Nottinghamshire County Council

Health and Wellbeing Board (Shadow)

Date: Wednesday, 27 June 2012
Time: 14:00
Venue: County Hall
Address: County Hall, West Bridgford, Nottingham NG2 7QP

AGENDA

Nottinghamshire County Council

Report to the Health and Wellbeing Board

27th June 2012

Agenda Item:3

REPORT OF THE CHIEF EXECUTIVE

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Purpose of the Report

1. To note the Membership of the Health and Wellbeing Board.

Information and Advice

2. The membership of the Board comprises:

COUNTY COUNCILLORS

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

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts

OFFICERS

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

NHS CLINICAL COMMISSIONING GROUPS

Dr Steve Kell - Bassetlaw
Dr Raian Shiekh - Mansfield and Ashfield

Dr Mark Jefford	-	Newark & Sherwood
Dr Guy Mansford	-	Nottingham West
Dr Tony Marsh	-	Nottingham North & East
Dr Jeremy Griffiths	-	Rushcliffe, Principia

LOCAL HEALTH WATCH

Jane Stubbings (Nottinghamshire County LINk)

PCT CLUSTER

Dr Doug Black (Director of Commissioning Development)

Statutory and Policy Implications

3. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder and those using the service and where such implications are material they have been described in the text of the report.

Recommendation

4. That the membership of the Board be noted.

MICK BURROWS
CHIEF EXECUTIVE

Service Director (Finance) Financial Comments

6. There are no specific financial implications arising from the report.

Legal Services Comments

7. This report is for noting only.

Background Papers Available for Inspection

None

Electoral Divisions Affected

All.

minutes

Nottinghamshire County Council

Meeting HEALTH AND WELLBEING BOARD

Date Wednesday 2nd May 2012 2pm – 4.05pm

membership
Persons absent are marked with `A'

COUNCILLORS

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

DISTRICT COUNCILS

Councillor Jenny Hollingsworth
Councillor Tony Roberts MBE

OFFICERS

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

CLINICAL COMMISSIONING GROUPS

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

LOCAL HEALTH WATCH

Jane Stubbings (Nottinghamshire County LINk)

PCT CLUSTER

A Dr Doug Black - NHS Nottinghamshire County

OFFICERS IN ATTENDANCE

Chris Holmes	-	Democratic Services
Cathy Quinn	-	Associate Director of Public Health
Dr Mary Corcoran	-	Public Health Consultant
Penny Spice	-	Adult Social Care, Health and Public Protection

ALSO IN ATTENDANCE

John Wilderspin - Department of Health

MINUTES

Minutes of the last meeting held on 7th March 2012 having been previously circulated were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence was received from Cllr Alan Rhodes (Personal), Dr Guy Mansford, Dr Tony Marsh and Dr Doug Black.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

STROKE AND PHYSICAL DISABILITY INCLUDING LONG TERM CONDITIONS

Dr Mary Corcoran, Public Health Consultant and Penny Spice from Adult Social Care, Health and Public Protection Department gave a presentation to the Board on provision in health and social care for both stroke and other long term neurological conditions, especially those causing physical disability.

They stated that the estimated annual number of strokes was due to increase and there was a need to plan for this. They referred to the National Stroke Strategy which had been issued in 2007 and refreshed 3 years later. The aim was to get everyone having a stroke admitted to a specialist unit, with 80% of patients spending 90% of their time in a stroke unit. An early supported discharge scheme was to be started in the south of the county. The Mansfield and Ashfield Scheme had been very successful. For management of TIA's (transient ischemic attack – mini stroke) clinicians in all parts of the county were to see high risk people. New clot bursting drugs were important and access to brain scans could tell whether patients would benefit from this drug. The main delay in patients receiving treatment was in them not realising they had had a stroke.

Case studies were used to highlight approaches to tackling strokes.

The presentation went on to outline long term neurological conditions. These could be sudden onset conditions e.g brain injury; intermittent and unpredictable conditions e.g epilepsy or migraine. They could also be progressive conditions e.g Parkinson's disease; or stable conditions with changing needs due to development or ageing e.g essential tremor. Again case studies were used to highlight services to people with long term conditions. They outlined social care support which was provided.

They concluded by outlining what had been achieved so far. In terms of strokes there were stroke units and pathways at acute hospitals. A full early supported discharge scheme was in place or being piloted in the north of the county with a partial scheme in the south. There were TIA clinics at acute trusts and access to thrombosis across the county. Stroke ability sessions were held across the county except in Bassetlaw. Hopes for the future were a full early supported discharge scheme in the south of the county and integrated rehabilitation support after hospital discharge. There was also a wish for improved support for patients with communication problems. With regard to long term neurological conditions what had been achieved so far was a pilot for personal health budgets. There was also start (short term assessment and re enablement team), specialist nurses and telecare. The hopes for the future were personal health budgets in place and integrated patient pathway development.

During the discussion the following points were made :-

- There was a need to pull together the 3 outcomes framework. Whilst these were reviewed at Clinical Commissioning Group level comparative data should be reviewed by the Board as well.

- A question was raised about the reliability of the estimated number of people having strokes. It was explained that some patients would not appear on the stroke data as they would appear in statistics for another condition e.g diabetes.

- Clarity was needed about which hospitals had stroke units, given the issues about services to Newark Hospital. It was explained that stroke units were at provider Trusts which in the case of the Newark area was at Sherwood Forest Hospital.

- The main delay to patients receiving treatment for strokes was in them not being sure what was wrong. Once the surgery or ambulance service was contacted there was no delay. Often a patient had a mini stroke or a TIA and went to see a doctor at their convenience without realising what had happened. There was a need to emphasise and publicise the FAST test.

- Due to the number of providers involved there was a need for an integrated information strategy to be in place to ensure information was shared.

- A lot of data existed about people in hospital and the costs. Costs were an issue going forward and it was known good outcomes can be achieved in the community at a lower cost.

- The provision of personal budgets in adult care had taken a massive technical and cultural change and it was necessary to get clinicians to understand personal budgets. It was explained that the Department of Health had a project group working on this drawing on the experiences from adult services. Personal budgets will be offered to patients with continuing health needs and continuing care assessment nurses would be dealing with them.

- There was a need for one assessment, one care package and one funding agreement with access to long term physio's which could be at day centres. There was a need to review the assessment process so that it was joined up.

- For stroke recovery gentle exercise had been found to be beneficial. The social side of being in a group had also been found to be important to avoid isolation.

The Board thought that more work was needed on considering how the County Council, Primary Care Trusts and GP Commissioning Groups work together on these services. It was agreed that a further report should be brought back to the next meeting with proposals.

RESOLVED 2012/012

(1) That the following actions be supported:-

Stroke

- Full implementation of the early supported discharge scheme in the south of the county.
- Implement integrated rehabilitation support after hospital discharge.
- Provide improved support for people with communication difficulties.

Long Term Neurological Conditions

- Implement personal health budgets for people with long term neurological conditions.

(2) That a further report be brought to a future meeting as to how the County Council and the Primary Care Trusts engage with the Clinical Commissioning Groups to ensure the needs of people with physical disability, and long term neurological conditions are effectively and jointly addressed.

TERMS OF REFERENCE FOR THE HEALTH AND WELLBEING IMPLEMENTATION GROUP

Consideration was given to the proposed membership, purpose and responsibilities of the Health and Wellbeing Implementation Group. It was reported that it was proposed that the core membership be increased to include 2 GP leads from the Clinical Commissioning Groups.

RESOLVED 2012/013

(1) That the terms of reference of the Health and Wellbeing Implementation Group be endorsed.

(2) That it be noted that the core membership of the Implementation Group will include 2 GP leads from Clinical Commissioning Groups within Nottinghamshire.

NOTTINGHAMSHIRE HEALTH AND WELLBEING STRATEGY 2012-13

Chris Kenny introduced the report on the development of the Health and Wellbeing Strategy. He indicated that the strategy would be underpinned by a work programme to identify specific actions. He also stated that Clinical Commissioning Groups would also produce commissioning action plans.. He added that the work on outcomes was not yet completed and would be brought to a future Board meeting. It was proposed to constantly update the strategy so that it did not become out of date.

During the discussion the following points were made:-

- Having actions in the strategy was of critical of importance. It was stated that a report on integrated commissioning and how this related to actions would come to the next Board meeting.

- Reference was made to aim in the ambitions for people to have 'happier lives' and whether this was measurable and should be included. Others felt that happiness was a relative concept and it was appropriate to strive for. It was pointed out that there was a national requirement to measure satisfaction of service users and quality of life.

- The document contained many references to joined up working and there was a need to explain how this would work and which organisation was responsible for leading. It was noted that Clinical Commissioning Groups were autonomous bodies and there would therefore be differences in different parts of the county.

- There was a need to inspire people to make necessary changes to practices and consideration needed to be given as to how communication of the strategy and actions would take place to bring this about.

RESOLVED 2012/014

(1) That the process followed in the development of the Health and Wellbeing Strategy be endorsed.

(2) That the Health and Wellbeing Strategy for 2012-13 be endorsed.

(3) That the County Councils Policy Committee be requested to ratify the Health and Wellbeing Strategy.

(4) That a follow up report be presented at the Board's September 2012 meeting outlining the action plan developed and progress being made on the implementation of the Health and Wellbeing Strategy.

JOINT STRATEGIC NEEDS ASSESSMENT

Chris Kenny reported orally on the refresh of the Joint Strategic Needs Assessment.

The importance of communication to both the public and GP's was stressed. It was pointed out that the Board would increase its credibility from actions coming out of its decisions. The Board had to be a catalyst for change and the Implementation Team needed to challenge the current system.

RESOLVED 2012/015

That the report be noted.

HOLDING BOARD MEETINGS IN VARIOUS LOCALITIES

It was suggested that meetings of the Board should be held in the various Clinical Commissioning Groups localities. This would enable patients and staff to be aware of the Board's work. It was pointed out that there were certain legal requirements which needed to be met for public meetings.

RESOLVED 2012/016

That it be agreed in principle that alternate meetings of the Board be held in the various Clinical Commissioning Groups localities.

WORK OF THE NATIONAL LEARNING SET FOR CHILDREN AND YOUNG PEOPLE

Anthony May outlined the work that had been done as part of the learning set of children and young people. This was to ensure that Health and Wellbeing Boards made an effective contribution to improving health and wellbeing outcomes for children and young people. Copies of the poster which had been produced was circulated. This gave details of the key success factors, key strategic questions and challenges for Board's, and signposts to resources.

RESOLVED 2012/017

That the report be noted

The meeting closed at 4.05pm.

CHAIRMAN

Nottinghamshire County Council

Report to the Health and Wellbeing Board

27th June 2012

Agenda Item:7

REPORT OF DIRECTOR FOR PUBLIC HEALTH

TACKLING OBESITY IN NOTTINGHAMSHIRE – INCLUDING PHYSICAL ACTIVITY AND HEALTHY EATING – JUNE 2012

Purpose of the Report

1. This report provides information regarding obesity, including physical activity and healthy eating. It outlines the current position in relation to obesity within Nottinghamshire, information on policy drivers, an overview of current service provision as well as recommending further action.

INFORMATION AND ADVICE

What is Obesity?

2. The terms overweight and obesity refers to when weight gain, in the form of fat, has reached a point which affects a person's health. Excess weight gain in adults is caused by an imbalance between 'energy in' and 'energy expenditure'. It is important to maintain weight in a healthy range (rather than having a weight that is too high or too low).

Measurement of Obesity in Adults

3. It is important to establish the ranges of weight at which health risks increase. In adults there are two main methods of assessing whether someone is overweight or obese; Body Mass Index (BMI) and waist circumference. For adults overweight and obesity are commonly defined by Body Mass Index (BMI), which is calculated by dividing an individual's weight in kilograms by the square of their height in metres (kg/m²). This remains relatively constant, regardless of age. Table 1 shows the weight classification and BMI measurement.

Table 1: NICE classification of overweight and obesity in adults

Weight classification	BMI = weight(kg) /height (m)²
Underweight	< 18.5
Normal	18.5 - 24.9
Overweight	25 – 29.9
Obese	30 – 39.9
Morbidly obese	> 40

Source: National Institute for Health and Clinical Excellence, (NICE), 2006

4. However, BMI is not always an accurate predictor of body fat or fat distribution, particularly in muscular individuals, because of differences in body fat proportions and distribution. For this reason it is suggested that waist circumference is used, as this assesses abdominal fat mass or central fat distribution and is linked to disease risk such as Coronary Heart Disease and type 2 Diabetes. The current waist circumference thresholds used to assess health risks in the general adult population are shown in Table 2.

Table 2: Waist Circumference Thresholds for the General Adult Population

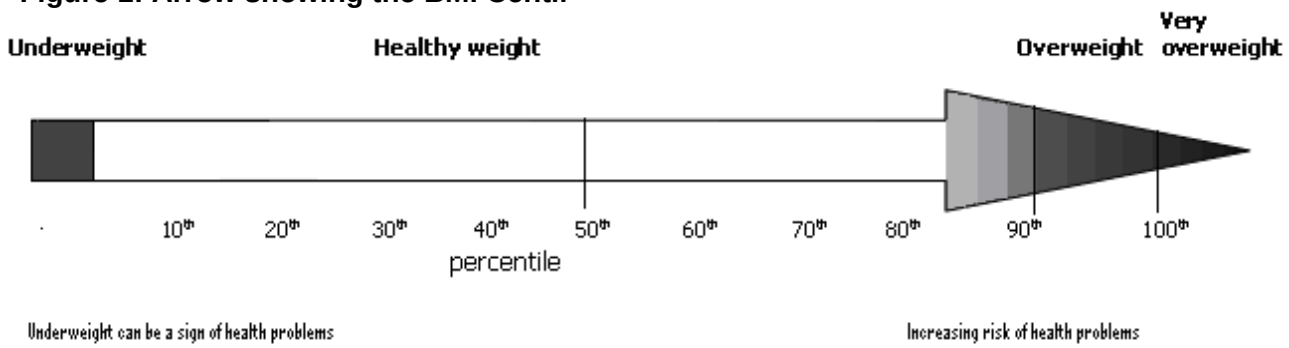
	Male	**Female**
Increased risk	94cm (37 inches) or more	80cm (31 inches) or more
Greatly increased risk	102cm (40 inches) or more	88 (35 inches) or more

Measurement of Obesity in Children

5. Assessing the BMI of children is more complicated than for adults because a child's BMI changes as they mature. Growth patterns differ between boys and girls, so both the age and sex of a child needs to be taken into account when estimating whether their BMI is within a healthy range. Also getting the energy balance right is more complex as growth is only possible if energy in (food intake) is greater than energy expenditure (activity). If there is more than required for appropriate growth, the excess energy will become excess fat.

6. Instead of using fixed BMI thresholds (as in adults) BMI centile growth charts are used to determine whether a child is within a healthy weight range. Once a child's BMI centile has been calculated, they will be in one of four categories, underweight, healthy weight, overweight, and very overweight, as illustrated by Figure 1 below. NICE (2006) recommends that waist circumference should not be used as a means of diagnosing childhood obesity.

Figure 1: Arrow showing the BMI Centil



Why Obesity is a Public Health Issue

7. Obesity is a major public health problem. Unhealthy diets combined with physical inactivity have contributed to an increase in obesity in England and almost a quarter of adults and almost a sixth of children under the age of 11 are obese (the Information Centre, 2009). It is predicted that by 2050, 60% of adult men, 50% of adult women and 25% of children may be obese (Foresight, 2007). Alongside this, being overweight has become usual, rather than unusual. Obesity threatens the health and wellbeing of individuals and will place a national financial burden in term of health and social care costs, on employers through lost productivity and on families because of the increasing burden on long-term chronic disability (Butland et al. 2007). It is responsible for an estimated 9,000 premature deaths per year in England (National Audit Office, 2001).

Compared with a healthy man, an obese man is:

- Five times more likely to develop type 2 diabetes
- Three times more likely to develop colon cancer
- More than two and a half times more likely to develop high blood pressure - a major risk factor for heart disease and stroke.

Compared with a healthy weight woman, an obese woman is:

- Almost thirteen times more likely to develop type 2 diabetes
- More than four times more likely to develop high blood pressure
- More than three times more likely to have a heart attack.

8. There has been an increase in obesity and type 2 diabetes affecting children and young people in the last decade. These life-shortening conditions, which can lead to other illnesses and which can seriously affect a person's quality of life. It is essential to focus on the causes and to ensure that the rights of children and young people to health and a healthy environment are fully respected. In particular, measures need to be taken to promote healthy nutritional habits and a healthy lifestyle (in the family, at school and in the community), as well as a healthy (natural and built) environment.

At Risk Groups

9. The burden of obesity is uneven across our communities, with certain groups being more at risk e.g. lower socio-economic and socially disadvantaged groups, particularly women. Data on the prevalence of obesity in different ethnic groups is limited because national surveys tend to sample only relatively small numbers from minority groups. However, according to The Health Survey for England (2007), obesity is currently greatest in the Caucasian and Bangladeshi populations (Butland, 2007). Other groups of people at risk includes people with physical disabilities (particularly in terms of mobility which makes exercise difficult), people with learning difficulties, people diagnosed with a severe and enduring mental illness, particularly schizophrenia or bipolar disease (Department of Health, 2006) and older people.

Economic Cost / Opportunity Cost

10. Apart from personal and social costs there are significant health and social care costs associated with the treatment of obesity (Foresight, 2007). In 2002 the House of Commons Health Select Committee estimated that the total annual cost of obesity and overweight for England was nearly £7 billion, of which £1 billion is the direct health service costs (costs of treatment) and the cost of dependence on state benefits and indirect costs such as loss of earnings and reduced productivity. The NHS costs alone linked to overweight and obesity equate to 2.3%-2.6% of total NHS expenditure (2001/2002). Foresight (2007) estimate that by 2050, the cost to the NHS of overweight and obesity could rise to £9.7 billion, with the wider cost to society being £49.9 billion (at today's prices).

Causal Factors

11. The rapid rise in obesity rates has occurred too quickly for genetic changes to be the cause (Swanton and Frost, 2006). Society has experienced many behavioural and environmental changes, for example, in work patterns, transport, food production, leisure activities, food

sales, motorised transport, more sedentary lifestyles and energy-dense diets contributing to a variety of health problems (Foresight, 2007) and causing the population to be obesogenic. According to Foresight, key elements of the wider obesogenic environment, other than diet and physical activity, include:

- The activity environment: the influence of the environment on an individual's activity behavior, for example a decision to cycle to work may be influenced by road safety, air pollution or provision of a cycle shelter and showers;

- Societal influences: the impact of society, for example the influence of the media, education, peer pressure or culture;

- The food environment: the influence of the food environment on an individual's food choices, for example a decision to eat more fruit and vegetables may be influenced by the availability and quality of fruit and vegetables near home.

Obesity and Diet

12. Good nutrition is vital to good health. Whilst many people in England eat well, a large number do not, particularly among the more disadvantaged and vulnerable in society. In particular, a significant proportion of the population consumes more than the recommended amount of fat, saturated fat, salt and sugar. Such poor nutrition is a major cause of ill health and premature death in England. About one third of cancers can be attributed to poor diet and nutrition. Patterns of food consumption: the quality, quantity (portion sizes) and frequency (snacking patterns) of an individual's diet can influence obesity rates.

Obesity and Alcohol

13. There is no clear causal relationship between alcohol consumption and obesity. However, there are associations between the two influenced by a number of factors including lifestyle, genetic and social factors. Alcohol accounts for nearly 10% of calorie intake amongst adults who drink (Bates and Lennox, 2009) and there is a lack of public awareness about the calorific content of alcoholic drinks. Also, alcohol lacks most essential nutrients and vitamins.

Obesity and Physical Activity

14. Physical activity is a critical public health issue. Improving physical activity levels has the potential to improve both physical and mental health. Lack of physical activity is associated with increasing risks to health, including heart disease, diabetes, cancer, obesity and musculoskeletal conditions such as osteoporosis. Heart disease, stroke and cancer are the major causes of death in England, accounting for almost 60% of premature deaths. The benefits of regular physical activity are well evidenced. For adults doing 30 minutes of, at least, moderate intensity physical activity on at least 5 days a week helps to prevent and manage over 20 chronic conditions including coronary heart disease and stroke.

National Drivers

Health and Social Care Act 2012

15. From April 2013, upper tier local authorities will be responsible for obesity interventions, locally-led nutrition initiatives and increasing levels of physical activity. Ensuring the effect commissioning and delivery of the National Childhood Measurement Programme will also be one of their five mandatory functions.

Healthy Lives, Healthy People: a call to action on Obesity in England

16. In October 2011 the Department of Health issued "Healthy Lives, Healthy People: a call to action on Obesity in England". This sets out the national strategy to tackling excess weight, and refers to new approach which encourages a wide range of partners to play their part. The strategy sets new national ambitions:

    - A sustained downward trend in the level of excess weight in children by 2020
    - A downward trend in the level of excess weight averaged across all adults by 2020.

17. The new level of ambition involves adopting a 'life course' approach from pre-conception through to older age. There are specific opportunities and challenges at each stage of the life course and action is needed at all ages to avert the short and long-term consequences of excess weight and to ensure health inequalities are addressed. Action needs to encompass an appropriate balance of investment and effort between prevention, treatment and support. The main components of this new approach are:

    - Empowering individuals
    - Giving partners the opportunity to play their full part
    - Giving local government the lead role in driving health improvement and harnessing partners at local level
    - Building the evidence base.

National Institute for Health and Clinical Excellence (NICE)

18. NICE has produced several guidance documents in relation to the reduction of obesity. This type of guidance is used by commissioners to inform our local strategic approach, and so shapes the services that our patients receive. Current NICE guidance includes:

    - Overweight and obesity prevention and management of both adults and children
    - Promoting physical activity in the workplace
    - Due to be published later this year is public health guidance on Obesity - working with local communities.

Public Health Outcomes Framework

19. Published by the Department of Health, January 2012, there are several indicators directly relating to adult and childhood obesity:

    - Utilisation of green space for exercise/health reasons (from the Monitor of Engagement with the National Environment Survey).
    - Diet (the indicator needs further development at a national level).

- Excess weight in adults (number of adults who are classified as overweight or obese – this data source needs further development although it is likely to be derived from Sport England's Active People Survey. Currently there is only information with regard to obese adults available).
- Proportion of physically active and inactive adults (from the Sport England's Active People Survey).
- Excess weight in 4-5 and 10-11 years olds (from the National Child Measurement Programme).

Local Drivers

20. The Joint Strategic Needs Assessment (JSNA) includes information relating to the challenge of obesity and as a result this issue has been identified as a priority in the Nottinghamshire Health and Wellbeing Strategy. The Nottinghamshire Clinical Commissioning Groups are currently developing their local health priorities, and obesity is being identified as an issue that they wish to address.

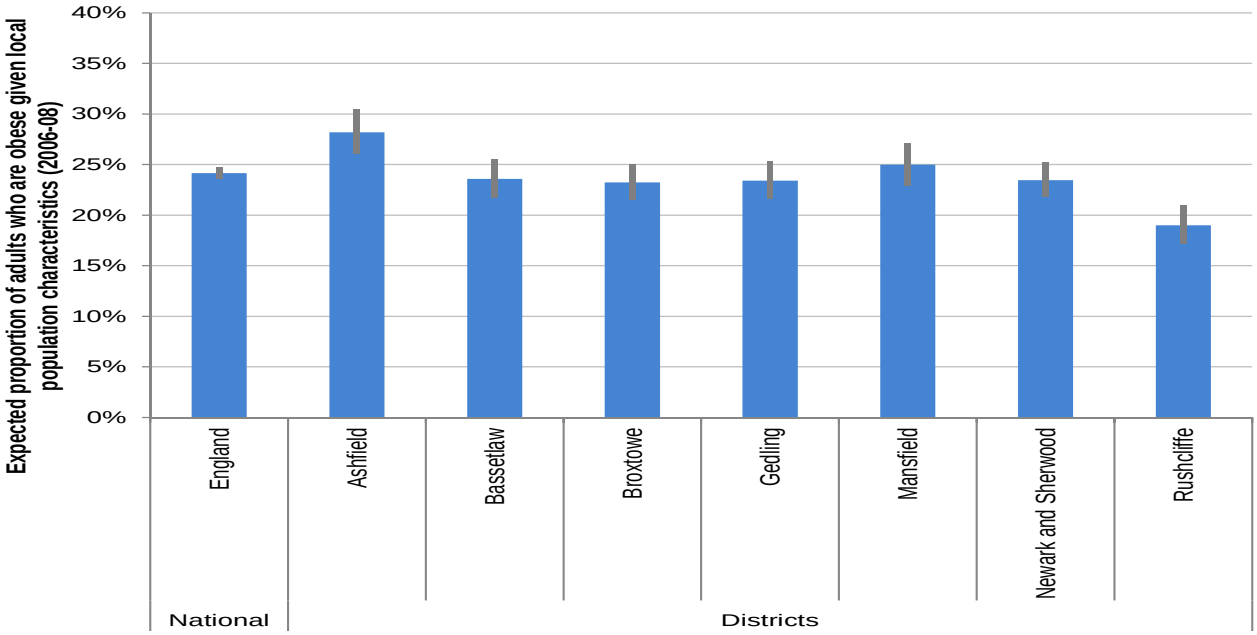
A Picture of Nottinghamshire

Adult Obesity Rates

21. The main source of data on the prevalence of obesity in England is the Health Survey for England (HSE). The East Midlands Public Health Observatory has developed an obesity ready reckoner using HSE data and mid-year NHS population data from 2006. Based on this calculation almost a quarter of adults (24%) across Nottinghamshire are estimated to be obese.

22. Further model-based estimates have been produced at district level (Figure 2). This shows that the adult obesity rate for Rushcliffe is significantly lower than England a contrast with Ashfield where the rate is significantly higher than England. All other districts are not significantly different from England

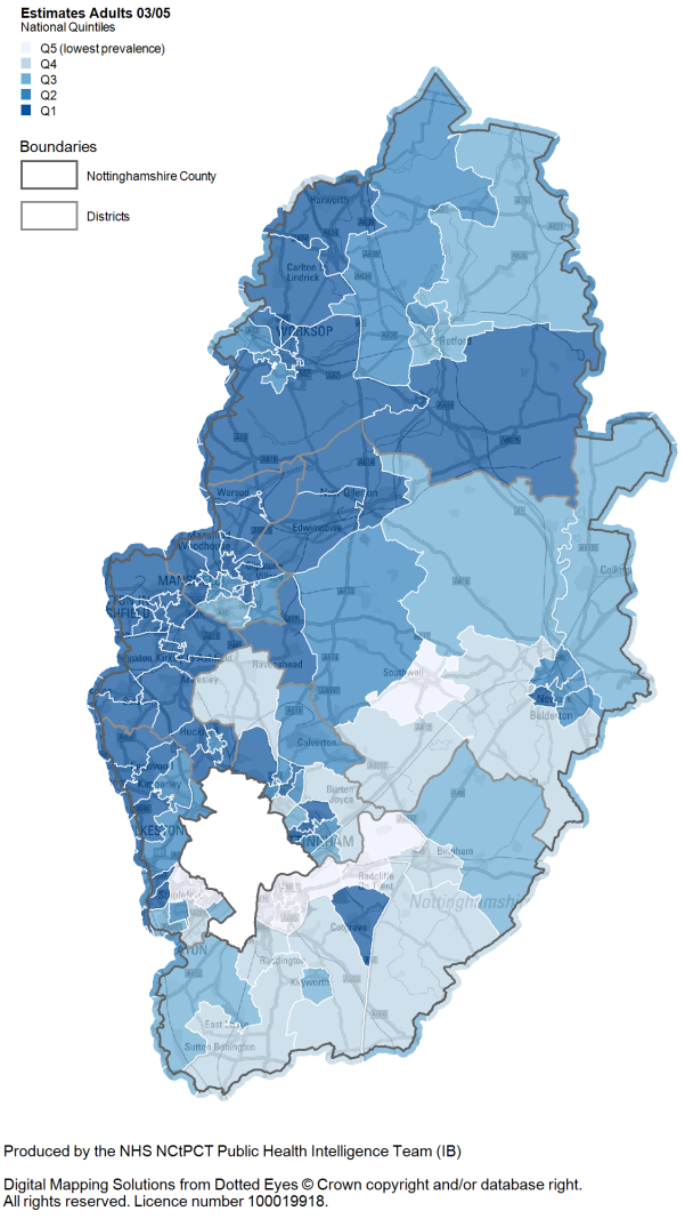
Figure 2: Model-based estimates for adult obesity in Nottinghamshire Local Authorities and England 2006-08



Error bars shown are 95% Confidence Intervals, calculated using the Wilson score method. Indicators which have Confidence Intervals that do not overlap (for different areas or different time periods) can be described as significantly different.
Source: Health Survey for England 2006 to 2008

23. There are national surveys which collect data on all weight categories; however the numbers/sample sizes involved at a local level are too small for any meaningful interpretation. So to drill down further, the Department of Health has produced synthetic estimates at Middle Super Output Area (Figure 3). The darker the colour, the higher the rates of obesity.

Figure 3: Model-based estimate of the proportion of adults who are obese by Middle Super Output Area* in Nottinghamshire, 2003-05



Produced by the NHS NCtPCT Public Health Intelligence Team (IB)

Source: National Centre for Social Care Research with the Health and Social Care Information Centre, Neighbourhood Statistics: LA Model-Based Estimates of Healthy Lifestyles Behaviours: 2003-05

* Middle Super Output Area is a consistent geographical unit based on an average of 7,500 people per unit.

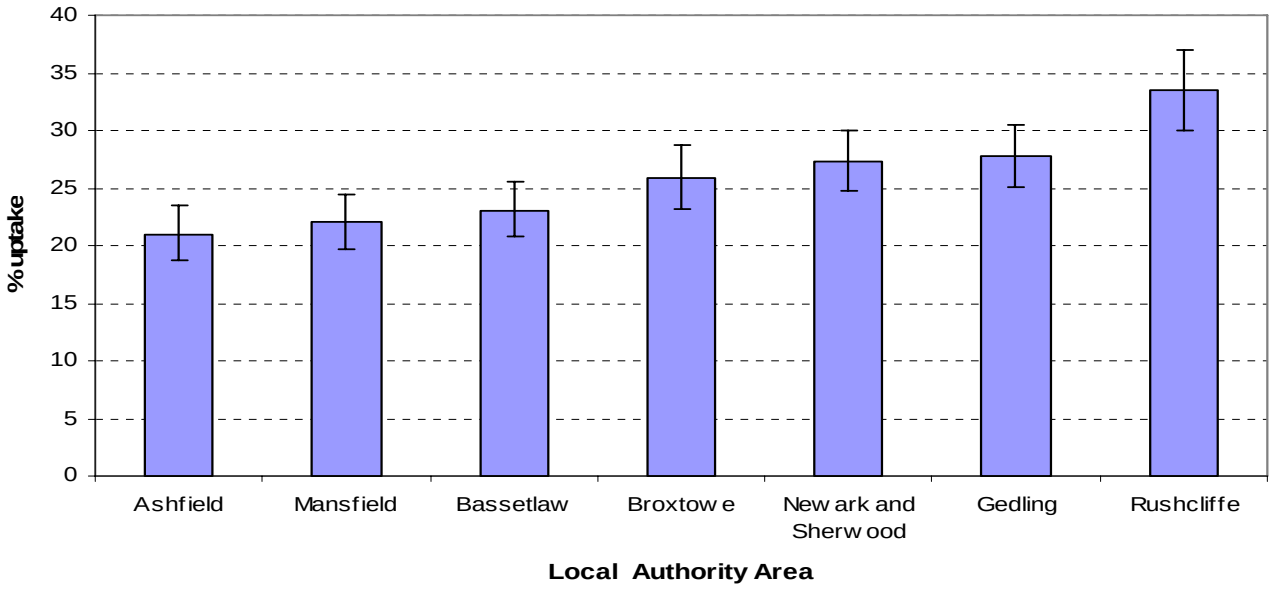
Consumption of Fruit and Vegetables

24. Evidence suggests that eating at least 5 varied portions of fruit and vegetables a day can reduce the risk of death from chronic disease, stroke, and cancer by up to 20%. The national "5-A-DAY" programme is part of a preventative strategy aimed at improving diet and nutrition in the general population. Current guidelines recommend that adults and children should aim to eat five or more portions of fruit and vegetables each day.

25. The 2009 Health Survey for England indicates that more women than men consumed the recommended five or more portions of fruit and vegetables daily (25% of men, 28% of women). These proportions are similar to those reported in 2008, but are slightly lower than in 2006, when 28% of men and 32% of women consumed at least five portions daily.

26. Across Nottinghamshire synthetic estimates of fruit and vegetables consumption show on average 1 in 4 people over the age of 16 consume 5 or more portions of fruit and vegetables. Figure 4 shows the estimated difference in consumption of 5-a-day across the Nottinghamshire Districts. Ashfield has the lowest rate of fruit and vegetable consumption, which is significantly lower than consumption rates in Newark and Sherwood, Gedling and Rushcliffe. The highest consumption rate is from people who live in Rushcliffe.

Figure 4: Synthetic estimates of fruit and vegetable consumption (adults) for local authority areas in Nottinghamshire, 2003-2005

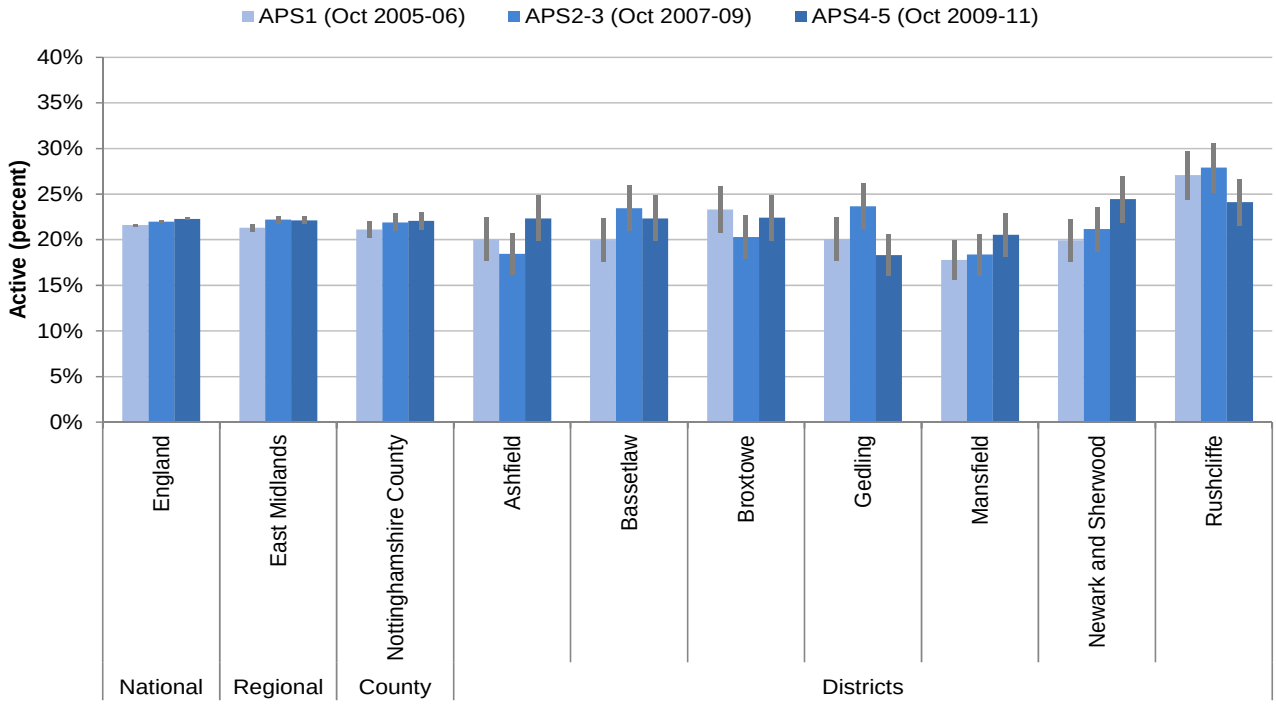


Source: Health Survey for England 2003 to 2005

Physical Activity Participation by Adults

27. Each year Sport England carries out an Active People's Survey (APS). In 2011 the survey was in its fifth year and the results were published in December. Figure 5 shows the percentage of the respondents in District Councils in Nottinghamshire who said that they participate in at least 30 minutes of sport and active recreation (including recreational walking and cycling) of at least moderate intensity on at least 3 days a week. Adults who live in Newark and Sherwood and Rushcliffe have the highest rates of physical activity. Rates are lowest in adults from Gedling and these are significantly lower than the national rates.

Figure 5: Active Adults in Nottinghamshire



APS = Active People's Survey

28. Table 3 shows the changes in adults' participation over the years 2005-06 to 2010-11. This illustrates an increase in the rates in Newark and Sherwood, and no change in other areas and across the county as a whole. However, there has been a slight increase across England and East Midlands.

Table 3: Adult Participation in Sport and Active Recreation (16+)

Area	APS* Oct 2005 – Oct 2006 (%)	APS* Oct 2007- Oct 2009 (%)	APS* Oct 2010 – Oct 2011 (%)	Any significant change?
Ashfield	20	18.5	22.4	No change
Bassetlaw	20	23.5	22.3	No change
Broxtowe	23.3	20.3	22.4	No change
Gedling	20.1	23.7	18.3	No change
Mansfield	17.8	18.4	20.5	No change
Newark & Sherwood	19.9	21.2	24.5	Increase
Rushcliffe	27.1	27.9	24.1	No change
England	21.6	22.0	22.3	Slight increase
East Midlands	21.3	22.2	22.1	Slight increase
Nottinghamshire County	21.1	21.9	22.1	No change

*APS = Active People's Survey

Childhood Obesity Rates

National Child Measurement Programme (NCMP)

29. The NCMP was established in 2005, and involves the annual weighing and measuring of all eligible children in reception (aged 4-5 years) and Year 6 (aged 10-11 years). It has two key purposes:

    - To provide surveillance data on the weight status of children
    - To provide parents/carers with feedback on their child's weight status and information with regard to where they can access support and advice.

30. In Nottinghamshire, all parents of children participating in the programme receive feedback. This includes signposting families with children classified as underweight, overweight or obese to appropriate services.

31. From April 2013, the NCMP will be a mandated function of Nottinghamshire County Council. The resource to deliver the programme from April 2013 will be made through the ring-fenced public health grant for local authorities provided by the Department of Health.

NCMP 2010/11 - Participation Rates

32. Table 4 shows the participation rates for Nottinghamshire County comparing it to the East Midlands and England. It shows that Nottinghamshire County has slightly lower participation rates compared with both the East Midlands and England as a whole. However, it remains above the 85% Department of Health (2008) Healthy Weight, Healthy Lives target.

Table 4: Participation Rates by County, Region and England (%) 2010/11

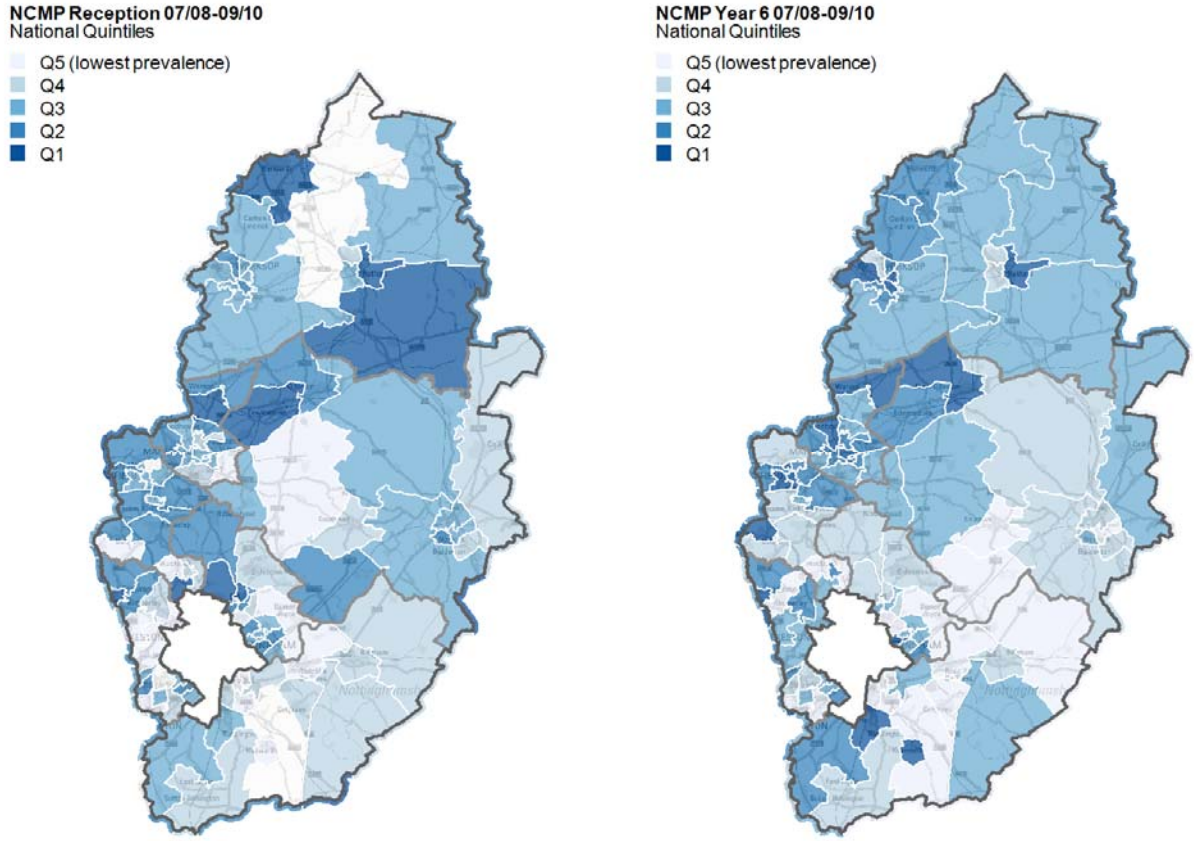
	2010/11	
	Reception (%)	**Year 6 (%)**
Nottinghamshire	89.7	87.2
East Midlands	92.4	92.2
England	93.4	91.8

Source: National Child Measurement Programme Results: The Information Centre

Childhood Obesity Prevalence Rates

33. The results of the NCMP programme enable access to accurate and timely data relating to prevalence in the two cohorts (reception and year 6). Figure 6 shows two prevalence maps of obesity rates in both reception and year 6 for the years 2007/08 through to 2009/10. The darker the colour, the higher the prevalence of obesity.

Figure 6: NCMP Obesity Prevalence Maps for Reception and Year 6, 2007/08 through to 2009/10 pooled data

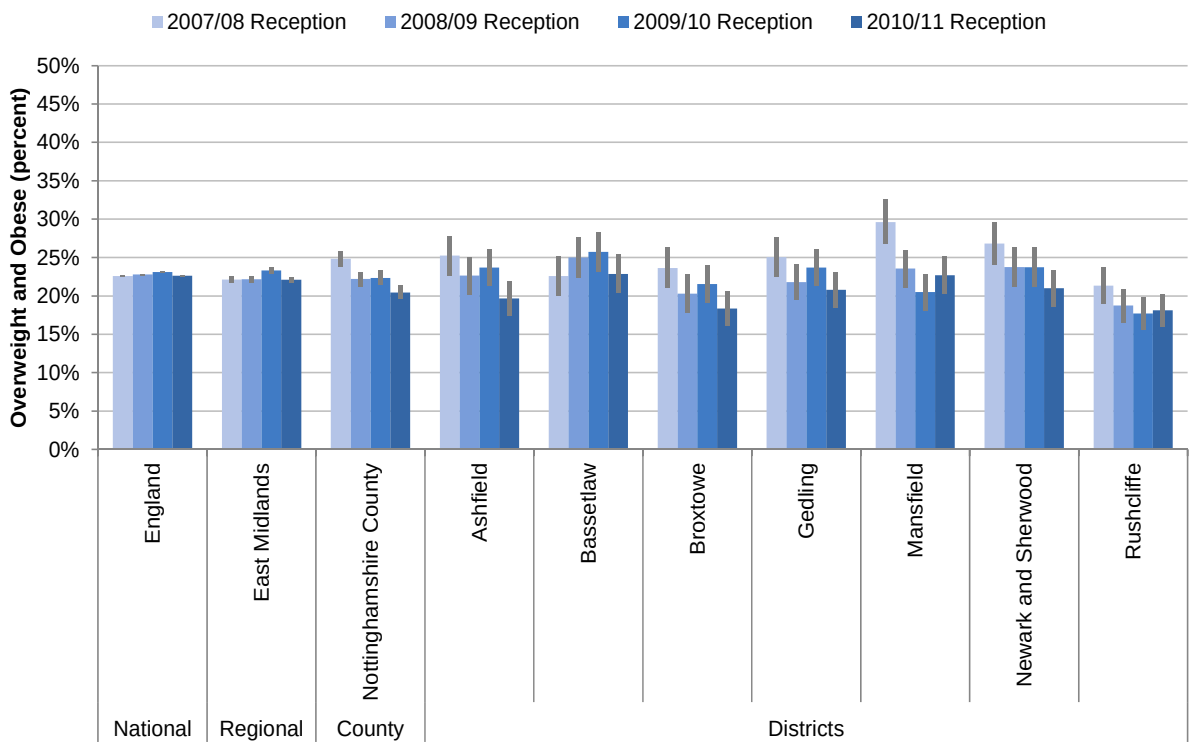


34. With regard to children in reception, Figure 7 shows:

- In 2010/11 there has been a *statistically significant decrease* in the Reception overweight and obesity prevalence rate across Nottinghamshire County over the past four-years. This is mirrored in Ashfield, Broxtowe, Mansfield and Newark and Sherwood.

- There has been *no significant difference* in the overweight and obesity prevalence rate for East Midlands region and England between the years 2007/08 and 2010/11 in Reception Year. This is reflected in Bassetlaw, Gedling and Rushcliffe.

Figure 7: District, County, Regional and National Overweight and Obesity Rates – Reception Year, Years 2007/08 to 2010/11

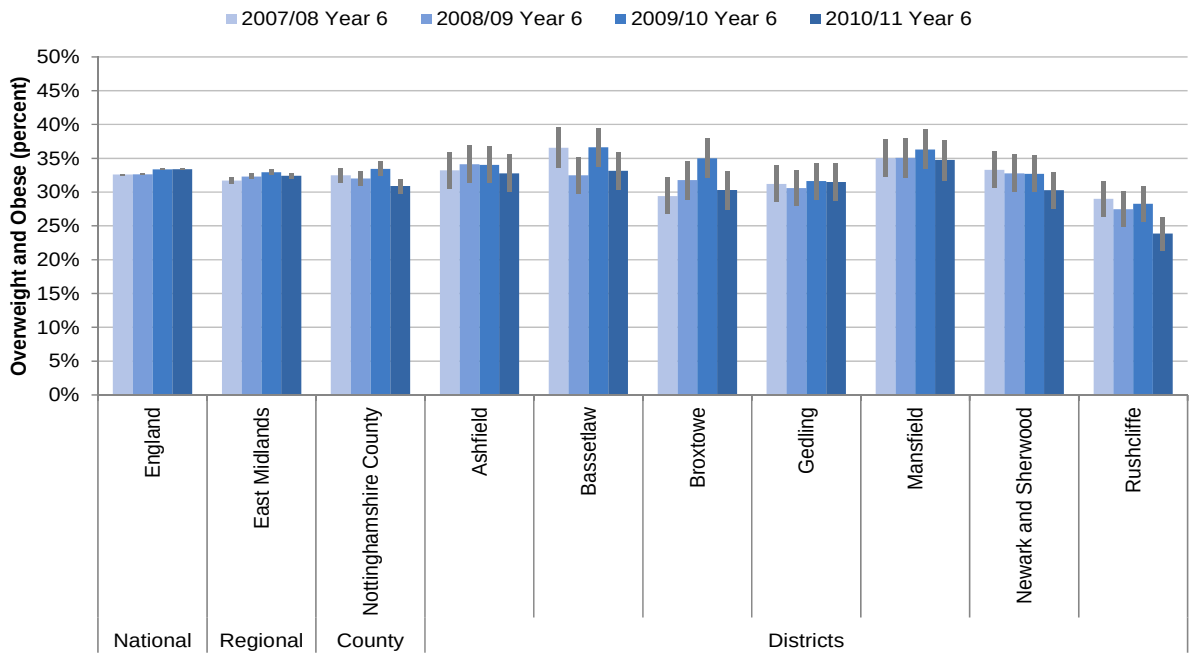


43. With regard to children in year 6 Figure 8 shows:

- There has been *no significant change* in Year 6 overweight and obesity prevalence since 2006/07 in Nottinghamshire County. There is a similar pattern across all districts except Rushcliffe where there has been a slight significant decrease in rates.

- In 2006/07 Nottinghamshire County's Year 6 overweight and obesity prevalence was significantly lower to that of England.

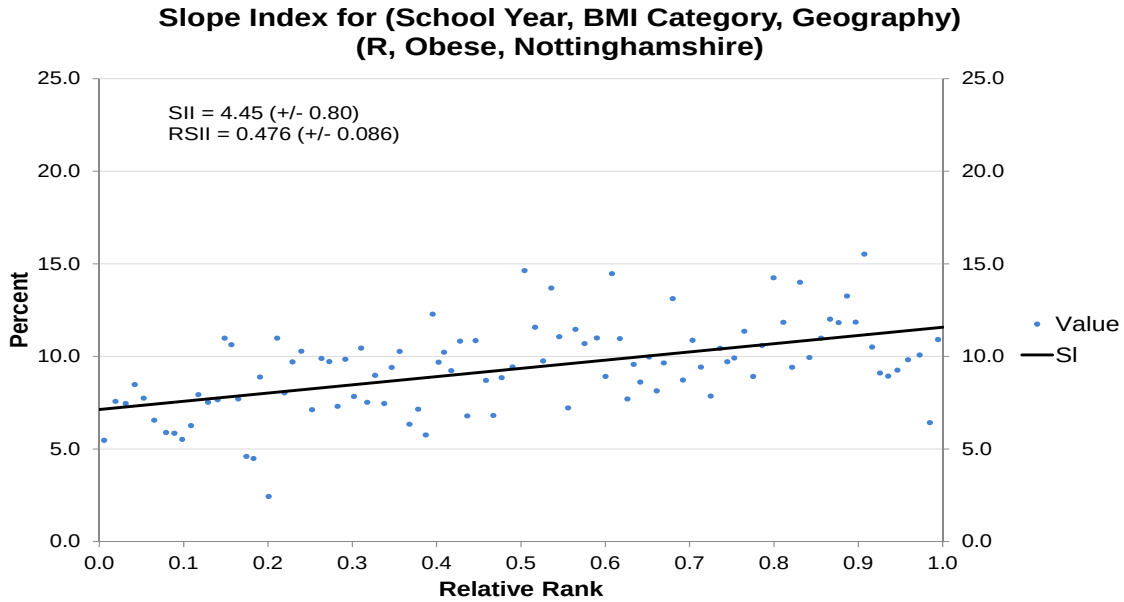
Figure 8: Overweight and Obesity Rates –Year 6, Years 2007/08 to 2010/11



Slope Index of Inequality and the NCMP Results

35. In order to quantify the gap in prevalence of obesity between the most and least disadvantaged areas within Nottinghamshire, the Slope Index of Inequality (SII) has been calculated. This gives a single score based on the relationship between prevalence of obesity (taken from NCMP data) and deprivation scores across the county. The gradient of the SII 'slope' shows the degree of inequality, with greater inequality shown by a steeper gradient. Figure 9 shows the pooled data from 2007/08 to 2009/10 for obese children in reception year, as measured by the NCMP, in Nottinghamshire. Each dot represents approximately 300 children. The figure shows there is a 4.45% difference in obesity rates between reception children who live in the least disadvantaged areas of Nottinghamshire compared to those that live in the most disadvantaged areas. This measure will be used locally to determine the extent to which changes in population prevalence are impacting on inequalities.

Figure 9: Slope Index of Inequality between Reception Year Obese Children across Nottinghamshire



Breast Feeding

36. A large body of published research shows that breast feeding has clear health benefits for both mothers and infants. Breastfed babies are less likely to suffer from conditions such as gastroenteritis, chest, urinary tract or ear infections, diabetes in childhood, and childhood obesity. The World Health Organisation (WHO) recommends exclusive breast feeding for the first six months of an infant's life. This guidance was adopted by the UK health departments in 2003. Patterns of breast feeding can be described using several different measures, and in line with Department of Health requirements, data is collected based on the definitions below:

- Initiation of breast feeding: "the mother puts the baby to the breast, or the baby is given any of the mother's breast milk, within the first 48 hours of birth"

- Prevalence of breastfeeding at 6-8 weeks: "the proportion of babies being breastfed at 6-8 weeks, including babies that also receive infant formula or solid food".

Table 5: Breastfeeding Initiation Rate and Prevalence of Breastfeeding at 6-8 Weeks

	October – December 2011 (Q3 – 2011/12) - %	
	Breastfeeding Initiation Rate	**Prevalence of Breastfeeding at 6-8 Weeks**
England	74.1	49.4
East Midlands	73.0	44.2
NHS Nottinghamshire County	70.3	38.0
NHS Bassetlaw	67.5	33.6

37. Table 5 shows the results for both indicators, as reported for October-December 2011. Rates for NHS Nottinghamshire County and NHS Bassetlaw are lower than both England and the East Midlands.

Action on Obesity

Change4Life - Three Year Social Marketing Strategy (DH, 2011)

38. The Change4Life social marketing programme was launched by the Department of Health in January 2009. Originally it was developed as part of the childhood obesity prevention strategy targeting parents of children aged 5 to 11. Although the programme is government instigated it sought to inspire a broader societal movement through which everyone who had an interest in combating obesity could work together under a common banner.

39. It was estimated that between February 2009 and May 2009 14.3% of NHS Nottinghamshire County residents and 3.14% of NHS Bassetlaw residents had registered, online, with the Change4Life programme. The Change4Life branding continues to be used extensively to promote healthy eating and physical activity messages through:

- The development of Change4Life road-shows in partnership with Nottinghamshire County Council has engaged with schools around the campaign with activity focused on healthy eating
- The development of the Change4Life convenience store project with one store in Mansfield taking part. The aim to increase access to fresh fruit and vegetables particularly in deprived communities
- Local Walk4Life activities in schools and communities
- Branded physical activity projects such as Swim4Life in Mansfield
- The branding of workplace wellbeing schemes
- The rebranding of local obesity training programmes
- The creation of social marketing projects with local communities to help reduce the consumption of sugar sweetened beverages.

40. In June 2012 there will be a national launch of Games4Life. The launch is timed to coincide with preparations for the Olympics. The overall aim is to make England the most active host nation ever, and to help people get more active every day by offering free, personalised, summer activity plans to anyone in England who want one.

Weight Management Treatments and Interventions in Nottinghamshire

41. The complexity and interrelationships of the causes of obesity require the need for a multi-faceted approach. There are four tiers to the treatment and management of obesity, as shown in Figure 10. This triangle illustrates the wider population receive Tier 1 Primary Prevention and as they progress through the tiers, less people receive the intervention/treatment.

42. The current Nottinghamshire obesity strategy, Healthy Weight, Healthy Nottinghamshire 2009-11, is currently structured around five themes, and focuses on interventions in Tiers 2 and 1.

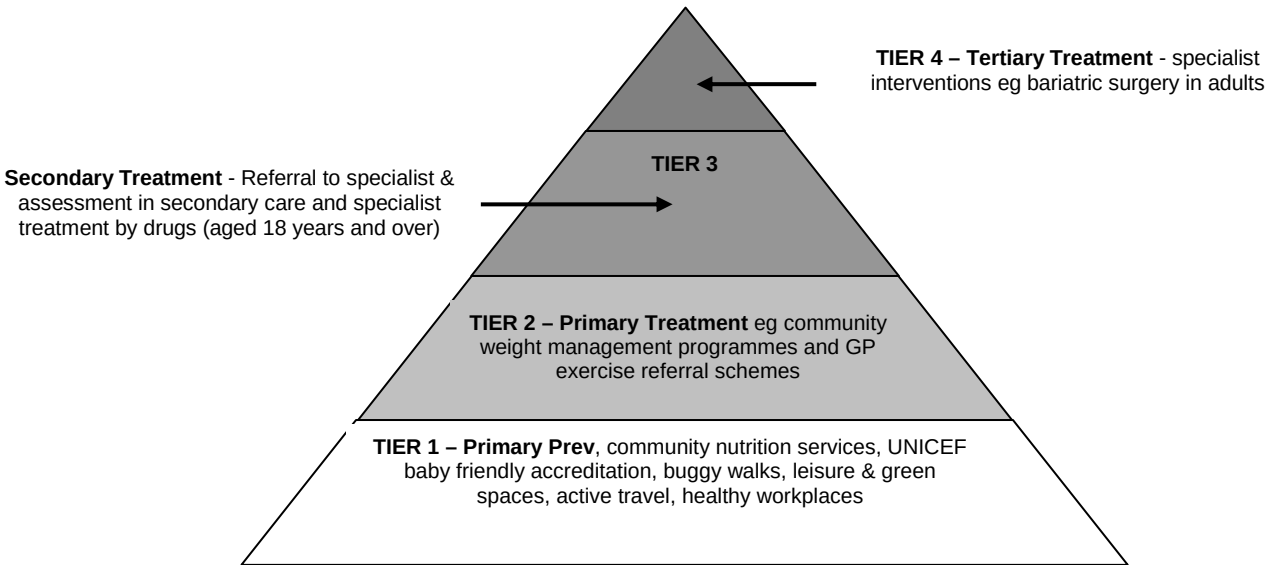
43. Tier 1 focuses on primary prevention. The programmes are listed in Table 6, with a brief overview linking them to the themes from the Nottinghamshire obesity strategy. In addition to the programmes, Public Health staff are supporting districts to refresh their physical activity strategies, for example, the Active Ashfield Strategy. Sport Nottinghamshire is developing a strategy and input is being given to develop work around the theme of getting people in Nottinghamshire are more active, more often.

Table 6: Examples of Tier 1 work that is taking place across the county in support of the strategy themes

Theme	Activity
1. To support a healthy weight in children through healthy eating and physical activity	Play strategies in districts
	National Child Measurement Programme
	Healthy Schools Programme - in the county, 92% of schools have 'Gold' status, which is the equivalent of the National Healthy Schools Standard. The approach taken includes; developing policy and practice in healthy eating, physical activity, Personal, Social Health and Economic and emotional health and wellbeing.
	'Start to Play' programme in all Children's Centre County
	School travel plans
	Implementation of the national Healthy Start programme
	Supporting the Nottinghamshire Community Nutrition Group which meets to share good practice. A Social Marketing seminar took place recently where staff presented their projects, including evaluation.
2. To promote healthier food choices for adults and children in a range of settings	UNICEF Baby Friendly Initiative
	Healthy tuckshops in schools
	Promoting the 5-a-day message
3. To ensure the physical activity is encouraged throughout life	'Raise the Issue' of weight & obesity (Brief Intervention Training) in order to support people to achieve and maintain healthy weight.
	Buggy walks – countywide through districts councils/ NCC
	District Council Physical activity strategies and plans
4. To encourage healthier workplaces	EatWell4Life healthy eating workplace courses
	Through the Local Transport Plan, a programme of cycling and walking network improvements have taken place
5. To maintain and develop access to advice and support on diet, weight and physical activity for adults and children.	Community nutrition service in all districts – delivering a variety of adult and children programmes e.g. Big Cook, Little Cooks, Fun with Food Workshops, weaning cafes/ babies that lunch.
	Children's Centre staff trained to deliver basic healthy eating messages, raise awareness of simple healthy eating messages with all, and develop resources.

44. Tier 2 focuses on primary treatment and includes interventions such as the MEND programme (Mind, Exercise, Nutrition….Do it). Currently there are no Public Health funded MEND programmes in Nottinghamshire. District Councils have been developing Exercise Referral Schemes, for example, Be Healthy, Be Active in Ashfield. Some of these are Public Health funded, but as it is limited, needs to be reviewed to ensure the resources are targeted to the areas of greatest need.

Figure 10: Obesity Model showing the treatment and weight management interventions



45. Tier 3, includes the use of pharmacotherapy. NICE (2006) recommends that drugs should only be considered after dietary, exercise and behavioural approaches have been started and evaluated. They should only be used in adults aged 18 years and over.

46. Tier 4 includes Bariatric Surgery for adults defined as morbidly obese that is if they have a BMI either equal to or greater than 40 kg/m². Surgery to aid weight reduction (bariatric surgery) may be considered for people defined as being morbidly obese when all other measures have failed. In the East Midlands, people must have a BMI of 50 kg/m² and above to be eligible for surgery. The East Midlands Specialised Commissioning Group, currently commission bariatric surgery. This function will transfer to NHS England from 1st April 2013. Estimates indicate 64 people per year across Nottinghamshire will have this intervention.

Further Work Required - Gaps/Risk Areas

47. A priority is the implementation of previously developed and agreed **obesity care pathways for children and adults**. Areas requiring further development are:

- Ensuring front-line health professionals have the skills to work with parents and adults to raise the issue of obesity, assess and signpost to local services (linked to *making every contact count*)
- Providing evidence-based community services for weight management for children and families, and adults with a BMI over 30 with co-morbidities
- Evaluating the impact of current services to support weight reduction/maintenance including exercise referral schemes for adults and children.

48. More effective **links to the delivery of the NHS Health Check programme** is needed. Evaluation of the first year of the programme shows that adults who were at high-risk of developing a long-term conditions, such as diabetes, who had a health check were given advice, but referrals to services, such as weight management and nutrition services were

low. Ensuring a fully funded weight management pathway is in place will increase the referrals of high-risk patients to appropriate services and in the long-term reduce costs.

49. **Resources need to be realigned with areas of highest need**. The NCMP shows no significant change in Year 6 overweight and obesity prevalence since 2006/07 across the County. The previous rise in prevalence has been halted, but a downward trend now needs to be established.

50. **Exercise Referrals Schemes** across the county incorporate two elements; rehabilitation (primarily cardiac) and primary prevention. This is currently being reviewed because from next year the commissioning of the rehabilitation element will be transferred to Clinical Commissioning Groups. Development of a new Exercise Referral Service Specification teasing out rehabilitation is currently underway this will be informed by on previous evaluation recommendations and practice.

51. **A revised local obesity strategy** is currently under development, incorporating the new national ambition for tackling obesity in adults and the indicators from the Public Health Outcome Framework. As part of this, the services that are currently commissioned by Public Health (exercise referral schemes and community nutrition services, currently provided by some district councils and County Health Partnerships) will be reviewed.

52. There is a plethora of good, evidence-based work taking place at a local level. A mapping exercise of what other services, local action and initiatives are taking place in relation to diet and nutrition and physical activity is being undertaken. This will identify any gaps and unmet needs to inform the development of our **commissioning intentions for 2013** onwards to ensure resources are allocated in the most effective way. This will form part of an implementation plan which will outline what needs to be done. Further work will take place to ensure that universal exercise opportunities encourage participation by young people.

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board:

1) Note and endorse the content of the report.

2) Note the mandatory responsibility of the upper tier Local Authority in delivering the National Child Measurement Programme from 1st April 2013, as per national guidance.

3) Endorse the use of earmarked obesity resources in 2012/13 (Primary Care Trust allocation) to develop the identified programme to plug gaps which have been identified. In particular, the development of targeted children and adult weight management pathways and the service redesign of the adult exercise referral schemes to ensure they are ‘fit for purpose’ for April 2013 onwards.

4) Request the development of a full action plan to ensure the issues in this report come to fruition.

CHRIS KENNY
Director of Public Health

For any enquiries about this report please contact:
Barbara Brady
Consultant in Public Health

Constitutional Comments (LMc 12/06/2012)

53. The recommendations in the report fall within the remit of the Health and Wellbeing Board although the Board does not have any decision making powers.

Financial Comments

54. None.

REFERENCES

1) Butland, D.B. et al (2007) Foresight Tackling Obesity: Future Choices – Project Report www.foresight.gov.uk

2) Department of Health (2006). Choosing Health: Supporting the physical health needs of people with severe mental illness. Commissioning Framework. London: Department of Health.

3) Department of Health (2011). Healthy Lives, Healthy People: a call to action on Obesity in England. London: Department of Health.

4) National Institute for Health and Clinical Excellence (2006). Obesity: The prevention, identification, assessment and management of overweight and obesity in adults and children. London: NICE www.nice.org.uk/guidance/CG43

5) Nottinghamshire Strategic Group, NHS Nottinghamshire County (2009) Tackling Obesity: Healthy Weight, Healthy Nottinghamshire Strategy 2009-2011.

6) Swarton, K. and Frost, M. (2006) Lightening the Load: tacking overweight and obesity – a toolkit for developing local strategies for tacking obesity in children and adults. The National Heart Forum.

Electoral Division(s) and Member(s) Affected

All.

HWB39

Nottinghamshire County Council

Report to the Health and Wellbeing Board

27th June 2012

Agenda Item:8

REPORT OF DIRECTOR FOR PUBLIC HEALTH

JOINT STRATEGIC NEEDS ASSESSMENT RAPID REFRESH - APPROVAL

Purpose of the Report

1. This report provides an overview of the rapid refresh of the Joint Strategic Needs Assessment. It provides a summary of the consultation comments received through the public consultation of the draft document. The report presents the final JSNA (via a website link) for endorsement by the Health and Wellbeing Board.

Information and Advice

2. In July 2011, the Health and Wellbeing Board approved a recommendation to review the current Joint Strategic Needs Assessment (JSNA) by the JSNA Steering Group. The purpose of the refresh was to ensure the JSNA informed the development of the Health and Wellbeing Strategy (HWS) and Clinical Commissioning Group Plans (and subsequently also support authorisation).

3. Further reports were presented to the Board between January 2012 and May 2012 to provide information on the development of the JSNA, including presentation of the draft JSNA for consultation.

Consultation

4. The public consultation for the rapid refresh of the Joint Strategic Needs Assessment was conducted between 14th March and 23rd April 2012. Consultation was limited to 6 weeks in this initial phase as plans are in place to develop a longer term work programme including wide engagement and consultation, ensuring the views of communities are captured in a meaningful way. The aim of the consultation was to inform the development of this ongoing work programme.

5. The consultation was primarily a web-based consultation, hosted on a Nottinghamshire County Council webpage. Copies of the draft JSNA key messages were also made available in audio and braille format. In addition, invitations were sent to selected groups across the core organisations/partnerships to participate in the consultation.

6. Individuals were asked whether they agreed or disagreed with a number of statements regarding the draft JSNA chapters and they were also given the opportunity to make comments.

7. One hundred and sixty-one (161) responses were received from individuals / groups via the web-based questionnaire and 8 other written responses were received. However, one hundred and forty-five (145) of the responses appear to have been from the same individual and therefore have been included only once.

8. The responses were similar for both the Adults and Older People's Chapters: Most respondents agreed that the key messages were clear, relevant groups and populations had been included, that information was presented at an appropriate level of detail and was easy to use. A number of respondents disagreed that it provided a picture of health and wellbeing needs, that future needs of populations had been addressed, and gaps had been identified.

9. The main comments have been summarised below:

    - Feedback on specific topics highlighted the importance of housing, and mental health for both chapters and for homelessness in the Adults and Vulnerable Adults chapter. Improved focus on early intervention and prevention strategies and links to long-term health and wellbeing issues was also suggested.

    - In terms of general content, views were expressed that health issues within the JSNA were presented in silos. A greater emphasis on the inter-relationships between factors and conditions that impact on health and wellbeing outcomes could be made. Some comments suggested there was an over emphasis on clinical health and a need to better identify where gaps in knowledge or data exist.

    - There were several comments made regarding data sources and presentation of data in the JSNA. There were a number of suggestions that the range of data sources, particularly in relation to housing and homelessness, could be expanded. The inclusion of data at lower geographical levels or the ability to identify small pockets of populations with higher needs was raised.

    - A number of respondents indicated their organisation would welcome greater involvement in the development of the JSNA, particularly district councils.

    - A number of respondents gave very detailed feedback on particular sections.

10. All comments received will be considered in the development of the on-going work programme for the JSNA. A summary of the comments will shortly be available on the Joint Strategic Needs Assessment webpage.

Final Content, Format and Delivery of the Strategy

11. The content of the Draft Joint Strategic Needs Assessment for 2012-13 has not been amended since the consultation. It is currently being formatted in preparation for publication.

12. An electronic version of the JSNA and key messages is available to access and download from the JSNA webpage: www.nottinghamshire.gov.uk/jsna

Endorsement of the Strategy

13. It is proposed that the Health and Wellbeing Board endorse the JSNA acting on behalf of their representative organisations. This decision can then be ratified by Primary Care Trust Boards to ensure robust governance. Clinical Commissioning Group Boards may also wish to endorse the JSNA.

Statutory and Policy Implications

14. 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

It is recommended that the Health and Wellbeing Board:

1. Endorses the process followed in the development of the Joint Strategic Needs Assessment.

2. Endorses the Joint Strategic Needs Assessment for 2012-13.

3. Requests that the Nottinghamshire County Council Policy Committee and Primary Care Trust Boards ratify the Health and Wellbeing Strategy.

4. Requests a follow-up report to be presented at the September 2012 Health and Wellbeing Board meeting, outlining the on-going work programme for the JSNA.

CHRIS KENNY
Director of Public Health

For any enquiries about this report please contact:
Kristina McCormick
Public Health Information and Intelligence

Constitutional Comments (LMc 12/06/2012)

15. The recommendations in the report fall within the remit of the Health and Wellbeing Board although the Board does not have any decision making powers.

Financial Comments

16. None.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB40

Nottinghamshire County Council

Report to the Health and Wellbeing Board

27th June 2012

Agenda Item:9

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

NOTTINGHAMSHIRE COUNTY COUNCIL OVERVIEW REPORT FOR CLINICAL COMMISSIONING GROUPS

Purpose of the Report

1. The report is to present the joint paper produced by the Adult Social Care, Health and Public Protection department and the Children, Families and Cultural Services department on the responsibilities, priorities and direction of the Council and these 2 departments in particular. The paper is intended for presentation at the Clinical Commissioning Groups (CCGs) by the lead Service Director.

Information and Advice

2. Each Clinical Commissioning Group has been linked with a Service Director from either Children's or Adults' services within the Council. The names of the Service Directors and the CCGs they are linked to are included in the paper attached.

3. The Corporate Directors from Adult Social Care, Health and Public Protection and Children, Families and Cultural Services requested an overview paper and presentation to help CCGs to understand the role and responsibilities of the Council in order to promote and support integrated working between them and the Council.

Other Options Considered

4. Not applicable.

Reason/s for Recommendation/s

5. Improving outcomes for service users and providing cost effective health and social care services requires excellent joint commissioning. In order to support this work it is important for the CCGs to have a good understanding of the Council's areas of responsibility and priorities.

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

It is recommended that:

1) The Health and Wellbeing Board comments on the responsibilities, priorities and direction of Nottinghamshire County Council's Adult and Children's Services.

2) The Clinical Commissioning Group Leads arrange for the paper to be put on the CCG board agendas for discussion, with a supporting presentation by the Service Director.

DAVID PEARSON
Corporate Director, Adult Social Care, Health and Public Protection

For any enquiries about this report please contact:
Jennie Kennington
Senior Executive Officer
jennie.kennington@nottscc.gov.uk

Constitutional Comments

7. Because the report is for noting only, no constitutional comments are required.

Financial Comments

8. The report is for noting purposes only.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

HWB41

Nottinghamshire County Council – an overview

Council Structure and Broad Responsibilities

Nottinghamshire County Council is the largest employer in the county employing over 27,000 people, with a budget of £1.4bn that delivers more than 500 services to 790,000 people. This makes Nottinghamshire the 11th largest local authority in England.

The Council has a £1.3 billion budget and 12,000 employees who work directly for the Council along with 15,000 employed by schools and other bodies. The budget for schools amounts to £510m.

The Council is ultimately responsible for the provision and performance of over 500 statutory and discretionary services to 790,000 people across Nottinghamshire including the vital range of services for children, public protection, social care and highways as well as many discretionary services relating to the social, environmental, and economic well being of the area. The Council is developing new responsibilities including working in partnership with the Health Service, City, District and Borough Councils, Police, Fire and Rescue and many other statutory and non-statutory organisations. All this happens in the context of democratic politics, meeting increasing needs and providing greater transparency.

The Chief Executive of the Council is Mick Burrows. The Council has 4 departments:

Adult Social Care, Health and Public Protection – Corporate Director: David Pearson
Children, Families and Cultural Services – Corporate Director: Anthony May
Environment and Resources – Corporate Director: Tim Gregory
Policy, Planning and Corporate Services – Corporate Director: Jayne Francis-Ward.

The Council's priorities are identified in the Strategic Plan. They are:

- to foster aspiration, independence and personal responsibility
- to promote the economic prosperity of Nottinghamshire and safeguard our environment
- to make Nottinghamshire a safer place to live
- to secure good quality, affordable services
- to be financially robust and sustainable.

Nottinghamshire has a two tier system of local government. This means that services are sometimes shared between 2, or 3, councils. Nottingham City Council is a unitary authority which means it is responsible for all local government services in the city.

Nottinghamshire County Council is a 1st tier local authority responsible for the services already identified. The second tier is made up of 7 District or Borough Councils which are responsible for functions such as housing, collection of council tax, pest control, refuse collection and parks and leisure centres. Collectively they spend £84m per year on providing services.

The councils are:

- Ashfield District Council
- Bassetlaw District Council
- Broxtowe Borough Council
- Gedling Borough Council
- Mansfield District Council
- Newark and Sherwood District Council
- Rushcliffe Borough Council.

In some areas of the county there may be also be a 3rd tier – a Town or Parish Council. These councils have a wide range of functions and are the most local form of democratically elected local government. Collectively they spend £4m per year on recreational facilities, parks and open spaces, cemeteries, public conveniences, car parks, village halls and community facilities. In Nottinghamshire there are 150 Parish Councils, 10 Town Councils and 38 parish meetings.

The Political Structure of the Council

There are 67 Councillors in the County Council and all elected Councillors sit in Full Council. The elected Councillors are known as Members of the County Council. Most County Councillors are members of a political party but there are 8 independent Councillors at present. The composition is as follows:

The composition of the County Council as of March 2012 is:

- Conservative Party: 35 seats
- Labour Party: 15 seats
- Liberal Democrat: 9 seats
- Mansfield Independent Forum: 4 seats
- Selston Area Independents – Putting People First: 1 seat
- Independent: 2 seats
- UK Independence Party: 1 seat.

These Members have formed the following Groups:

- Conservative Group: 35 seats
- Labour Group: 15 seats
- Liberal Democrat Group: 9 seats
- Nottinghamshire Independent Group: 8 seats.

The Council has a constitution, which sets out the legal rules it must follow, how the Council operates and how decisions are made. This ensures that procedures are

followed correctly and that they are efficient, transparent and accountable to local people.

In May 2012, the County Council introduced a committee system to replace the Leader and Cabinet format.

The change to the committee system reflects new powers given to local authorities as part of the Localism Act. This gives greater freedom to local authorities and allows them to decide for themselves what system of governance they want to operate. Committees are made up of councillors from all parties to reflect the political balance of the authority and all decisions, with the exception of day-to-day operational matters, will be made by the committees. This represents a drive for greater transparency, accountability and more democratic decision making by Councillors.

There are 19 committees, 7 sub committees and Full Council, which meet every 8 weeks.

Adult Social Care, Health and Public Protection (ASCH&PP)

It is the ambition of Adult Social Care, Health and Public Protection (ASCH&PP) that

We will commission services which embrace personalisation and promote safety and wellbeing and are accessible and affordable

This ambition is based on the following approach:

- Commission Services to provide quality and value for money
- Embracing Personalisation
- Promoting Safety
- Promoting Health & Wellbeing
- Ensuring Accessibility
- Ensuring Affordability.

The purpose of ASCH&PP is to maximise independence, choice and control, keep people safe and support the wellbeing of vulnerable adults.

It has specific responsibility for:

- planning and delivery of health and social care services across Nottinghamshire
- delivery of housing related support services on behalf of the Supporting People partnership
- leading the implementation of national and local standards in our services
- working in partnership with other care providers, service users, carers and local stakeholders to develop, plan and deliver services
- promoting social inclusion and wellbeing
- emergency planning to ensure that effective arrangements are in place to manage emergencies and civil contingencies in the county
- registration of births and deaths, and conducting civil marriages, civil partnerships and citizenship ceremonies
- ensuring a fair and safe trading environment for consumers and reputable traders.

Key strategies and service developments

Personalisation - The most significant change for adult social care is 'personalisation' and offering choice and control to people through use of Personal Budgets and Direct Payments. From 3rd October 2010, all new service users were put onto a Personal Budget and this has taken place alongside reviewing every service user eligible for a Personal Budget.

Good progress has also been made in offering a direct payment to service users with dementia and Nottinghamshire is one of the better performing local authorities in this respect, according to the Alzheimer's Society. During 2012/13 the department will focus on extending the offer of a personal budget to new service user groups and ensuring all service users are on a personal budget regardless of the care setting,

such as residential homes. Work will also be undertaken to increase the number of people who take their personal budget as a direct payment.

Reablement - The department aims to provide support to people that will enable them to regain or maintain their independence wherever possible, to avoid unnecessary hospital admissions and support successful discharge from hospital care, and to avoid the need for long term care support. To this end, the department is promoting flexible ways of working across the County to provide an effective multidisciplinary reablement service through a range of flexible services in a variety of community settings, including intermediate care and home based services.

The Short-Term Assessment and Reablement Team (START) works with people to help them regain the skills and confidence to live as independently as possible. It helps with personal care and domestic care tasks. START staff may suggest doing things differently to how they have been done in the past, offer small items of equipment to make tasks easier and inform people about other kinds of help they could receive. This support normally lasts for up to six weeks and is free of charge. During this time support needs are constantly reviewed to see if people will require any long-term personal support.

Joint Commissioning – There is a significant inter-relationship between services to adults with social care needs and many health services, as well as a significant overlap in relation to cost. Improving outcomes for service users and providing cost effective health and social care services requires excellent joint commissioning. The Health and Wellbeing Board is well placed to provide leadership to promote integrated commissioning and provision between health, public health and social care. From April 2013 the Health and Wellbeing Board is legally required to produce a Health and Wellbeing Strategy to advise on how to improve the health and wellbeing of the Nottinghamshire population.

Organisational structure

Four Service Directors oversee key functions within the department:

- The **Promoting Independence and Public Protection** service is responsible for the management of customer access to adult social care services, the development of the personalisation agenda and personal budgets, provision of reablement services and trading standards, emergency management and registration services.

- The **Joint Commissioning, Quality and Business Change** service is responsible for the management of business change and support, safeguarding adults, joint commissioning, policy and performance, and supported employment services.

- The **Personal Care and Support Younger Adults** service is responsible for the assessment and commissioning of a range of support services to younger adults (under 65) with physical disabilities, mental health needs and learning disabilities. This includes a team for adults with asperger's syndrome. The service also manages day and residential services.

§ The **Personal Care and Support Older Adults** service is responsible for the assessment and commissioning of a range of support services to older adults (over 65). The service also continues to manage 6 residential homes which have been retained following a major project to sell Council owned homes.

Budget

The department is responsible for a gross budget of £301m. This includes income of £97m, giving a net revenue budget of £204m. The department provides health and social care services for 20,000 people every week. A further 16,000 people each year receive housing-related support organised by the department. The department manages a care market of £225m and works in partnership with over 300 care providers from the voluntary, statutory and independent sectors.

In 2010 NHS Support to Social Care funding (£9.624m) was allocated to Nottinghamshire PCTs with the requirement that the funding was transferred to local authorities for the purpose of supporting effective and timely hospital discharges. This comprised of £1.371m for Bassetlaw PCT and £8.253m to Nottinghamshire County Teaching PCT. For 2012-13, Nottinghamshire will receive £9.262m, with £1.319m to Bassetlaw and £7.942m to Nottinghamshire County. In January 2012 the Department of Health announced an additional one-off allocation for 2011/12 of £2.233m.

In common with other departments and the Council as a whole, Adult Social Care, Health and Public Protection is making savings and is forecast to save £65m in the 4 year period from 2011/12 to 2014/15. This includes £61.7m of savings planned for 2011/12 to 2013/14.

There are currently 49 savings and efficiencies projects in progress across the 4 service areas (41 within the Adult Social Care and Health and 8 relating to Public Protection) with the aim of making these savings. Over 2011-12, 16 projects have been fully completed. A further 8 projects were added at the February 2012 Council budget meeting.

The 10 high governance projects (including two new projects) are listed below:

- Reablement
- Day Services modernisation
- Fair Access to Care Services (FACS)
- Sale of residential care homes (soon to be completed)
- Alternatives to Residential Care
- Review expenditure on Learning Disability and Mental Health community care
- Supporting People
- Organisational re-design
- Sherwood Industries
- Redesign of commissioning of community-based care services.

Performance

Previously all Councils were expected to report to the Care Quality Commission (CQC) on their achievements and areas for improvement. For adult social care the CQC then awarded a performance rating. In 2009-10 the CQC judged that Nottinghamshire County Council was 'performing excellently'. This was the third year in succession that the Council was judged as excellent – the only Council in the East Midlands to be in this position.

In April 2010 the Government changed the way it expects local authorities to report on their performance. The Council is now required to be 'self regulating', meaning that it is now the Council's responsibility to monitor and report on its own performance. Although the authority is no longer required to report to the Government on a large number of national performance indicators, we continue to assess ourselves against some of these to help improve our performance.

The Government does require the Authority to monitor and report on performance against four categories within an Outcomes Framework. The categories require us to look at how well services:

- **Enhance the quality of life for people with care and support needs**
- **Delay and reduce the need for care and support**
- **Ensure that people have a positive experience of care and support**
- **Safeguard adults whose circumstances make them vulnerable and protect them from avoidable harm**

In January 2012 the department published a Local Account on performance in adult social care services for the period April 2010 to March 2011. Nottinghamshire was one of a small number of councils that produced a Local Account, and was the first Council in the East Midlands to do so. The next Local Account will be produced in the summer for the period covering March 2011 to April 2012.

Key responsibilities and processes

Assessment and eligibility for services

The department uses Government guidance to decide whether a person's ability to live independently would put them at risk if services are not provided or arranged to help them. This is called Fair Access to Care Services guidance (FACS). If there is a risk to a person's independence the department has to decide whether the risk is critical, substantial, moderate or low. Councils have a statutory responsibility to meet needs that are not met by other means, such as through care provided by informal carers or the health service.

People will be **eligible for help** with any problems that pose a **critical or substantial risk** to their independence. If the identified problems pose a **moderate or low risk** to their independence people **may not be eligible for help** from the Council.

The Council has a significant role in providing information and advice for people who are not eligible for Council provided social care services. The Social Care directory and the Notts 50+ website allows people to find out what services and resources are available to provide support across Nottinghamshire.

The Self-Directed Support Assessment is the core assessment used by staff to assess the needs of all service users.

The community care assessment (SDSA) is used to:

- assess presenting need and agree level of support required
- establish the amount of unpaid care that is available
- determine eligibility for long term social care support. Staff must provide evidence to support their decision, based on Fair Access to Care Services guidance.
- collect information to inform a referral to other agencies if required. It is the responsibility of the worker to make the necessary referrals or enquiries to other agencies based on the information provided by the service user or carer during the assessment

If an assessment identifies eligible need people will be offered a personal budget. This is an amount of money agreed with the individual to meet their long-term social care needs. Personal budgets can be provided in three different ways:

Direct payment - this is a cash payment given to allow people to buy the support they need. A direct payment allows people the most flexibility and control over the support they need. It also means people have more responsibility for arranging their own support.

Managed personal budget – the council arranges the services that meet a person's support needs. A managed personal budget is less flexible than a direct payment but people have less responsibility to arrange their own support.

Mixed personal budget – people can arrange part of their support themselves using a direct payment and ask the Council to arrange the rest using a managed personal budget.

Charging for services - Service users have a financial assessment to decide the contribution towards their Personal Budget. This is undertaken in line with the Fairer Contributions Policy which was introduced nationally in 2010. Fairer Contributions represents a fundamental shift from charging for units of service (Fairer Charging guidance) to people making a contribution to their total service package.

Support planning

Once people know their indicative personal budget they need to make a support plan. This must clearly show what support they need (such as help with washing or dressing or getting out in the community); what services or activities they intend to spend their personal budget on to meet these needs, what plans they have for an emergency (for example carers being ill) and any risks there are in the support plan.

Social care staff will help people complete their support plan, as well as family, friends or an advocate. The support plan has to be agreed by the Council to ensure it is affordable, legal and a proper use of social care funds. The department publishes a social care directory, which provides details of a range of organisations across Nottinghamshire that can provide support, services and activities that can be used in support planning. The Support with Confidence register provides a list of approved personal assistants who have been trained in supporting people to live independently. They have all had enhanced Criminal Records Bureau checks and supplied references.

The Future of Adult Social Care

The Commission on Funding and Support of Social Care, headed up by Sir Andrew Dilnot, published its recommendations and report in July 2011. The Commission identified that under the current system adult social care expenditure will need to increase from £14.5 billion to £22.8 billion, the equivalent of £125 million for Nottinghamshire by 2025. Prior to that, the Law Commission had published a report proposing the need for a major review of the law relating to adult social care.

The Queen's Speech included a draft bill to modernise adult care and support in England, setting out what support people could expect from government and what action the government would take to help people plan, prepare and make informed choices about their care. The draft Bill focuses on:

- modernising care and support law to ensure local authorities fit their service around the needs, outcomes and experience of people and consolidating the existing law with a single statute, supported by new regulations and statutory guidance

- maintaining the focus on putting people in control of their care and giving them greater choice, building on progress with personal budgets

- simplifying the system and processes to provide the freedom and flexibility needed by local authorities and social workers to allow them to innovate and achieve better results for people, and

- giving people a better understanding of what is on offer to help them plan for the future and ensure they know where to go for help when they need it.

Children, Families and Cultural Services (CFCS)

The ambition of Children, Families and Cultural Services is:

We want Nottinghamshire to be a place where children are safe, healthy and happy, where everyone enjoys a good quality of life and where everyone can achieve their potential

The work of the Department is focused around nine priorities:

- continue to improve our work to keep children and young people safe
- continue to improve how well children and young people achieve in schools and colleges
- reduce the gap in educational achievement for all ages
- improve children and young people's health and wellbeing
- continue to improve our early intervention services to ensure that children, young people and families in the greatest need receive appropriate support
- increase opportunities for children, young people and families to take part in learning, sporting, leisure and cultural activities, to develop new skills and to have fun
- conserve and enhance our country parks, green places and cultural heritage and contribute to an improved visitor experience for Nottinghamshire
- commit to a whole department quality assurance approach with individual accountability
- improve the efficiency of our service delivery and supporting infrastructure.

The CFCS annual budget for 2012-13 is £152m, with £138m allocated to Children and Young People's Services and £14m allocated to Cultural Services. The budget for schools amounts to £510 million**.**

<u>Key Responsibilities</u>

The Department is responsible for the delivery of a range of services to children, young people and their families as well as to the wider community, many of these being statutory services. These include:

- Children's social care, supporting the most vulnerable children and young people. Services include child protection, children looked after by the local authority, fostering and adoption services and support for disabled children.

- Early intervention services for children, young people and their families, ensuring that families are provided with support when they experience difficulties in their lives. Early intervention services include preventative work

and support for children, young people and families who are vulnerable, but do not meet the threshold for support through children's social care. Services are provided to younger children and their families through Sure Start Children's Centres, and to young people through targeted youth support services. The Youth Justice service provides prevention, restorative justice and statutory criminal justice services.

- Education standards and improvement, ensuring that all children and young people in Nottinghamshire have access to high quality learning provision and support that meets the needs of all learners. This includes support to schools to enable them to improve their performance, and planning to ensure that sufficient school places are available in the localities where they are needed. The Special Educational Needs and Disability (SEND) Service delivers a range of services to ensure that children with SEND are supported to access education.

- A range of cultural services, including arts and sports services in schools, outdoor education, youth services, adult community education, libraries and archives services and country parks.

To deliver this wide range of services, the CFCS Department is organised in three divisions:

- The **Children's Social Care Division** aims to provide the most vulnerable children and young people in Nottinghamshire with the support and protection that they need to be safe, secure and happy, and to achieve their full potential. The division's current structure comprises the following service groups:

  - Regulated and Corporate Parenting Services
  - Fieldwork Social Work Team (North)
  - Fieldwork Social Work Team (South)
  - Disabled Children's Service
  - Safeguarding and Independent Review.

Children's Social Care is implementing a transformation programme, to improve local arrangements for safeguarding children, and is in the process of restructuring its service groups over the next few months.

- The Education Standards and **Inclusion Division** is responsible for raising standards and aspirations for all children and young people in Nottinghamshire. Services provided are:

  - Behaviour Service
  - Special Educational Needs and Disability Policy and Provision
  - Education Improvement, Strategic Planning and Schools Admissions
  - Business Development and Support.

- The **Youth Families & Culture Division** serves children and young people and their families, and also provides cultural services to the wider community. Services provided are:

- Young People's Service
- Targeted Support and Youth Justice Service
- Early Years and Early Intervention Service
- Libraries, Archives and Information
- Cultural and Enrichment Services
- Country Parks.

Many of these CFCS services work in partnership with other organisations, including Health Services. Much of this work is co-ordinated by the Children's Trust, which is a partnership of organisations providing services to children, young people and their families. The Children's Trust Executive oversees joint planning and commissioning for children's services, and reports to the shadow Health and Wellbeing Board.

(For more information: http://cms.nottinghamshire.gov.uk/home/learningandwork/childrenstrust.htm)

Key Developments

Together with its partner organisations, the County Council has developed a Pathway to Provision, to support practitioners across the Children's Trust in identifying the most appropriate level of support required by a child, young person or family. This describes the child's pathway through our services, the access points and levels of service provided for all levels of need, from universal services through early intervention and targeted services to specialist and statutory support, including children's social care, specialist health services and support for children with special educational needs (SEN) and disabilities.

(For more information: http://cms.nottinghamshire.gov.uk/home/learningandwork/childrenstrust/earlyinterventionandprevention.htm)

Children's Social Care is delivering a transformation programme, which is central to work to improve local arrangements for safeguarding children. Over the last year, we have achieved significant improvements in the quality and timeliness of children's safeguarding services, validated by a successful Peer Challenge through Local Government Improvement and Development (LGID) and a successful re-inspection of safeguarding services and the removal of the Council's Improvement Notice. The transformation programme is driven from within, by people in the service, together with colleagues across partner organisations. It will embed a new, resource-efficient model for children's social care, creating a high quality service that inspires confidence and pride in the community, partners, county council staff and political leaders. This new model will comprise:

- the Multi Agency Safeguarding Hub (MASH); a single, multi-agency point of entry for vulnerable children
- district child protection teams;
- a dedicated through care service for looked after children
- improved arrangements for disabled children's making transitions from children's to adult's services.

Nottinghamshire County Council is recommissioning its Children's Centres services. Fifty-eight Children's Centres are currently located within the Council's Early Years

and Early Intervention Service with services delivered by the County Council and a number of other organisations. A recent service review has clarified the core purpose of Children Centres, with early intervention at its heart, and the recommissioning process is underway with new contractual arrangements due to start in April.

The Targeted Youth Support offer sets out the services provided for young people aged 8-18 who are vulnerable but who are not immediate risk of harm. About one in ten young people will require targeted support at some time during their adolescence Targeted Support is a partnership managed by the local authority and with involvement by the police, health services, Probation and not-for-profit and voluntary sector agencies. Young people can refer themselves to Targeted Support or be referred by a professional.

The Country Council's relationship with schools is evolving, reflecting its role in education provision for children and young people to improve their lives and life chances. The Department for Education expects local authorities to:

- drive up standards of achievement
- secure access and sufficiency of high quality places for all children and young people
- promote the development of new provision, particularly parent-led provision
- secure choice for learners and parents
- ensure value for money.

In Nottinghamshire, overall educational attainment has improved significantly over the last few years, with results at KS2 (age 11) and KS4 (age 16) improving at a rate greater than the national average for the last four years. If the recent trend of improvement continues in 2012, it is likely that KS4 outcomes will be in line with the national average for the first time. There remains work to be done to reduce the attainment gap between more vulnerable children and their peers, and to improve educational performance post-16.

The Department has benefited from large scale capital investment, including more than £100 million into schools and more than £25 million into youth services. The Council was also successful in the recent bidding for the Priority Schools Building Programme, receiving 15 projects, more than any other Council. There is also a capital programme investing in library services. This includes major projects delivering new library premises in Mansfield and West Bridgford.

Demographic Information

The priorities of the CFCS Department and of the Children's Trust have been developed after considering the needs of children, young people and families, and using customer feedback. The demographic needs of children and young people are identified in the 2010 refresh of the children's chapter of the JSNA. Key findings are that:

- there are 179,500 children and young people aged 0-19 in the county and the 0-19 population is predicted to increase by 13% on average across the county by 2030, with the largest growth in the 5-9 population (23%).

- there is an estimated 6.6% black and minority ethnic 0-19 population in Nottinghamshire, concentrated in the conurbation areas of Broxtowe, Gedling and Rushcliffe. 3.5% of Nottinghamshire school pupils speak English as an additional language

- more than 20% of Nottinghamshire pupils have some kind of special educational need (SEN) and 1.1% have a Statement of SEN. The main SEN is behavioural/emotional/social need, and diagnoses of Autistic Spectrum Disorder have seen a steep rise in recent years.

- 17.5% of children were identified as living in poverty in 2009 (from data available September 2011). Child poverty is concentrated in the north-west of the county, with additional clusters in Retford, Newark, Arnold and Carlton, Hucknall and several scattered wards in Broxtowe.

(For the full refresh of the children and young people's chapter or the JSNA, including district profiles, see: http://cms.nottinghamshire.gov.uk/home/learningandwork/childrenstrust/jointstrategicneedsassessment.htm)

Clinical Commissioning Group links

Newark and Sherwood	Jon Wilson, Service Director, Personal Care and Support, Younger Adults
Bassetlaw	David Hamilton, Service Director, Personal Care and Support, Older Adults
Nottingham North and East	Paul McKay, Service Director, Promoting Independence and Public Protection
Principia (covering Rushcliffe)	Caroline Baria, Service Director, Joint Commissioning, Quality and Business Change
Mansfield and Ashfield	Steve Edwards, Service Director, Children's Social Care
Nottingham West	Derek Higton, Service Director, Youth, Families and Cultural Services

Joint Health and Social Care Agenda

There are established joint commissioning arrangements in place for the following areas:

- Children & young people (Teenage Pregnancy, Disability and CAMHS/emotional wellbeing)
- Younger adults (Mental Health, Learning Disability & Autistic Spectrum Disorder, Carers)

- Older adults (Older People & Older People Mental Health, Carers, Physical Disability, Sensory Impairment)
- Substance Misuse.

The Health and Wellbeing Implementation Group will oversee the development and delivery of the joint commissioning agenda. This is currently being reviewed to link the work under the umbrella of the Health and Wellbeing Board.

A shadow Health and Wellbeing Board was established in 2011 and there have now been 6 meetings. The Board is chaired by the Deputy Leader of the Council and includes 5 Councillors (including the Leader and Deputy Leader), 6 GPs from the Clinical Commissioning Groups, representatives from the District Councils, LINks, Director of Children's, Families and Cultural Services, Director of Public Health and Director of Adult Social Care, Health and Public Protection.

The Board is responsible for the production of a Joint Strategic Needs Assessment and a Health and Wellbeing Strategy for the County.

Nottinghamshire Children's Trust oversees joint planning and commissioning for services to children, young people and their families. Its business is managed by the Children's Trust Executive which reports to the shadow Health and Wellbeing Board. Joint commissioning groups for children and young people's services report to the Children's Trust Executive (groups for disabled children, CAMHS and emotional wellbeing and teenage pregnancy). The Children's Trust supports work on young people's substance use, but accountability for this area of joint commissioning is with the Safer Nottinghamshire Board.

The Children's Trust Executive is chaired by the Corporate Director for CFCS, and includes representatives of the County Council, Health Services (commissioners and providers, including Clinical Commissioning Groups),the Police, District Councils, and the voluntary sector. The Children's Trust Executive approves joint commissioning strategies related to its priorities, and receives six-monthly performance reports on these. This work is being integrated into the Health and Wellbeing Board performance reporting, and the County Council's committee structure. The Children's Trust contributes to the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, ensuring these embrace all aspects of children's wellbeing, including health, social care, educational and community needs.

The joint planning and commissioning priorities of the Children's Trust are set out in the Children, Young People and Families Plan 2011-14. This has been approved by Nottinghamshire County Council will in future be approved by the Council's Children and Young People's Committee, chaired by the Cabinet Member for Children and Young People's Services, and reported to the shadow Health and Wellbeing Board. The Children's Trust joint planning and commissioning priorities are:

- Early intervention
- Safeguarding
- Disabled children
- Child poverty

- Educational achievement, reducing the gap in achievement between more vulnerable groups and their peers
- Educational achievement for 16-19 year olds and the employment of young adults
- Emotional wellbeing.

The Nottinghamshire Safeguarding Children Board (NSCB) is the key statutory mechanism for agreeing how relevant organisations co-operate to safeguard children and ensure the effectiveness of what they do. It also provides inter-agency training for colleagues working with children, young people, adults and families. The work of the NSCB fits within the wider context of the Children, Young People and Families Plan and the Board is responsible for some of the activities that contribute to the safeguarding priority of this plan. The NSCB has a scrutiny and challenge role within the Children's Trust, and has an independent Chair, who is also a member of the Children's Trust Executive.

Locality Management Groups have been established in each of Nottinghamshire's seven districts, responsible for local planning of partnership activities, with an emphasis on early intervention work. These groups report to the Children's Trust Executive and build on the previous work of Local Strategic Partnership Children (LSP) Children and Young People's sub-groups, and in some districts continue to report to the LSP. These groups are developing local action plans, and would like to work involve local Clinical Commissioning Groups in this work.

(The Nottinghamshire, Children, Young People and Families Plan, plus associated joint commissioning strategies, including those for disabled children, emotional well-being, are available at: http://cms.nottinghamshire.gov.uk/home/learningandwork/childrenstrust/childrenyoungpeopleandfamiliesplan.htm)

Nottinghamshire County Council

Report to the Health and Wellbeing Board

27th June 2012

Agenda Item:10

REPORT OF CHAIR OF THE BASSETLAW CLINICAL COMMISSIONING GROUP

CLINICAL COMMISSIONING GROUP AUTHORISATION PROCESS

Purpose of the Report

1. The purpose of the report is to provide information to members of the Health and Wellbeing Board about the process for authorisation of the six Clinical Commissioning Groups (CCGs) in the current NHS Nottinghamshire County Primary Care Trust area.

Information and Advice

2. The NHS Commissioning Board, when established, will have a duty to ensure that by 1st April 2013 every GP practice in England is a member of a CCG and that the geographical areas covered by CCGs cover the whole country. For unregistered patients, the responsible commissioner will be the CCG in whose area they live. CCGs will also be responsible for providing for emergency and urgent care for those within their boundary at the time of need.

3. The process for authorisation as a Clinical Commissioning Group consists of three stages:

   (a) **Pre-application**: in addition to the responsibilities undertaken as part of the scheme of delegation, CCGs participated in a self-assessment diagnostic and assemble the evidence needed as part of the application submission

   (b) **Application**: Submission of an application form to the NHS Commissioning Board, together with supporting evidence and self-certification on some of the criteria for authorisation.

   (c) **NHS Commissioning Board Assessment**: Only the NHS Commissioning Board can legally make a decision on authorisation, although it must have regard to the assessment and views of Strategic Health Authorities, the NHS Commissioning Board Authority and other parties. The formal assessment will be based on the evidence gained from several key components including 360° survey, Desk-top Reviews, Case Studies and site visits.

Authorisation Domains

4. The authorisation content is structured around 6 domains:

    - A strong clinical and multi-professional focus which brings real added value
    - Meaningful engagement with patients, carers and their communities
    - Clear and credible plan which continues to deliver the Quality Improvement, Productivity and Prevention (QIPP) challenge within financial resources
    - Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities
    - Collaborative arrangements for commissioning with other CCGs, local authorities and the NHS Commissioning Board as well as appropriate commissioning support
    - Great leaders who individually and collectively make a real difference.

Key Documents in the Authorisation Process

5. Clinical Commissioning Groups will need to supply a number of key documents as part of the application process, and ensure that the documents provide the necessary evidence in the relevant domains.

6. Key documents include:

    - Proposed CCG constitution, signed off by all member practices
    - Documents detailing governance, financial management, integrated risk management arrangements.
    - CCG Organisational structure & Organisational Development Plan
    - Minutes of multi-professional meetings, governing body and other committees
    - Draft Joint Strategic Needs Assessment
    - Joint Health and Wellbeing Strategy
    - Draft commissioning intentions for 2013/14
    - List of collaborative commissioning arrangements
    - Service Level Agreement with assured commissioning support provider
    - Case studies – providing evidence across a range of domains and service areas
    - Communication and engagement strategy.

Declaration of Compliance

7. The application will be signed by the Chair and Accountable Officer of the CCG and will include a declaration of compliance. This will be made available on the CCG's website, together with key documents. It covers areas including promotion of research, promoting the NHS constitution, promoting choice and shared decision making, environmental and social sustainability, education and training, innovation, the public sector equality duty and procurement requirements,

statutory responsibilities, and detail on the CCG's commissioning arrangements for the main areas of:

- Mothers and newborn
- People with need for support with mental health
- People with learning disabilities
- People who need emergency and urgent care
- People who need routine operations
- People with long-term conditions
- People at the end of life
- People with continuing healthcare needs.

360 Degree Stakeholder Survey

8. The aim of the 360 degree survey is to assess whether foundations for key stakeholder relationships are present at authorisation, and whether relationships are likely to provide a sufficient basis for effective commissioning.

9. The 20 minute website survey will be carried out by Ipsos MORI 6 weeks prior to the application date to enable the results to be collated, fed back to the CCG and the CCG to prepare and submit a commentary with their application.

10. Clinical Commissioning Groups will be asked to submit contact details to Ipsos MORI for the following people, having obtained permission from each of them to do so:

- All constituent member practices
- Other relevant CCGs
- Health and Wellbeing Boards
- Local Authorities, both upper and lower tier
- LINks and other patient groups
- NHS providers
- Clinical networks
- Commissioning Support Services

Desk Top Review

11. The evidence portfolio will consist of the CCG application and accompanying documents, the 360 degree stakeholder survey report, the CCG data profile and the SHA report. The review of the evidence will take place in three stages:

a. a document assessment made by trained and accredited assessors who will assess different types of document depending on their background and experience, and consider the quality of the documents, areas of good practice, areas of concern and areas for development and produce clear reports in the form of a populated template.

b. A domain assessment undertaken by trained domain assessors under the guidance of six national domains leads, one for each domain of assessment following the reports of the document assessors. The domain leads are clinicians who will be the same across each wave of application to ensure that the domains are assessed appropriately and consistently throughout the accreditation process. The domain

assessors will independently assess the documents to judge them against the 6 domains and will produce a report giving strengths, weaknesses or anomalies of the domain in question.

c. Key assessment, which is an overview and triangulation of the findings led by a key assessor allocated to the CCG who will become an expert in that CCG's profile, strengths and challenges. That person considers the CCG application, the submitted documents, the 360 degree summary report and domain reports, and co-ordinates a meeting of the domain assessors which is in two parts, the first considering the evidence submitted and remaining gaps, uncertainties and conflicts to gain a consensus view of the CCG's strengths and weaknesses. A report on the submission is produced prior to the second part of the meeting, to ensure effective triangulation. This second part looks at the SHA progress report, 360 degree report and data profile. The final summary report is then sent to the CCG who are given two days to carry out a factual check on the report prior to the site visit.

Site Visit

12. There will be a one day site visit for each CCG from a team consisting of a senior representative from the NHS Commissioning Board, a member of the NHS Commissioning Board authorisation team, a clinical leader from a CCG from a different area, a lay assessor, finance and commissioning experts.

13. Fairness and equality will be ensured through a standardised authorisation process for every CCG. Assessors will be trained to the same standards and provided with the same guidelines to assess against, applicable to every emerging CCG in England. Conflicts of interest will be carefully monitored and mitigated against with every assessor providing a declaration of interests. Assessors will not take part in the authorisation process for CCGs with whom they have connections.

Timescales for Authorisation

	Wave 1	**Wave 2**	**Wave 3**	**Wave 4**
Stakeholders for 360° surveys contacted, their permission gained.	04/05/2012	22/06/12	20/07/12	17/08/12
360° survey takes place	14/05/12 – 08/06/12	16/07/12 – 10/08/12	13/08/12 – 07/09/12	10/09/12 – 05/10/12
Application submitted	01/07/2012	01/09/2012	01/10/2012	01/11/2012
Authorisation decision back to CCG	31/10/2012	30/11/2012	31/12/2012	31/01/2013

14. All the authorisation waves are equal and there is no difference between a CCG in wave one or wave four in terms of competence. Proposed CCGs in each wave will continue to develop throughout the year as they take on increasing responsibilities, and could have conditions set irrespective of the wave in which

they are placed. There is no advantage in being part of any particular wave as all CCGs will take on their new commissioning duties, if authorised, on 1st April 2013, regardless of their wave.

15. The NHS Commissioning Board is on schedule to have completed the authorisation process by January 2013. The wave process will comprise: 35 proposed CCGs in wave one; 70 in wave two; 67 in wave three; and 40 in wave four. The majority of proposed CCGs were able to secure their first choice of 'wave' but, due to the fact those applications for wave two exceeded availability, some were asked to move into an alternative. These moves were agreed between the proposed CCG and the SHA cluster. Following the initial view of the national authorisation profile for waves two to four, a total of 44 CCGs were asked to move, 22 from wave two to wave three and 22 from wave three to wave four.

16. Within Nottinghamshire :

Wave 1	Bassetlaw
Wave 2	Nottingham West Nottingham North East Rushcliffe
Wave 3	Mansfield and Ashfield Newark and Sherwood

Nottingham City CCG will be going in Wave 2.

17. Whilst Mansfield and Ashfield and Newark and Sherwood CCGs had asked to go in wave 2, the SHA asked them to delay until wave 3 because of the oversubscription for wave 2. There are considerable interlinks between all CCGs in Nottinghamshire County and Nottingham City and the authorisation teams from the NHS Commissioning Board will need to take account of this and the different timescales.

Potential Outcomes for the Assessment Process

18. There are three possible outcomes of the assessment process:

a. **Fully authorised** - satisfies all requirements set out in the legislation
b. **Authorised with Conditions** - conditions or directions specific to the particular criteria which have not been satisfied.
c. **Established but not authorised** - The NHS Commissioning Board will make alternative arrangements for commissioning for that population until the shadow CCG ready to move forward.

All CCGs will have a development plan reflecting the outcome.

Clinical Commissioning Groups Names

19. The expectation is that the requirement for CCG names is likely to be made of three constituent parts only:

    a. the term 'NHS';
    b. a geographical reference;
    c. The term 'clinical commissioning group' or the acronym CCG following a and b.

20. Principia Rushcliffe have, therefore, been asked to change their name to Rushcliffe CCG. The CCG is currently considering this, and it will be confirmed by the governing body. The Strategic Health Authority is using the term Rushcliffe CCG for now.

Other Options Considered

21. There is a requirement for all CCGs to go through the authorisation process before April 2013, and there are therefore no other options to consider.

Statutory and Policy Implications

22. 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.

Implications for Service Users

23. The authorisation process includes rigorous standards for service user participation, and since decisions will now be taken at the most local level possible and appropriate, there will be greater opportunities for services user to influence service design and outcomes.

Financial Implications

24. Each CCG will have a limit of £25 per head in operating costs. All CCGs are within this limit. The joint commissioning work between CCGs therefore gives a good balance in terms of local decision making, and making best use of available commissioning resource.

Human Resources Implications

25. Staff currently employed by Nottinghamshire County PCT will be transferred under TUPE in April 2013 to the CCGs, the NHS Commissioning Board, or the Commissioning Support service.

Implications for Sustainability and the Environment

26. As part of the authorisation process, CCGs will have to demonstrate their commitment to environmental and social sustainability. They will therefore continue and develop the work already begun by the PCT on this area.

RECOMMENDATION/S

It is recommended that the Health and Wellbeing Board:

1) are asked to note the authorisation process for CCGs
2) members will be asked to participate in the 360 degree survey as key partners.

DR STEVE KELL
Chair of the Bassetlaw Clinical Commissioning Group

For any enquiries about this report please contact:
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Constitutional Comments

27. The recommendations within this report fall within the remit of the Health and Wellbeing Board.

Financial Comments

28. The plans within this report will be delivered within the budget allocated.

Background Papers

None.

Electoral Division(s) and Member(s) Affected

All.

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