service NHS Trust contract and review locally in order to inform future commissioning intentions**	15-16	Erewash CCG and City and County CCGs	- To determine whether current capacity supports appropriate and timely transfer - To inform future commissioning of the Street Triage service - To ensure arrangements promote parity of esteem and the principle of least restraint
5	**To provide training for custody suite staff, 1200 uniform officers and Police Community Support Officers around the Mental Capacity Act, Mental Health Act and s136 policy**	January-July 2015	Nottinghamshire Police	- Appropriate training for police officers - To ensure that those with mental health problems coming into contact with police are supported by the correct services
6	**Mental health awareness training for 239 police control room and contact management staff**	March-May 2015	Nottinghamshire Police	- Appropriate training for police officers - To ensure that those with mental health problems coming into contact with police are supported by the correct services
7	**To distribute a booklet on mental health guidance to all relevant individuals in Nottinghamshire Police**	April 2015	Nottinghamshire Police	- Appropriate training for police officers - To ensure that those with mental health problems coming into contact with police are supported by the correct services
8	**To ensure compliance with recommendations from Her Majesty's Inspectorate of Constabulary report from March 2015, *The welfare of vulnerable people in custody***	15-16	Nottinghamshire Police working with the Partnership Board	- To ensure that those with mental health problems coming into contact with police are supported by the correct services
Improved information and advice available to front line staff to enable better response to individuals				
1	**To review current training arrangements for Emergency**	15-16	Nottingham University	- To support Emergency Department to identify mental health problems and make appropriate

	Department staff		Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust	referrals; to ensure staff are equipped to identify or intervene with those at risk of suicide; to ensure staff are able to screen service users who have self-harmed
2	**East Midlands Ambulance Service NHS Trust mental health action plan:** - To review available appropriate restraint packages for use within the ambulance service - To incorporate restraint into the education work plan - To continue to engage with National Ambulance Mental Health Group to create mental health education for paramedics to be agreed nationally - To continue to engage with the national Joint Royal Colleges Ambulance Liaison Committee working group in the development of mental health guidelines	15-16	East Midlands Ambulance Service NHS Trust	- Enhanced levels of mental health training for ambulance staff - Appropriate training around restraint to ensure safety of service users
Improved services for those with co-existing mental health and substance misuse issues				
1	**To review pathways between mental health, domestic violence and substance misuse services**	15-16	Nottingham Crime and Drugs Partnership, Nottinghamshire County Public Health	- To identify gaps in provision and inform future commissioning intentions

4. Quality of treatment and care when in crisis				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
1	**To ensure that review of Parity of Esteem is embedded in the scope of the Partnership Board** Physical health of mental health service users is addressed and opportunities for improving the mental health of physical health service users are maximised. This will include under-18s and consideration of parity of esteem between adults' and children's services.	15-16	Partnership Board	- To ensure that physical health concerns of service users receiving treatment for mental health conditions are
2	**Mental health service providers to collect data on the 9 protected characteristics as part of the 15-16 Mental Health Contract** Work with Public Health to analyse the information provided.	15-16	All CCGs, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham City and Nottinghamshire County Public Health	- To support the Equality Act - To ensure appropriate access to services for all service users
3	**To revise the current arrangements for quality visits and service reviews and strengthen as part of contract management processes**	15-16	All CCGs	- Services are subject to systematic review, regulation and reporting
4	**To ensure that service specifications are current and reflective of guidance from bodies including the National Institute for Health and Care**	15-16	All CCGs	- Services are subject to systematic review, regulation and reporting - Action is taken where services are not meeting required standards

	Excellence, Mind and the Royal College of Psychiatry; key performance indicators are relevant measures of quality and performance			
5	**On-going review and support of Nottinghamshire Healthcare NHS Foundation Trust's 'No Force First' programme around restraint**	15-16	Nottinghamshire Healthcare NHS Foundation Trust	- To ensure principle of least restraint - To safeguard service users and staff
6	**To review information provided to children and young people when coming into contact with services**	15-16	Nottinghamshire Healthcare NHS Foundation Trust	- Easily accessible and age appropriate information about facilities - Clearly stated standards about how each service involves or informs children and young people about their care
7	**To review the level of need and demand for independent advocates to work with children and young people**	15-16	All CCGs	- Children and young people should have access to an advocate - To inform future commissioning intentions
Service User safety and safeguarding				
1	**Monitor and scrutinise service user safety issues and safeguarding by analysing and responding to individual serious incidents, ensuring appropriate practice and lessons are learned across organisations whom services are commissioned from**	15-16	Commissioned services, all CCGs	- To understand range of issues and risks via routine reporting - Opportunities for appropriate scrutiny and confirm and challenge
2	**To request and receive regular reports from commissioned services that evidence trends and highlight issues and risks and take action as appropriate**	15-16	All CCGs Working with: all providers	- To understand local issues, pressures and risks - To put appropriate plans in place to improve service user safety

Staff safety				
1	**To monitor incidents involving staff to understand issues and to ensure risks are minimised when managing service users in community settings and performing 24/7 assessments as part of the enhanced Crisis Resolution and Home Treatment service**	15-16	Commissioned services, all CCGs	- To ensure that Nottinghamshire Healthcare NHS Foundation Trust staff are appropriately protected and understand any issues presenting
2	**To explore broader risks with other stakeholders to identify if action is required in relation to the management of service users in community settings**	15-16	Partnership Board	- To understand the risks to staff across the broader community
Primary care response				
1	**To explore and design a Protected Learning Time (PLT) session for GPs focusing on crisis pathways and referrals**	15-16	Nottingham City CCG, GPs Working with: Nottinghamshire Healthcare NHS Foundation Trust	- To ensure appropriate level of knowledge around crisis and crisis pathways in primary care
2	**To ensure the CCGs' clinical leads are fully briefed and informed of the local Concordat action plan and can contribute to the plan as appropriate**	15-16	All CCGs, GPs	- To ensure local clinical engagement and understanding
3	**Review of primary care referrals to crisis services** Review the appropriateness of referrals and whether an 'urgent' but not 'emergency' response level is required	15-16	All CCGs, Nottinghamshire Healthcare NHS Foundation Trust, GPs	- To develop a seamless pathway from primary to secondary care that utilises resources in the most appropriate manner

5. Recovery and staying well / preventing future crisis				
No.	**Action**	**Timescale**	**Led By**	**Outcomes**
Joint planning for prevention of crises				
1	**To implement and monitor a Commissioning for Quality and Innovation (CQUIN) framework for crisis planning for service users at particular risk of mental health crisis in the Adult Mental Health and Mental Health Services for Older People directorates at Nottinghamshire Healthcare NHS Foundation Trust** Applying to: • All admitted to an inpatient ward in either directorate • All community service users who are identified as at high risk of admission	15-16	All CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust	- To ensure that all service users at risk of crisis have a crisis plan that is accurate and accessible - Learning to be shared with all partners
2	**To review criteria for entry and discharge from mental health acute care as part of wider Crisis service pathway review** To include review of protocols to ensure service users can access preventative specialist health and social care	15-16	All CCGs, Nottinghamshire Healthcare NHS Foundation Trust	- Service users' transitions between primary and secondary care will be improved
3	**To develop a pathway between Child and Adolescent Mental Health Services tier 4 inpatient beds and the Child and Adolescent Mental Health Services Crisis Service**	15-16	All CCGs, Nottinghamshire Healthcare NHS Foundation Trust	- Service users' transitions between primary and secondary care will be improved

Nottinghamshire County Council

Report to Health and Wellbeing Board

2 September 2015

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 2015/16.

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 (NS)

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 Work Programme 2015 - 16

7 October 2015	**Pre-meet discussion with district council representatives**
	Excess Winter Deaths (Mary Corcoran/Joanna Cooper) **JSNA annual report** (Chris Kenny/Kristina McCormick) **BCF update** (Lucy Dadge) **Young People's Health Strategy** - progress update (Kate Allen/Gary Eves) *Plans for dealing with winter pressures in Nottinghamshire (TBC)* **Chairs report:** • Update on tobacco declaration • Update on Nottinghamshire County Wellbeing@Work • Update from Clinical Senate/networks – quarterly report (paper via regional network) • Update & learning from the third sector better data project (paper via regional network)
4 November 2015	**** CLOSED WORKSHOP **** **Health & social care workforce (Assembly Hall, County Hall)**

Health and Wellbeing Board & Workshop Work Programme 2015 - 16

2 December 2015	**Community empowerment & resilience programme** (Caroline Agnew) **BCF update & progress** (Lucy Dadge) **CYP Public mental health/academic resilience** (Kate Allen) Follow up to CAMHS paper Dec 2014 **Building a healthier environment** (Barbara Brady/Anne Pridgeon) follow up to workshop **Children's Safeguarding Board Annual Report (Chris Few/Steve Baumber)** **Update on the Tobacco Declaration** (John Tomlinson) *Update on 7 day working in Nottinghamshire (TBC)*
6 January 2016	**Nottinghamshire County Wellbeing@Work** (Mary Corcoran/Cheryl George) requested March HWB meeting *The impact of legal highs (TBC)* *Housing – progress in delivering the Health & Wellbeing Strategy (TBC)* *Implementation of the Care Act – update (TBC)* *NHS Five Year Forward View – new models of care update from CCGs (TBC)*
3 February 2016	**Dementia update** (Mary Corcoran/Gill Oliver)
2 March 2016	**Adults Safeguarding Board Annual Report** (Allan Breeton)
6 April 2016	*Mental health – crisis support (TBC)*